Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

1 September 2026

09:30 GMT+1 Europe/London

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

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2609 - A OPENING ITEMS

09:30

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00 - Board of Directors Public Agenda - 1 September 2026 v1.7.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
Tuesday 1 September 2026 at 9:30am
Boardroom, Doncaster Royal Infirmary

		Purpose	Page	Time
A	**OPENING ITEMS**			**9:30**
A1	Welcome, apologies for absence and declarations of interest *Mark Bailey, Interim Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known*			10
A2	Actions from previous meeting *Mark Bailey, Interim Chair*	*Review*		
B	**STRATEGY**			**9:40**
B1	Chair's Report including Partnership Update *Mark Bailey, Interim Chair*	*Information*		10
B2	Chief Executive's Report including Partnership Update *Richard Jenkins, Interim Chief Executive*	*Information*		10
B3	Reset Programme Update *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Note*		15
C	**PERFORMANCE**			**10:15**
C1	Integrated Performance Report *(including finance report)* *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Assurance*		10
D	**PATIENTS**			**10:25**
D1	Q4 Learning from Deaths *Dr Joseph John, Medical Director for Operational Stability and Optimisation*	*Assurance*		10
D2	Patient Engagement Event *Karen Jessop, Chief Nurse*	*Decision*		10
D3	2025/26 Patient Experience Annual Report *Karen Jessop, Chief Nurse*	*Note*		5

D4	2026/27 Winter Plan *Denise Smith, Chief Operating Officer*	*Decision*		5
D5	Trauma & Orthopaedic Recovery Plan *Denise Smith, Chief Operating Officer*	*Decision*		10
E	**PEOPLE**			**11:05**
E1	DBTH Way in Action and Well-led *Zara Jones, Deputy Chief Executive* *Zoe Lintin, Chief People Officer*	*Assurance*		10
BREAK 11:15 – 11:30				
F	**STATUTORY & REGULATORY**			**11:30**
F1	Perinatal Safety & Quality (interim) Report *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery* *Dr Joseph John, Medical Director for Operational Stability and Optimisation* *Tomos Barani, Clinical Director Obstetrics & Gynaecology*	*Assurance/ Decision*		10
F2	Maternity and Neonatal 10 Point Plan & Triage Specification Baseline Assessment and NHSE Submission *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery* *Dr Joseph John, Medical Director for Operational Stability and Optimisation* *Tomos Barani, Clinical Director Obstetrics & Gynaecology*	*Decision*		20
F3	Mortuary Oversight – Board Assurance Statement *Dr Joseph John, Medical Director for Operational Stability and Optimisation*	*Note*		5
F4	Fire Safety Policy *Sam Wilde, Chief Finance Officer*	*Decision*		5
F5	NHS Premises Assurance Model Assessment Report 2025/26 *Sam Wilde, Chief Finance Officer*	*Decision*		10
G	**POUNDS**			**12:20**
G1	2025/26 Annual Report & Accounts *Zara Jones, Deputy Chief Executive* *Sam Wilde, Chief Finance Officer*	*Note*		5
H	**GOVERNANCE & ASSURANCE**			**12:25**
H1	Doncaster & Bassetlaw Healthcare Services Limited *Sam Wilde, Chief Finance Officer*	*Note*		5
H2	Constitution, Scheme of Reservation and Delegation & Standing Financial Instructions *Sam Wilde, Chief Finance Officer* *Brenda Thomas, Interim Company Secretary*	*Decision*		5

H3	Chair's Assurance Log - Finance & Performance Committee *Stephen Radford, Non-executive Director*	*Assurance*		5
H4	Chair's Assurance Log - Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5
H5	Chair's Assurance Log - Audit & Risk Committee *Stephen Radford, Non-executive Director*	*Assurance*		5
I	**INFORMATION**			**12:50**
I1	2025/26 Infection, Prevention & Control Annual Report *Karen Jessop, Chief Nurse*	*Information*		-
I2	2025/26 Safeguarding Annual Report *Karen Jessop, Chief Nurse*	*Information*		-
J	**INTEGRATED ASSURANCE**			**12:50**
J1	Board Assurance Framework including Trust Risk Register *Brenda Thomas, Interim Company Secretary* *Executive Directors*	*Approve*		10
J2	Triangulation of Information to Identify Agenda Item Themes *Mark Bailey, Interim Chair*	*Discuss*		5
J3	Board Effectiveness and Demonstrating the DBTH Way • Was sufficient time allocated to enable focused discussion for items? • Did papers contain the appropriate level of detail? • Was open and productive debate achieved? • What could we do less of – more of going forward? • Were discussions courteous and in line with the DBTH Way? *Mark Bailey, Interim Chair*	*Discuss*		5
K	**CLOSING ITEMS**			**13:10**
K1	Minutes of the meeting held on 7 July 2026 *Mark Bailey, Interim Chair*	*Approve*		5
K2	Pre-submitted Questions *Mark Bailey, Interim Chair*	*Discussion*		10
K3	Board of Directors Work Plan *Brenda Thomas, Interim Company Secretary*	*Information*		-
K4	Any other business (to be agreed with the Chair prior to the meeting) *Mark Bailey, Interim Chair*	*Discussion*		10

K5	**Date and time of next meeting:** **Date:** Tuesday 3 November 2026 **Time:** 9:30am **Venue:** Boardroom, Montagu Hospital	*Information*		
K6	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Mark Bailey, Interim Chair*	*Note*		
L	**MEETING CLOSE**			**13:35**

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.

M.C. Bailey

Mark Bailey
Interim Chair

2609- 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 (21.08.2026).pdf

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

Register of Interests

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

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

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

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

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

Richard Jenkins, Interim Chief Executive
Joint Chief Executive at Barnsley Hospital NHS FT & The Rotherham NHS FT
Well-led Advisor Care Quality Commission
Wife is a Community Nurse at York & Scarborough Teaching Hospitals NH FT
Member of the Labour Party

Michael Wright, Interim Assistant Chief Executive
Managing Director, Barnsley Hospital NHS FT
Non-Executive Director, Yorkshire Ambulance Service NHS Trust

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

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

(as at 21 August 2026)

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, Chief Medical Officer
Director - Doncaster and Bassetlaw Healthcare Services Ltd

Brenda Thomas, Interim Company Secretary
Director - BVOT Consulting Ltd
Chair - Activate Hope (Charitable Incorporated Organisation)

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

The following have no relevant interests to declare:

Helen Best	Non-Executive Director
Zara Jones	Acting Chief Executive
Nadeem Murtaza	Non-Executive Director

(as at 21 August 2026)

Fit and Proper Person Declarations

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

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

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

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

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

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

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

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

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

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

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

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

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

(as at 21 August 2026)

2609 - A2 ACTIONS FROM PREVIOUS MEETING

Standing item | Mark Bailey, Interim Chair | 09:30

10 minutes

REFERENCES

Only PDFs are attached

A2 - BoD Action Log - 7 July 2026.pdf

Action notes prepared by: Angela O'Mara
Updated: 12 August 2026

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	7 July 2026

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P26/03/D3**	**Speaking Up Reports** To provide a discussion paper to enable the People Committee to determine the focus and requirements of future Speaking Up reports at both People Committee and Board.	**ZL**	**July 2026**	**Update** - Included on the People Committee action log, discussion paper to be included on June's agenda for subsequent confirmation with the Board in July 2026. **Update 18/6/2026**: included on the agenda @ item E2, reporting frequency to continue as per current practice. **Action closed.**
2.	**P26/05/H1**	**Risk Appetite Statement** 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, ratified by the Board of Directors. **Action closed.**
3.	P26/07/B2	**Non-executive Director Oversight of National Reports / Guidance** To support increased awareness of national reports / guidance	**ZJ**	**September 2026**	**Update 12/8/2026 -** non-executive director colleagues to sign up to NHSE's The Week bulletin. Propose to close action

2609 - B STRATEGY

09:40

2609 - B1 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Mark Bailey, Interim Chair | 09:40

10 minutes

REFERENCES

Only PDFs are attached

B1 - Chair's Report including Partnership Update.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Chair's Report including Partnership Update**			
Sponsor:	Mark Bailey, Interim Chair			
Authors:	Adam Tingle, Deputy Director of Communications & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1-5			

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 July 2026.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	The report recognises the focus of the Reset Programme in improving patient care, experience, access and flow. Its success should be visible in safer, more reliable services and in the Trust's ability to deliver consistently for the patients and communities it serves.
People	The report recognises the central role of colleagues in delivering high-quality care every day. It highlights the need for strong leadership, clear expectations and an organisational design that supports staff to do their jobs well.
Partnerships	The appointment of an Interim Chief Executive working across DBTH, Barnsley and Rotherham creates opportunities to strengthen collaboration whilst maintaining organisational independence. The report emphasises that partnership working should be pursued where it benefits patients, colleagues and the organisations involved.
Pounds	The report links improvement, productivity and financial sustainability as connected priorities within the Reset Programme. It recognises the need to make best use of people, estate and resources so the Trust can remain financially and operationally sustainable for the future.
Health Inequalities	The report reflects the importance of organising services around the needs of the communities served by DBTH. Improvements to access, flow and service design should support more consistent care and help reduce variation in patient experience across different populations.
Legal/ Regulation:	
Partner ICB strategies	

Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

Chair Report September 2026

Since my last report, Dr Richard Jenkins has commenced as Interim Chief Executive of Doncaster and Bassetlaw Teaching Hospitals (DBTH), and I would like to begin by formally welcoming him to the Trust.

As Richard sets out in his first report to the Board, his initial focus is on listening, learning and developing a detailed understanding of DBTH, our services, colleagues and communities. He joins us at an important point, with considerable change already underway and a clear need to maintain momentum.

It is important through this period that we do not lose sight of the purpose behind that change.

Our Three-Year Plan sets out the direction for the organisation, supported by our Reset Programme: An organisation-wide programme of improvement focused on patient care and experience, how our workforce and services are organised, access and flow, productivity and financial sustainability, and our culture and leadership.

At its heart, Reset is about ensuring we provide high-quality, reliable care, support colleagues to do their jobs well and create an organisation that is sustainable for the future.

We should also not allow the scale of the challenge to obscure what happens across our Trust every day. As I reflected in my previous report following time spent with some of our clinical teams, what can feel routine to those working within healthcare is, when we step back, in reality extraordinary care every day.

Across our hospitals and services, colleagues provide care, compassion and expertise at moments which mean a great deal to patients and their loved ones.

We know, as a Board, our responsibility is to ensure that colleagues are supported by an organisation that enables them to deliver that standard of care consistently. That means guiding sustainable improvements to the way services are organised, improving access and experience, and creating the financial and organisational stability needed to support high-quality care for the long term.

Moving from planning to delivery

We have now moved into the second quarter of the first year of our Three-Year Plan and have confidence that the reset programme continues to provide a balanced and connected framework to meet our commitments.

Culture and leadership: Sustained improvement depends on the right culture, clear expectations and strong leadership at every level. The Board will continue to look for evidence that accountability, behaviours and leadership expectations are being embedded consistently across the organisation.

Shape of sites and services: We must continue to consider how services are best organised for the future, taking account of quality, access, sustainability and the needs of the communities we serve. This will require both a clear long-term view and a willingness to pursue opportunities as they emerge.

Workforce and organisational design: A sustainable organisation requires the right workforce, organised in the right way and supported to deliver high-quality care. The scale of the challenge means this work will need continued focus, appropriate support and pace.

Access and flow: Patients should be able to access care when they need it and move through services safely and efficiently. Improvement in this area remains central to both patient experience and the wider performance of the Trust.

Productivity and financial sustainability: The Trust must make the best possible use of its people, estate and resources. Progress in the other areas of Reset must ultimately translate into improved productivity and a more sustainable financial position.

The pillars of reset cannot be viewed in isolation. Financial sustainability is inseparable from the quality and design of our services, how effectively our workforce is organised, how patients move through pathways and the culture and leadership of the organisation.

A considerable amount of work has gone into understanding where are the improvement opportunities and establishing the actions needed and I want to thank all colleagues for engaging and their contribution. There is progress, but we also need to recognise that delivery is not yet consistently moving at the pace or scale required. As referenced within the Chief Executive Report, the next phase of Reset must therefore see us go further and faster - accelerating existing work, strengthening support where it is needed and identifying additional opportunities.

Leadership and partnership

Richard's appointment also represents a different leadership arrangement for DBTH.

Alongside his role here, he remains Chief Executive of Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. Each organisation remains independent, with its own Board, responsibilities and accountability.

That independence is important, but so too is the opportunity created by the arrangement. Where there is a clear benefit for patients, colleagues or the organisations themselves, we should be open to learning from one another, sharing expertise and strengthening collaboration.

I welcome Richard's pragmatic approach to this. The Board will remain closely engaged as opportunities develop and will continue to ensure that any future arrangements are considered in the interests of DBTH and the communities we serve.

I am also pleased to welcome Nadeem Murtaza as a Non-Executive Director, succeeding Dr Emyr Jones. Nadeem brings more than 25 years of senior leadership experience across local government, the NHS and the voluntary sector and will support the work of our People and Quality Board Committees.

Finally, I want to place on record my sincere thanks to Zara Jones.

Zara provided important stability and leadership during her period as Acting Chief Executive and has now returned to her substantive role as Deputy Chief Executive ahead of taking up her new position as Chief Executive of East Cheshire NHS Trust later this year.

She has played an important part in establishing the Three-Year Plan and Reset Programme and in supporting the organisation through a significant period of change. On behalf of the Board, I would like to thank Zara for her contribution and for her continued support through the leadership transition.

Looking ahead

We have a clear Three-Year Plan, an established programme of improvement and an increasingly clear understanding of both the risks we face and the opportunities available to us.

The focus now must be on delivery at greater pace and with greater intensity.

For our Board, our role will continue to be one characterised by engagement, support and encouragement, constructive challenge. We are resolved to recognise and celebrate progress as we meet the challenges and also understand the importance of Board oversight leading to timely and appropriate enablement action to support our colleagues to succeed.

Ultimately, the success of Reset should be evident in the experience of patients and colleagues and in the Trust's ability to deliver consistently against the standards expected of us.

The overall direction remains the right one and through all of this, we must continue to remember what sits behind every performance measure, improvement programme and financial discussion: the patients and communities we serve, and the colleagues who care for them.

Extraordinary care delivered every day across DBTH and care that we are all resolved to continually and sustainably improve.

2609 - B2 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Richard Jekins, Interim Chief Executive | 09:50

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:**	1 September 2026
Report Title/ Ref:	**Chief Executive's Report including Partnership Update**			
Sponsor:	Dr Richard Jenkins, Interim Chief Executive			
Authors:	Adam Tingle, Deputy Director of Communications & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1-5			

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 is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	The report highlights improvements in children's services, the launch of Martha's Rule and ongoing end-of-life care audit, whilst recognising that urgent, diagnostic and planned care timeliness remains a key area for improvement.
People	The report reflects a focus on recognising, developing and supporting colleagues, and progress through apprenticeship routes into clinical careers.
Partnerships	The report demonstrates strengthened partnership working with communities, local authorities, Armed Forces organisations, research partners and schools to improve services and inspire future health and care careers.
Pounds	The report identifies financial improvement as a significant priority, with the Reset Programme delivering in-year savings but requiring accelerated delivery, further schemes and stronger grip to support delivery in 2026/27.
Health Inequalities	The report supports action on health inequalities through improvements in access, experience and community engagement, including initiatives shaped with children and young people, veterans and local partners.
Legal/ Regulation:	The report references regulatory assurance through the Care Quality Commission's Good rating for Children's Services and the implementation of Martha's Rule.
Partner ICB strategies	

Assurance Route	
Previously considered by - including date:	N/A
Any outcomes/next steps / time scales	N/A

Chief Executive Report - September 2026

Organisational position

This is my first report to the Board since joining Doncaster and Bassetlaw Teaching Hospitals (DBTH) as Interim Chief Executive, and I would like to begin by thanking colleagues for the very warm welcome I have received.

My initial focus is on familiarising myself with the organisation, spending time with colleagues and patients, visiting services and developing a clear understanding of our strengths, the challenges we face and the opportunities ahead. Over the past few days, I have already begun visiting clinical areas alongside Karen Jessop, Chief Nurse, and these visits will continue over the coming weeks across our hospital sites and wider services.

I join DBTH at an important point in its development. The Trust has a clear Three-Year Plan and an established programme of improvement through Reset. Considerable work has been undertaken to understand where improvement is required and establish the actions needed in response.

The priority now is increasingly one of delivery, maintaining momentum, accelerating work already underway and identifying where we need to go further or intensify our efforts. This will require clear accountability, additional support where needed and a continued focus on ensuring that improvement translates into measurable benefits for patients, colleagues and the organisation.

Alongside my role at DBTH, I remain Chief Executive of Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. Each organisation remains independent, with its own Board, responsibilities, priorities and accountability to the communities it serves.

There is, however, an opportunity through this arrangement to strengthen partnership working where it makes sense to do so. Our organisations share many of the same challenges and serve neighbouring, and sometimes overlapping, communities, and I want us to be open to opportunities to learn from one another, share expertise and work together where there is a clear benefit for patients, colleagues or the organisations themselves.

Leadership continuity will also be an important focus over the coming months. Zara Jones has returned to her substantive role as Deputy Chief Executive following her period as Acting Chief Executive and will remain with the Trust ahead of taking up her new role as Chief Executive of East Cheshire NHS Trust later this year. I would like to thank Zara for the leadership she has provided and for her continued support during this transition.

One of my first priorities will be to begin recruitment to the substantive Deputy Chief Executive role, alongside recruitment of a new Chief People Officer. Following Zara's departure, and until a substantive Deputy Chief Executive is appointed, Michael Wright, former Managing Director at Barnsley Hospital NHS Foundation Trust, will provide additional senior leadership support to me and the Executive Team.

There is much for me to learn in these first weeks, but what is already clear is the commitment of colleagues across DBTH and the strength of the foundations already in place. My focus will be on working with the Board, Executive Team and colleagues across the organisation to build on those foundations and maintain the pace of improvement.

Progress against our strategic priorities

Patients: Children's Services at Doncaster Royal Infirmary and Bassetlaw Hospital have been rated Good by the Care Quality Commission across all five assessment areas - Safe, Effective, Caring, Responsive and Well-led - recognising improvements in the quality and delivery of care. Martha's Rule has also launched across inpatient areas at both hospitals, giving patients, families and carers an additional route to escalate concerns about deterioration. The latest National Audit of Care at the End-of-Life data is also informing work to further improve care and experience for patients approaching the end of life. Timeliness of care, whether in the Emergency Departments or for diagnostics or for planned treatments, is not good enough and is behind the trajectories that we have set for the year. I'm please to say that timeliness of cancer treatment is much better.

People: Nadeem Murtaza has joined the Board as a Non-Executive Director, bringing more than 25 years of senior leadership experience across local government, the NHS and the voluntary sector. The shortlist for the DBTH Star Awards 2026 has also been announced ahead of the ceremony in October, recognising the contribution of colleagues and teams across the Trust. In addition, Emily Gale has become DBTH's first apprentice midwife to qualify, demonstrating the value of alternative routes into clinical careers and our commitment to developing our workforce.

Partners: Partnership working continues to strengthen our links with the communities we serve. Paediatric services at Doncaster Royal Infirmary have achieved 'Consulted Child Friendly' status through Doncaster Council's Young Advisors, recognising the involvement of children and young people in shaping services. Working with Armed Forces organisations, veterans and community partners, we have also developed a new Hospital Guide and Veterans Passport. Our Children's Therapy team has reached its recruitment target for the national CHESS research study, while We Care into the Future has once again brought together schools and partners to inspire around 2,000 local young people to consider careers in health and care.

Pounds: At Month 4, the Reset Programme is delivering in-year savings but the focus now is on accelerating delivery across existing workstreams, identifying further schemes of work and providing additional support where needed to increase the pace of delivery. I will be reviewing the robustness of the current programme and am likely to take early action to strengthen delivery. Alongside this, we are exploring further opportunities to support the Trust's £46.3 million ambition for 2026/27 and make the best use of our resources. Whilst the financial improvement needed is challenging, it is also an opportunity for us to look hard at how we deliver services and find ways to do so more productively for our patients.

Looking ahead: Risks and priorities

Key risks

- Delivering recurrent financial improvement at the pace and scale required, including identifying and progressing further opportunities to support the Trust's 2026/27 plan and longer-term sustainability.
- Variation in operational performance and patient outcomes across services and sites, including sustained very long waits within a small number of challenged specialties but also too long generally for planned care.
- Improvement programmes, including Reset, not accelerating sufficiently or delivering measurable benefits at the pace and scale required, with a need to intensify existing work and identify additional schemes where necessary.
- Maintaining sufficient leadership capacity and organisational continuity during a period of Executive transition and recruitment, including ensuring appropriate support is available to maintain delivery.

- Capacity and capability to deliver significant organisational, workforce and digital transformation alongside operational priorities.
- Failure to consistently embed the behaviours, accountability and organisational grip required to sustain and accelerate improvement.
- Delivery risks associated with major programmes, including preparation for the Electronic Patient Record.

Key priorities to support addressing our risks

- Maintaining delivery of the Three-Year Plan while accelerating and intensifying progress through the Reset Programme.
- Going further and faster on productivity, efficiency, workforce improvement and service redesign, while identifying additional schemes and opportunities to support delivery of the financial plan.
- Continuing improvement in Urgent and Emergency Care, patient flow and reducing delays, with additional support targeted where progress needs to accelerate.
- Strengthening governance, assurance and accountability so that delivery is closely tracked and improvement activity translates into measurable benefits.
- Maintaining leadership continuity and sufficient capacity during Executive transition, with additional senior support in place where required.
- Embedding the DBTH Way, agreed organisational behaviours and clear expectations around accountability and delivery.
- Continuing preparations for implementation of the Electronic Patient Record alongside wider organisational transformation.
- Ensuring that existing programmes are supported to deliver at greater pace, while remaining open to further opportunities for improvement across the organisation.

Board takeaways

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

- My immediate focus is on developing a clear understanding of DBTH, its services, colleagues and communities, while maintaining momentum on the priorities already established.
- The Three-Year Plan and Reset Programme remain central to improvement. The next phase must be characterised by greater pace and intensity, accelerating existing work, strengthening accountability and identifying further opportunities where more is required.
- DBTH will remain an independent organisation, while the shared Chief Executive arrangement provides opportunities to strengthen collaboration with Barnsley and Rotherham where there is a clear benefit for patients, colleagues or services.
- Maintaining leadership capacity and continuity will be important over the coming months. Recruitment of a substantive Deputy Chief Executive and Chief People Officer will progress, with Michael Wright providing additional senior leadership support following Zara Jones' departure and until a substantive Deputy Chief Executive is appointed.
- Through this period of transition, our focus must remain firmly on delivering organisational stability, supporting areas that need to move faster and ensuring that improvement translates into demonstrable benefits for patients, colleagues and communities.

2609 - B3 RESET PROGRAMME UPDATE

Information Item | Zara Jones, Deputy Chief Executive & Executive Directors | 10:00

10 minutes

REFERENCES

Only PDFs are attached

B3 - Reset Programme Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Reset Programme: Month 4 Delivery and Financial Risk Update**			
Sponsor:	Zara Jones, Deputy 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 the Month 4 delivery position, material financial and workforce risks, the first tranche of additional actions and the next steps.			
Impacts on Strategic Risks (BAF 1-7)	BAF 1-7: the most direct impacts relate to financial sustainability, quality and access, workforce, service configuration, partnerships and delivery of transformation.			

Executive Summary – Key messages and Issues

At Month 4, the Reset Programme has moved beyond mobilisation into delivery, with evidenced progress in operational improvement, procurement, access and flow and culture and leadership.

The Trust delivered £1.5m of in-year savings in Month 4 against £3.2m planned. Cumulative in-year delivery at the end of month 4 is £9.7m against an original £11.4m plan which includes £3.9m of non-recurrent savings. The risk-adjusted in-year forecast, using the NHSE scheme development and risk rating is £27.7m.

Reset Board agreed a first tranche of nine additional actions centred on tighter existing controls and Trust-led cash delivery. Their current estimate is £0.9m-£2.5m in 2026/27. Further development of schemes will continue through Reset Board and strengthened financial turnaround arrangements from September.

Recommendations

The Board is asked to:

1. NOTE the Month 4 programme, performance, workforce and financial position,
2. NOTE the risk-adjusted in-year forecast of £27.7m.
3. NOTE the first tranche of additional actions agreed by Reset Board, with benefits subject to Finance and quality validation, and
4. NOTE the principal delivery risks and next steps.

Healthier together – delivering exceptional care for all

Patients	Operational efficiencies and model changes are subject to clinical, quality and access safeguards, with performance monitored through established routes.
People	Reset workforce impacts are subject to safe staffing controls, consultation, staff-side engagement and Finance validation.
Partnerships	Shape work depend heavily on ICB's, community and regional partners.

Pounds	The reset programme is the vehicle to delivery of the annual savings requirement.
Health Inequalities	Scheme-level EQIA, access analysis and mitigation are required as part of normal practice before implementation.
Legal/ Regulation:	Individual schemes remain subject to statutory, regulatory, quality, equality, employment, procurement, contractual and consultation requirements.
Partner ICB strategies	The programme aligns with neighbourhood health and care closer to home, but delivery timescales and financial treatment require explicit partner and commissioner agreement.
Assurance Route	
Previously considered by - including date:	Month 4 dashboard, pillar reports and additional options considered by Reset Board on 19 August 2026. Agency and bank deep dive considered by Finance and Performance Committee on 28 July 2026.
Any outcomes/next steps / time scales	Immediate controls and additional options progress from September 2026, next Reset Board on 16 September 2026. Agency and bank deep-dive follow-up to Finance and Performance Committee in October 2026.

1. Purpose

This paper provides the Board with the Month 4 position for the Reset Programme and the 2026/27 element of the Three-Year Plan. It brings together delivery, finance, workforce, pillar assurance and the additional actions agreed at Reset Board on 19 August 2026.

Across the major programmes, delivery activity is increasingly established, but the key requirement remains conversion into evidenced outcomes, validated WTE change and recurrent cash benefit.

2. Financial position and delivery

The annual in-year requirement remains £46.290m. The distinction between the formal target, currently identified value and risk-adjusted forecast is summarised below.

Efficiency Plan Status £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
Fully Developed - in delivery	4,077	20,319	19,034	(1,285)
Fully Developed - not yet started	0	1,487	437	(1,050)
Plans in Progress	10,311	400	6,335	5,935
Opportunity	31,902	24,084	20,484	(3,601)
Unidentified	0	0	0	0
Total	**46,290**	**46,290**	**46,290**	**(0)**

Efficiency Plan Risk £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
High	32,657	24,606	27,174	2,568
Medium	10,072	9,535	4,183	(5,353)
Low	3,561	12,149	14,934	2,785
Total	**46,290**	**46,290**	**46,290**	**(0)**

3. Major programme updates

3.1 Culture and Leadership

The Culture and Leadership work continues to embed consistent behavioural expectations, visible leadership and a stronger learning culture. The agreed behaviours are being incorporated into appraisal and leadership conversations, supported by work on civility, Just Culture, speaking up and colleague engagement. The next phase will focus on consistent implementation and finalising the measures used to demonstrate impact.

3.2 Shape of DBTH

Work continues to develop the Trust's longer-term service and estate models, including the future role of sites, paediatric services, neighbourhood health and opportunities to provide more care closer to home. Business case development, clinical analysis and partner engagement are progressing. Any future changes will remain subject to the appropriate clinical, financial, quality, engagement and decision-making processes.

3.3 Workforce and Organisational Design

The workforce programme continues to strengthen controls over agency and bank use and to progress corporate and divisional workforce reviews. Further workforce and organisational design options are being developed through the relevant Executive, workforce and financial processes. Implementation will continue to balance recurrent benefit with consultation, safe staffing and maintenance of patient services.

3.4 Access and Flow

Access and Flow work is moving from review into implementation across urgent and emergency care, elective care, theatres, outpatients and diagnostics. Improvement plans are being translated into clear actions and ownership, urgent care and ward process changes are progressing, and agreed inpatient consolidation work is moving forward with the required safeguards. The focus is on converting this activity into sustained performance improvement and validated financial benefit.

3.5 Productivity and Financial Reset

Procurement, medicines, estates and facilities workstreams continue to develop opportunities through contract review, benchmarking and service improvement, while roll-over and technical schemes remain on track. Some areas require additional capacity, approval or further validation before benefits can be confirmed. The immediate focus is on converting the pipeline into recurrent, Finance-validated savings.

4. Additional actions and strengthened turnaround

Reset Board agreed a first tranche of nine additional actions on 19 August 2026. These strengthen existing controls and prioritise cash-releasing actions within the Trust's decision rights while longer-lead clinical and partnership work continues.

Separately, the Interim Chief Executive has instigated a refreshed review of NHS and HFMA control checklists and is reviewing what additional support resource may be required. This is intended to evidence whether

existing controls are fully applied consistently across the Trust and to accelerate gap closure, while the Reset Programme continues to manage clinical and service transformation.

5. Governance, risks and next steps

Reset Board remains the central delivery forum, supported by the benefits tracker, finance validation, quality impact assessment, equality impact assessment where required, and clinical and professional engagement. The transition to integrated reporting to enhance visibility of programme delivery was not complete for August. Work continues to ensure this is resolved for future monthly reporting.

The next reporting period will focus on validating the additional actions, completing the control-checklist review and strengthened financial arrangements, aligning outputs to access and cash delivery, reconciling the workforce tracker and progressing clinical transformation work. The next Reset Board is on 16 September 2026. A follow-up to the recent Bank and Agency deep dive is due at the Finance and Performance Committee in October 2026.

2609 - C PERFORMANCE

10:15

2609 - C1 BOARD INTEGRATED PERFORMANCE REPORT (INCLUDING FINANCE REPORT)

Discussion Item | Zara Jones, Deputy Chief Executive & Executive Directors | 10:15

10 minutes

REFERENCES

Only PDFs are attached

- C1 - Integrated Performance Report.pdf
- C1 - Appendix 1 - IPR.pdf
- C1 - Appendix 2 - Finance & Activity Report 26-27 Month 4.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Integrated Performance Report**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Authors:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Nick Mallaband, Chief Medical Officer Sam Wilde, Chief Financial Officer Denise Smith, Chief Operating Officer		
Appendices:	Appendix 1 – IPR Appendix 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 July 2026 IQPR shows a mixed but improving position and continues to support Moderate Assurance. Urgent and emergency care improved during the month, cancer performance was above the monthly trajectory across all three reported standards, and the latest productivity measures place the Trust in the national top quartile. The most material gaps are understood, are concentrated in a number of specific pathways and services and are subject to established improvement plans and Executive oversight. Some measures remain unvalidated or are reported with a time lag and should therefore be considered alongside subsequent committee updates.

Within access, four-hour performance improved to 73.3% but remained below the 76% trajectory, and ambulance handovers within 15 minutes were 51.4%. The principal causes are known and include flow constraints following the decision to admit, delays in senior and specialty review, and inconsistent use of alternative pathways. The Bassetlaw site remains the main driver of handover performance, while T&O and ENT account for most long waits and MRI and Audiology for most diagnostic waits.

Key quality metrics continue to be the focus of attention, including SHMI, Sepsis, VTE assessment, Gram-negative infections and midwifery staffing. These measures are being managed through established clinical governance, case review, audit and targeted improvement work, with the Klebsiella and Pseudomonas reviews identifying no single systemic issue. Current controls include exception monitoring, workforce escalation and oversight through the relevant safety and quality forums.

<u>Financial Risks</u>

The financial risks are updated on a monthly basis following the 26/27 plan submission. There has been an improvement of £20.5m in the gross risk since the planning submission (£45.7m to £25.1m). The main risk is

centred around delivery the Improvement Delivery Programme (Reset). Mitigations have improved by £6.5m (£6.8m to £13.8m) since plan submission, with the main mitigations being related to contract negotiations with SY ICB and increasing maturity of delivery plans for the Reset Programme. The net risk has reduced by £27.0m to £11.9m.

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 4 the current underlying deficit is estimated at £51.0m and the 26/27 exit rate is estimated at £10.1m in line with plan.

Latest published data (to March 2026) shows that Implied productivity is 0.2% (per £) **above** and 2.9% (per WTE) **above** pre-COVID levels, placing the Trust in the best quartile of performance nationally on each measure. This is the first time implied productivity per £ has moved above pre-COVID levels and that the Trust has been in the top quartile of performance on that measure.

Efficiency schemes implemented during the year will yield recurrent full year savings of £10.6m going forward and a 42.5 WTE recurrent reduction in the funded establishment.

Delivering the 2025/26 committed plan

The Trust is reporting a £5.1m year to date deficit, which is £2.3m adverse to plan due to £1.7m shortfall on efficiency delivery and £1.3m month 4 Deficit Support Funding (DSF) not yet being earned, only being partially offset by non-recurrent technical benefits. Excluding the deficit support funding the Trust is £1.0m adverse. Q2 DSF is being withheld at this point but will be re-assessed at the end of September. To qualify for more DSF funding, further progress de-risking the plan must be demonstrated, in particular ensuring 100% of the CIP programme is fully developed (currently 42.1%).

Out-patient new and follow up and daycase activity are below plan in month. Elective activity is above plan mainly due to maternity admissions, however ERF 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 £1.1m, a £0.4m increase from M3 mainly in Surgery and UEC. Bank costs in month are £1.5m, in line with M3. Additional sessions increased by £0.3m, mainly within UEC.

The funded establishment has reduced by 145.1 Whole Time Equivalents (WTE) in month 4 due to CIP and is below (ie better than) plan. Based on the number of contracted staff, there is a 'vacancy' rate of 4.2% gross (down from 5.9% last month) but a 1.8% over-establishment net of temporary staffing (0.3% vacancy rate last month).

Latest published data (full year 2025/26) shows that Implied productivity is 11.4% (per £) and 8.7% (per WTE) **better** than 2024/25, placing the Trust in the best quartile of performance nationally for each measure.

Year to date in-year efficiency savings (which include non-recurrent efficiencies) are £9.7m (adverse to plan by £1.7m). Forecast full year in-year savings are £46.3m in line with plan, with a risk adjusted forecast of £27.7m.

The cash balance is £12m and has increased by £3.9m as a result of the receipt of quarterly Education monies £4m. Revenue cash support from NHSE is in the process of being requested to support the cash position

Capital expenditure (excluding charitable funds) is £1.0m against a plan of £2.0m YTD. Forecast expenditure remains in line with plan at £54.0m

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	

DBTH Integrated Performance Report

July 2026

Interpreting SPC charts

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

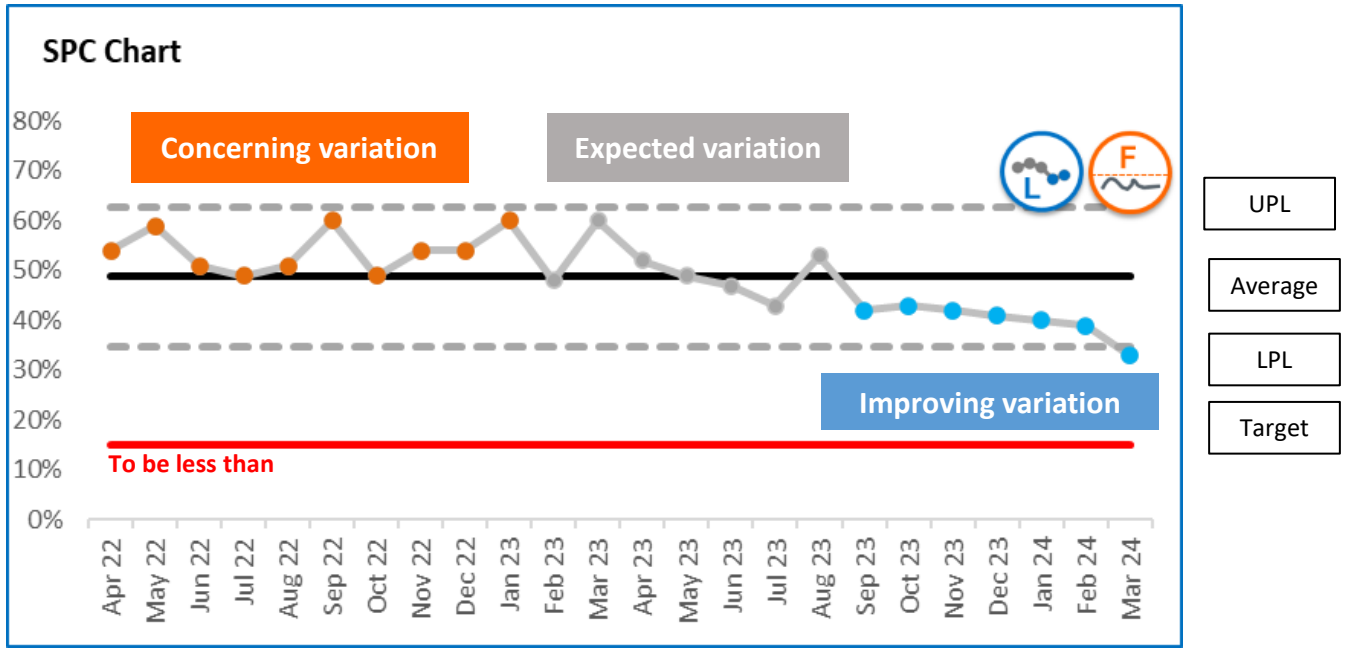
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Interpreting summary icons

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

These icons provide a summary view of the important messages from SPC charts.

		Assurance			
	Icon				No Target
Variation		Results outside the expected range in a positive direction. Performance is likely to remain above the expected level.	Results outside the expected range, but performance naturally moves around the expected level.	Results outside the expected range but still below the expected level — improvement is seen, but performance remains below expectation.	Results outside the expected range, but no expected level is set so assurance cannot be given.
		Results outside the expected range in a positive direction. Performance is likely to remain above the expected level.	Results outside the expected range, but performance naturally moves around the expected level.	Results outside the expected range but still below the expected level — improvement is seen, but performance remains below expectation.	Results outside the expected range, but no expected level is set so assurance cannot be given.
		Typical month-to-month variation, with performance consistently above the expected level.	Typical month-to-month variation — performance naturally moves around the expected level.	Typical month-to-month variation, with performance consistently below the expected level.	Typical month-to-month variation, but no expected level is set so assurance cannot be given.
		Results outside the expected range in a concerning direction, although performance remains above the expected level.	Results outside the expected range, but performance naturally moves around the expected level.	Results outside the expected range and below the expected level — and in a concerning direction.	
		Results outside the expected range in a concerning direction, although performance remains above the expected level.	Results outside the expected range, but performance naturally moves around the expected level.	Results outside the expected range and below the expected level — performance is likely to remain below expectation.	

NHS Oversight Framework 2026/27 KPIs - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q1 26/27	75.00%	**74.94%**			2.02
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q1 26/27	80.0%	**73.2%**			3.29
Community Services - Patients waiting over 52 weeks	May 26	-	0.00%			1.00
ED - Attendances managed within 4 hours - Acute trust footprint QTD	Q1 26/27	78.00%	**72.27%**			3.11
ED - Attendances over 12 hours in department QTD	Q1 26/27	-	4.7%			1.66
RTT - Patients waiting 18 weeks or less	May 26	-	62.58%			3.13
RTT - Patients waiting over 52 weeks	May 26	1.00%	**2.45%**			3.56
RTT - Planned v actual 18 week performance	Q4 25/26	0.0%	**-1.8%**			2.71

Key performance indicators - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	26/27 NOF 26/27 Standard contract 26/27 MTP	Jul-26	76%	14116	19256	73.3%	-2.7%	76%	54356	74877	72.6%	-3.4%
Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours.	26/27 MTP	Jul-26	69%	9477	14564	65.1%	-4.1%	69%	36346	56693	64.1%	-5.0%
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	26/27 MTP	Jul-26	96%	3234	3394	95.3%	-0.8%	96%	13387	14109	94.9%	-1.4%
12 hours in A&E department	26/27 NOF 26/27 Standard contract 26/27 MTP	Jul-26	4.9%	915	19256	4.8%	-0.1%	5%	3418	74877	4.6%	-0.7%
Ambulance handovers within 15 minutes	26/27 Standard contract	Jul-26	65%	2011	3911	51.4%	-13.6%	65%	8409	15435	54.5%	-10.5%
Ambulance handovers over 45 minutes	26/27 MTP	Jul-26	2%	134	3911	3.4%	1.8%	2%	454	15435	2.9%	1.0%
Average ambulance handover times	26/27 MTP	Jul-26	00:20:00	00:18:20	00:18:20	00:18:20	-00:01:40	00:20:30	00:18:20	00:18:20	00:18:20	-00:02:10
Overnight total general and acute bed occupancy %	26/27 MTP	Jul-26	95%	640	728	87.9%	-7.06%	95%	2728	2967	91.9%	-2.8%
Non elective LOS – acute	26/27 MTP	Jul-26	7.08	20366	2844	7.16	0.09	7.12	83324	11212	7.43	0.31
Percentage of patients discharged on discharge ready date	26/27 MTP	Jul-26	82.7%	2284	2844	80.3%	-2.41%	83%	8853	11212	79.0%	-3.8%
Average delay (exclude zero delay)	26/27 MTP	Jul-26	2.74	560	178	3.15	0.41	2.64	2359	750	3.15	0.51
Mixed Sex Accommodation - nationally reported breaches in month	26/27 Standard contract	Jul-26	0	1	1	1	1	0	3	3	3	3
30 day readmission rate band	26/27 NOF	24/25	A1 = Significantly higher than the national average at the 99.8% level									
14 day readmission rate	26/27 NOF	Jul-26		9232	110746	8.3%			36964	440785	8.4%	

Key performance indicators - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
14 day readmission rate	26/27 NOF	Jul-26		9232	110746	8.3%			36964	440785	8.4%	
Number of patients cared for in corridors - ED	26/27 NOF	Jul-26		-	-	78			-	-	462	
Percentage of patients waiting less than 18 weeks from referral to treatment	26/27 NOF 26/27 Standard contract 26/27 MTP	Jul-26	65.9%	34872	55132	63.3%	-2.6%	65.9%	34872	55132	63.3%	-2.6%
Referral to treatment percentage waits over 52 weeks for incomplete pathways	26/27 NOF 26/27 Standard contract	Jul-26	0.7%	1633	55132	3.0%	2.2%	0.7%	1633	55132	3.0%	2.2%
Number of 52+ week RTT waits	26/27 MTP	Jul-26	362	1633	1633	1633	1271	362	1633	1633	1633	1271
Percentage of patients waiting no longer than 18 weeks for a first appointment	26/27 MTP	Jul-26	77%	23831	32123	74.2%	-2.8%	76%	92847	124975	74.3%	-1.8%
RTT waiting list – total	26/27 MTP	Jul-26	54276	55132	55132	55132	856	54276	55132	55132	55132	856
28 day Faster Diagnosis Standard	26/27 NOF 26/27 Standard contract 26/27 MTP	Jun-26	80.0%	1795	2171	82.7%	2.7%	80%	4500	5867	76.7%	-3.8%
62 day referral to treatment for all cancer patients	26/27 Standard contract 26/27 MTP	Jun-26	72.7%	143.5	185	77.6%	4.9%	72%	436.5	574	76.0%	4.1%
31 day decision to treatment for all cancer patients	26/27 NOF 26/27 Standard contract 26/27 MTP	Jun-26	95.2%	203	210	96.7%	1.5%	95%	606	626	96.8%	1.5%
Diagnostic waiting times	26/27 NOF 26/27 Standard contract 26/27 MTP	Jul-26	81%	10493	14169	74.1%	-6.7%	79%	10493	14169	74.1%	-5.3%
Cancelled operations not rebooked within 28 Days	26/27 Standard contract	Jun-26	0	3	3	3	3	0	17	17	17	17
Percent of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance	26/27 MTP	Jul-26	3.3%	1743	49544	3.5%	0.2%	3%	1743	49544	3.5%	0.2%

Our Access domain matrix

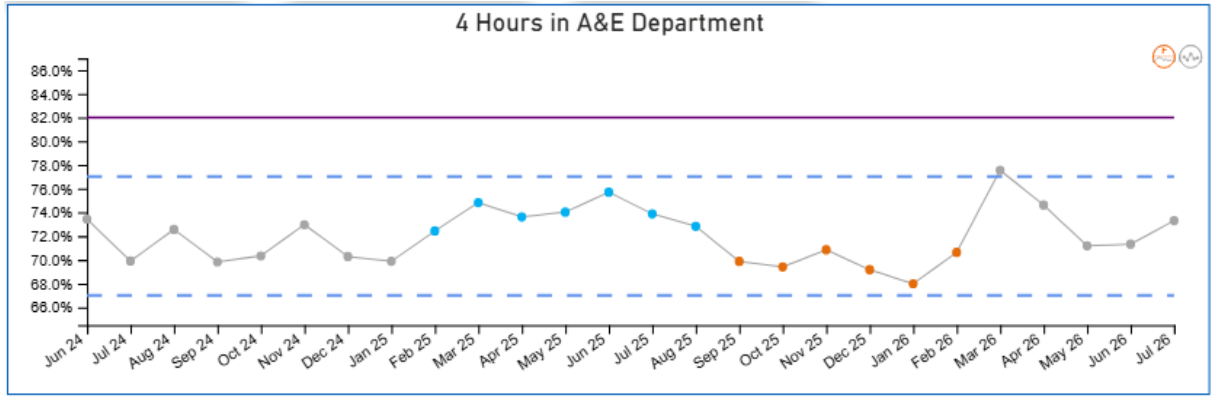
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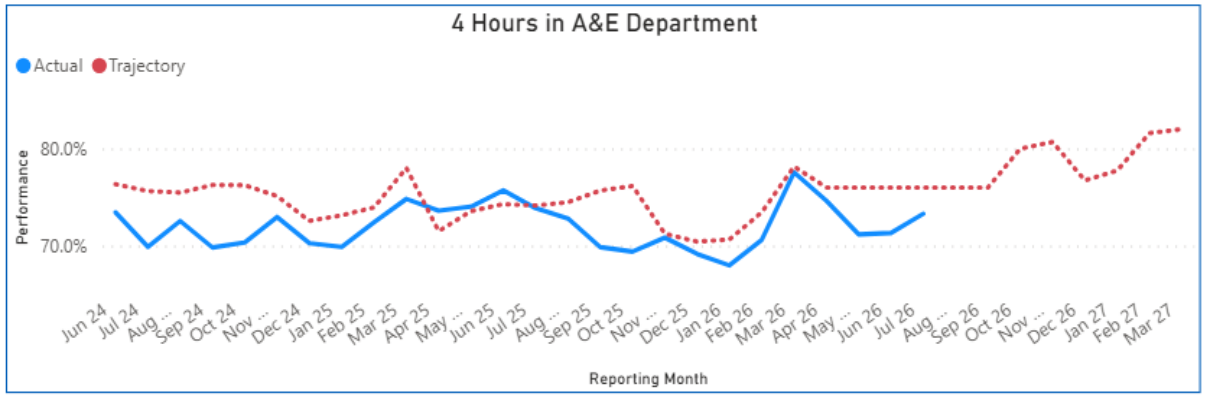
		Assurance			
	Icon				No Target
Variation				Ambulance handovers within 15 minutes Ambulance handovers over 45 minutes	
			Average ambulance handover times		
			12 hours in A&E department Overnight total general and acute bed occupancy % Percentage of patients waiting no longer than 18 weeks for a first appointment 28 day Faster Diagnosis Standard 62 day referral to treatment for all cancer patients Mixed Sex Accommodation - nationally reported breaches in month Cancelled operations not rebooked within 28 Days Percent of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance	Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours 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 31 day decision to treatment for all cancer patients Diagnostic waiting times Percentage of patients discharged on discharge ready date Average delay (exclude zero delay) Non elective LOS - acute	14 day readmission rate Number of patients cared for in corridors - ED
					
					

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours





Understanding the performance

In July 2026, 73.3% of A&E attendances (all types) were admitted, discharged or transferred within 4 hours of arrival. against a plan of 76%. Performance has improved from June but remains below plan.

The principal drivers are:

- Impact of performance at DRI on overall Trust performance (DRI 68.5%)
- Flow and capacity constraints within the admitted pathway, following a decision to admit. (29.5% admitted performance)
- Delays in ED and specialty review and discharge within ED impacting the non-admitted pathway (73.9% non admitted performance)
- The proportion of patients seen by a decision maker, with delays affecting timely decision-making and overall flow

Actions (SMART)

- **Admitted pathway**: Increase SDEC / admission avoidance to reduce admissions by 5 patients per day and improve admitted 4-hour performance by October 2026.
- **Clinical decision-making**: Increase the proportion of patients seen by a clinical decision maker within 60 minutes from 50% to 60% by October 2026.
- **Non-admitted pathway**: Improve specialty review and discharge processes to improve non-admitted 4-hour performance from 73.9% to 80% by October 2026.
- **EEMAC implementation**: Implement EEMAC at Bassetlaw to support the non-admitted pathway and improve 4-hour performance by 5 percentage points by October 2026.

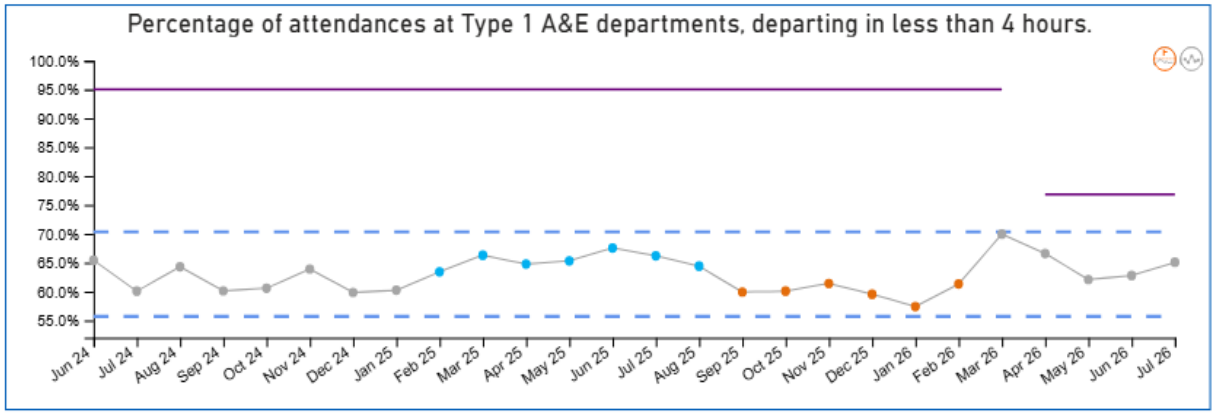
Risks

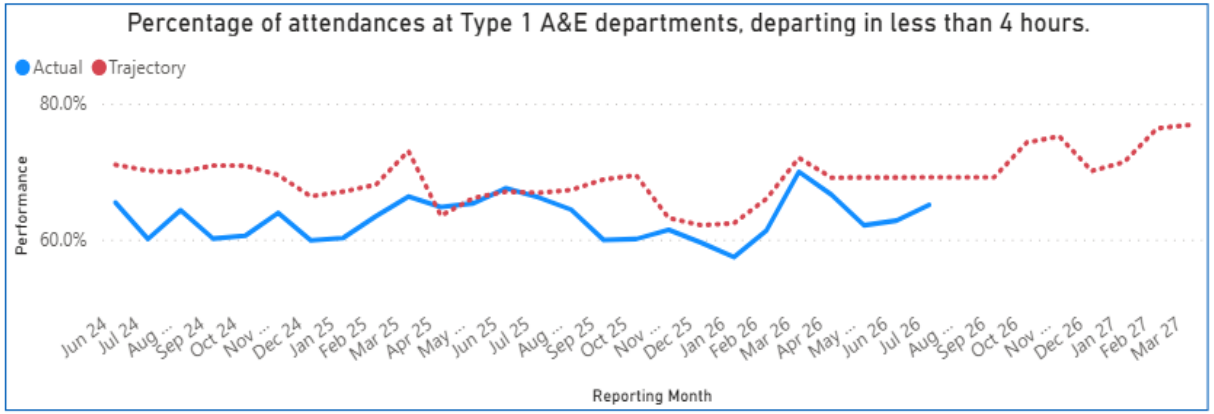
- **Workforce capacity:** Availability of senior decision makers, SDEC and specialty teams to deliver the models of care for ED, SDEC and the Acute pathway.
- **Bed and flow capacity:** Inpatient bed availability and delays to discharge may limit improvement in the admitted pathway.
- **Demand:** Higher-than-expected ED attendances or acuity may offset admission avoidance and pathway improvements.
- **Pathway adoption:** Variation in specialty embedding of new pathways specialty engagement and adoption of new pathways may limit impact.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours





Understanding the performance

In July 2026, 65.1% of attendances (T1) were admitted, discharged or transferred within 4 hours of arrival, against the plan of 69%. Performance has improved since June but remains below plan.

Principal drivers of Type 1 performance are:

- Impact of performance at DRI on overall Trust performance (DRI 68.5%)
- Flow and capacity constraints within the admitted pathway, following a decision to admit. (29.5% admitted performance)
- Delays in ED and specialty review and discharge within ED impacting the non-admitted pathway (73.9% non admitted performance)
- Inconsistent TTIA within 15 minutes and low streaming of lower-acuity patients, limiting use of alternative pathways.

Actions (SMART)

- **Admitted pathway**: Increase SDEC / admission avoidance to reduce admissions by 5 patients per day and improve admitted 4-hour performance by October 2026.
- **Clinical decision-making**: Increase the proportion of patients seen by a clinical decision maker within 60 minutes from 50% to 60% by October 2026.
- **Non-admitted pathway**: Improve specialty review and discharge processes to improve non-admitted 4-hour performance from 73.9% to 80% by October 2026.
- **EEMAC implementation**: Implement EEMAC at Bassetlaw to support the non-admitted pathway and improve 4-hour performance by 5 percentage points by October 2026.
- **Streaming**: Improve streaming of lower-acuity patients to alternative pathways to 15%-20% by the end of Q2.

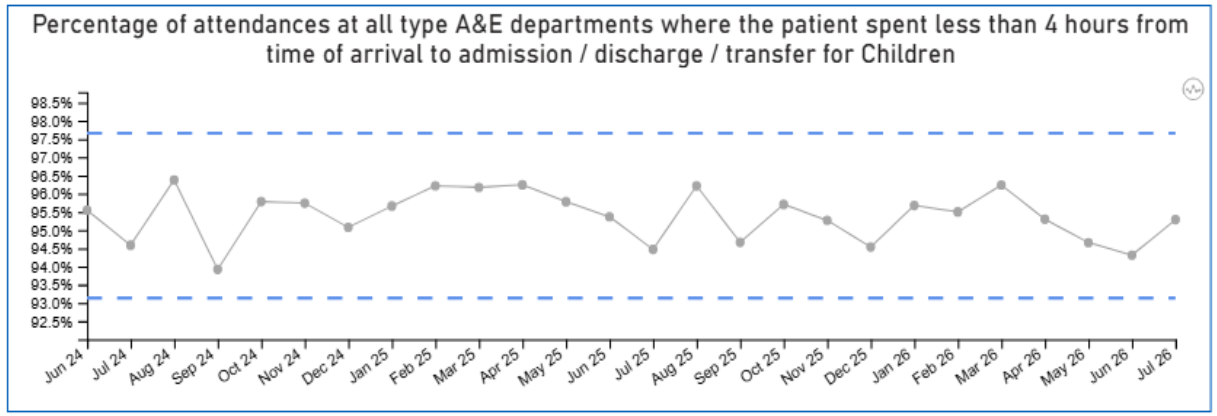
Risks

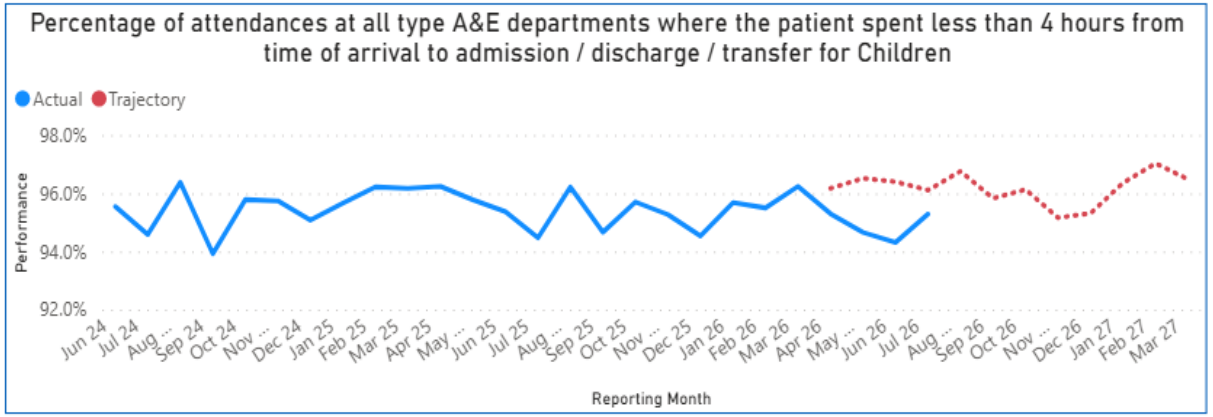
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- **Bed and flow capacity:** Inpatient bed availability and delays to discharge may limit improvement in the admitted pathway.
- **Demand:** Higher-than-expected ED attendances or acuity may offset admission avoidance and pathway improvements.
- **Pathway adoption:** Variation in specialty embedding of new pathways specialty engagement and adoption of new pathways may limit impact.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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





Understanding the performance

In July 2026, 95.3% of attendances (children) were admitted, discharged or transferred within 4 hours of arrival, against the plan of 96%%. Performance has improved since June but remains below plan.

The principal driver of the underperformance is Doncaster, with performance at 93.1%. The main delay in the pathway is the time to see senior decision maker in the children's area.

Actions (SMART)

- **Doncaster performance**: Improve children's 4-hour performance from 93.1% to ≥96% by September 2026 through an improvement in the time to see senior decision maker
- **EM leadership**: Recruit and appoint a Paediatric Emergency Medicine (PEM) Consultant to provide clinical leadership and drive improvement in the children's ED pathway by December 2026.

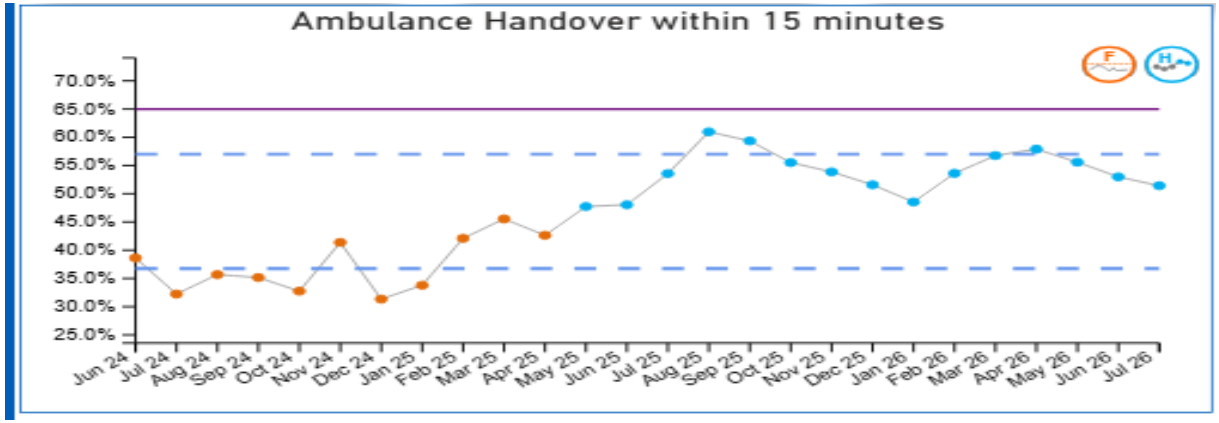
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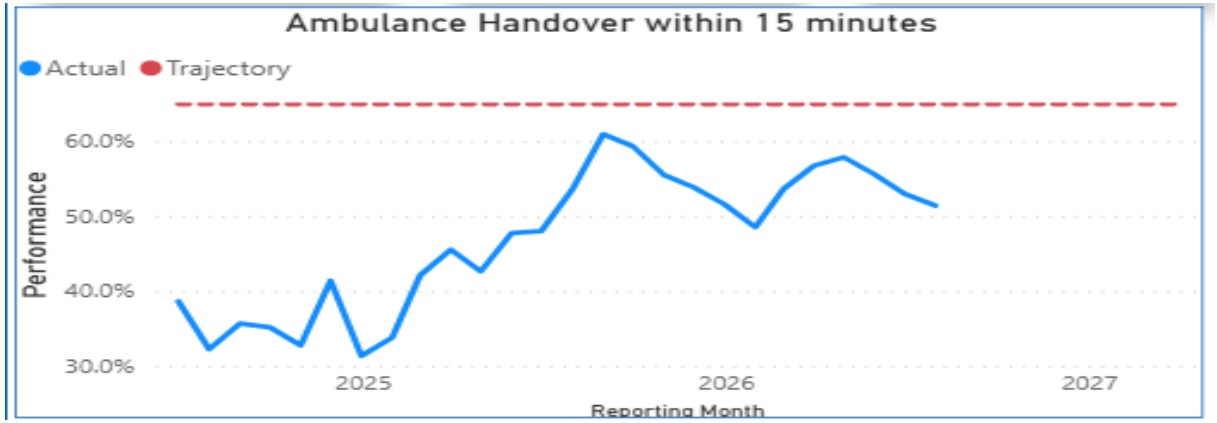
- **Recruitment:** potential delays to recruit a PEM Consultant within the required timeframe.
- **Workforce capacity:** Limited paediatric/ED clinical capacity may delay implementation of pathway improvements.
- **Retention:** Risk of sustaining improvements if PEM leadership capacity is not maintained.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Handovers between ambulance and hospitals within 15 minutes





Understanding the performance

In July 2026, 51.4% of ambulance handovers took place within 15 minutes against the contractual standard of 65%.

Bassetlaw is the key driver of the underperformance, with 39.5% of handovers taking place within 15 minutes. At Doncaster, 54.9% of handovers took place within 15 minutes.

Average ambulance handover time was 18:20, against the plan of 20:00.

Actions (SMART)

- **Protocol compliance**: Achieve consistent adherence to the ambulance handover SOP, including timely pinning and transfer-of-care timestamps, by October 2026.
- **Process:** continue weekly validation to identify and address any process issues.
- **Escalation**: Strengthen escalation capacity during periods of high ED occupancy by October 2026.
- **Alternatives to ED**: Increase utilisation of alternative pathways to reduce avoidable ED conveyances and ambulance demand through gap analysis and pathway review by October 2026.

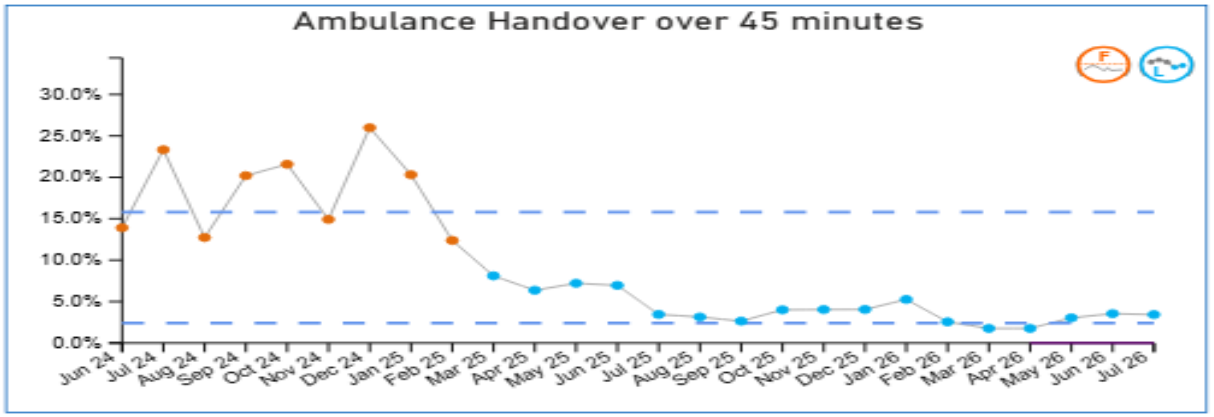
Risks

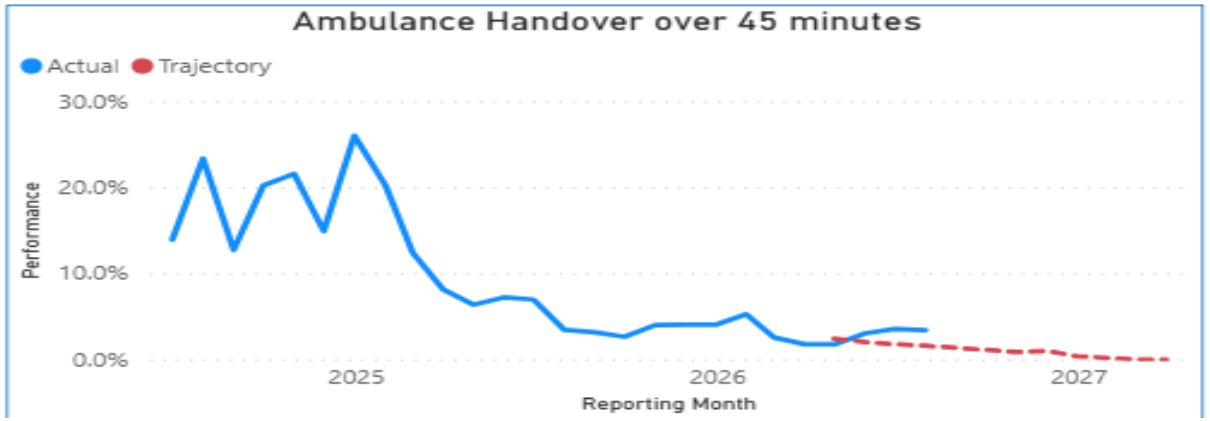
- **ED occupancy:** High occupancy may continue to restrict handover capacity.
- **Demand:** Increased ambulance conveyances may offset improvements.
- **Process variation:** Inconsistent practice between sites may limit improvement.
- **Workforce:** Staffing capacity may affect timely handover and flow.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Handovers between ambulance and hospitals within 45 minutes





Understanding the performance

In July 2026, 3.4% of ambulance handovers took > 45 minutes, against the plan of 1.6%.

The principal driver is at Bassetlaw, where 8.66% too > 45 minutes. At Doncaster, 1.89% of handovers took > 45 minutes.

Implementation of the transfer of care protocol within 45 minutes was implemented in summer 2025 at Doncaster and in the autumn at Bassetlaw. The revised protocol has not fully embedded at Bassetlaw. In addition, daily validation of handover times has demonstrated opportunities for improvement in handover process with the ambulance service.

Actions (SMART)

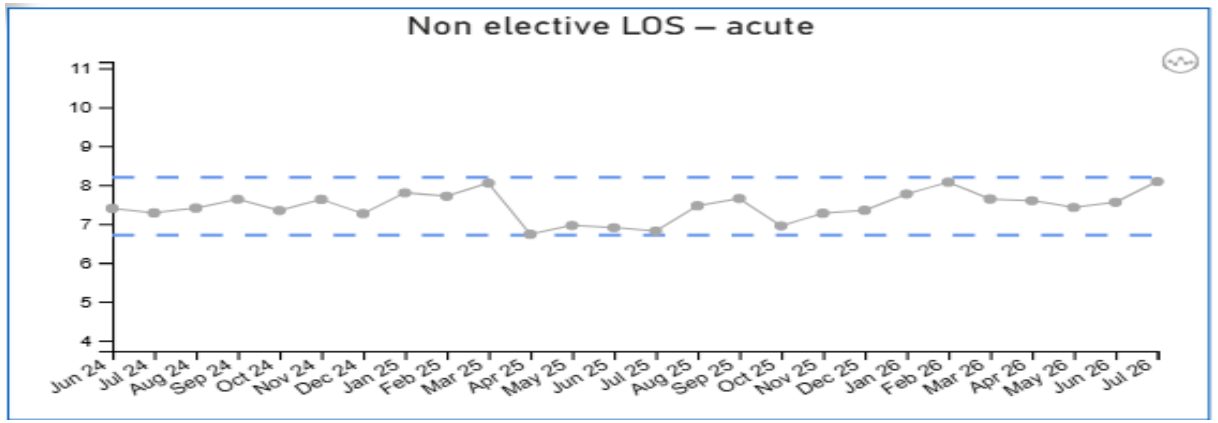
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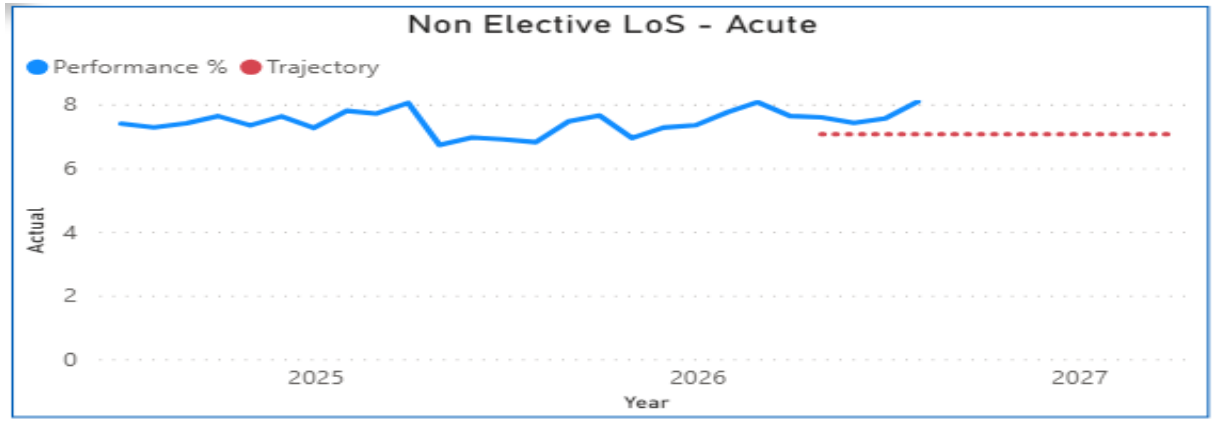
Risks

- **Capacity:** High ED occupancy may continue to limit timely handover and escalation capacity.
- **Process adherence:** Inconsistent adherence to the SOP, including timely pinning and timestamping, may sustain reported breaches.

Assurance report

Non elective length of stay





Understanding the performance

In July 2026, non-elective LOS was 7.16 days against the plan of 7.08 days.

Emergency admissions overall remain within plan; however, LoS has increased at Bassetlaw and Doncaster.

Performance reflects an increase in the number / % of patients with a length of stay> 14 days / > 21 days.

Actions (SMART)

- **Ward processes**: implementation of the standardised ward process, as part of the UEC improvement programme for 2026/27.
- **NCTR**: Strengthen daily identification and escalation with actions tracked through ward and site flow reviews.
- **Flow / Capacity** :Review the surgical pathway and bed model to ensure capacity is aligned to demand and patient flow improves by the end of Q2.

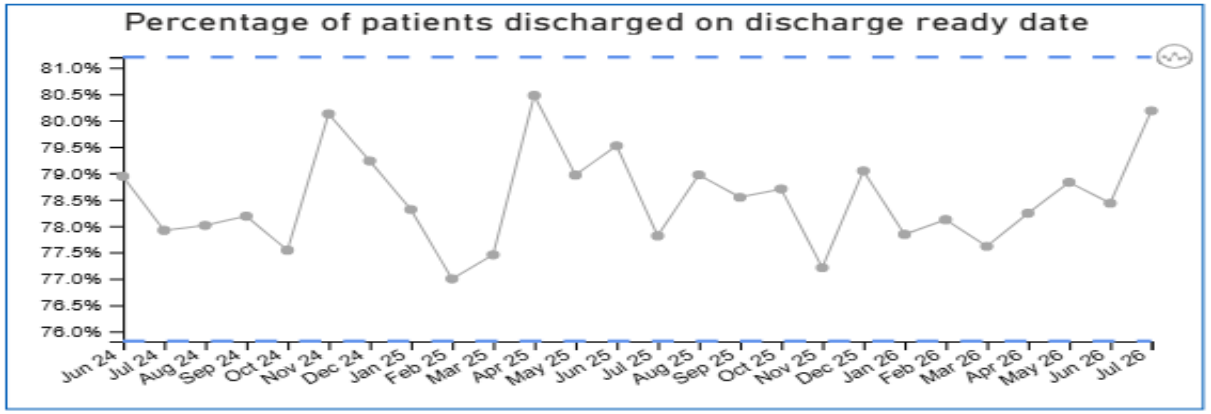
Risks

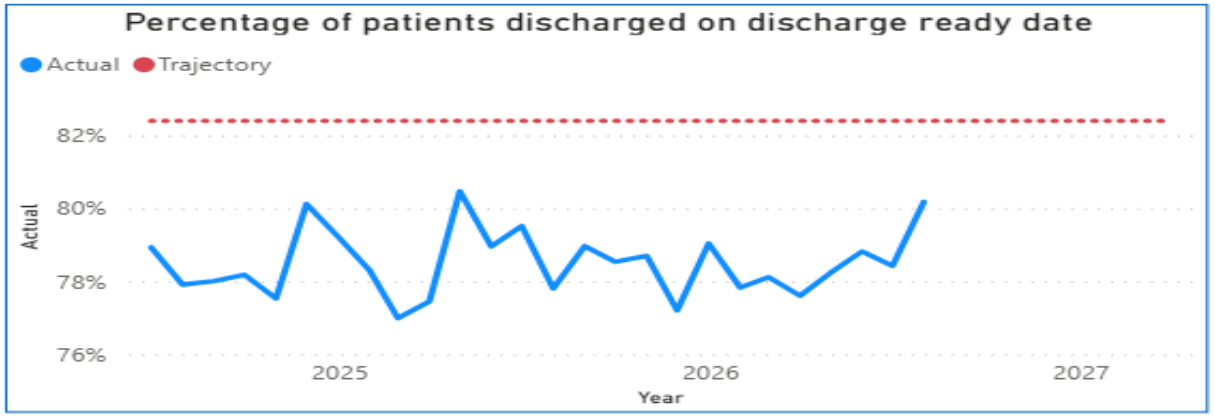
- **Inpatient capacity:** Current bed configuration may not align with demand, limiting flow improvements.
- **Longer LoS / NCTR:** Increasing > 14/21 day stays and NCTR patients may continue to constrain capacity.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patients discharged on discharge ready date





Understanding the performance

In July 2026, 80.3% of patients were discharged on their discharge-ready date against the plan of 82.7%. Performance has improved from June but remains below plan.

The improvements noted in July are due to reduced variation for pathway 0 discharges through the identification and resolution of internal delays during days 3 – 6.

Actions (SMART)

- **Ward processes**: implementation of the standardised ward process, as part of the UEC improvement programme for 2026/27.
- **3–6 day LoS**: Maintain progress made to resolve any internal delays earlier in the length of stay.
- **Simple discharges**: Standardise the simple discharge pathway to further improve discharge-ready performance by the end of Q3.

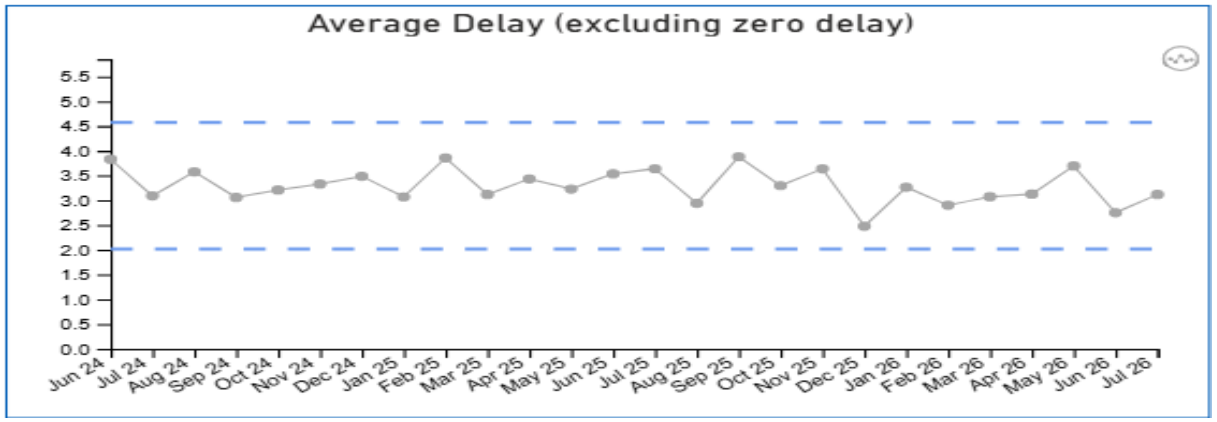
Risks

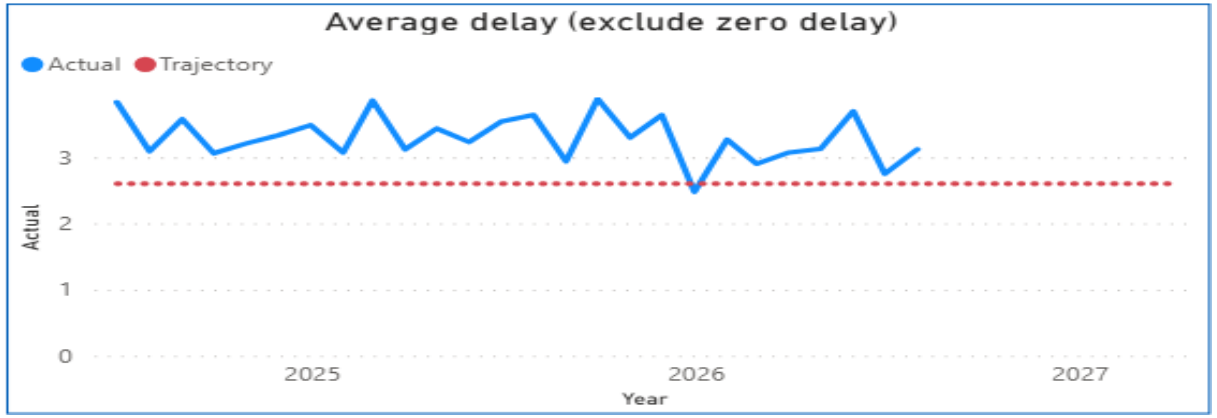
- **Process variation:** Inconsistent ward and discharge processes may limit improvement.
- **Partnership working:** effective discharge arrangements are reliant on timely access to care across acute, community and social care

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Average delay to discharge (exclude zero delay)





Understanding the performance

In July 2026, the average delay discharge (excluding zero delay) was 3.15 days against the plan of 2.74 days.

Actions (SMART)

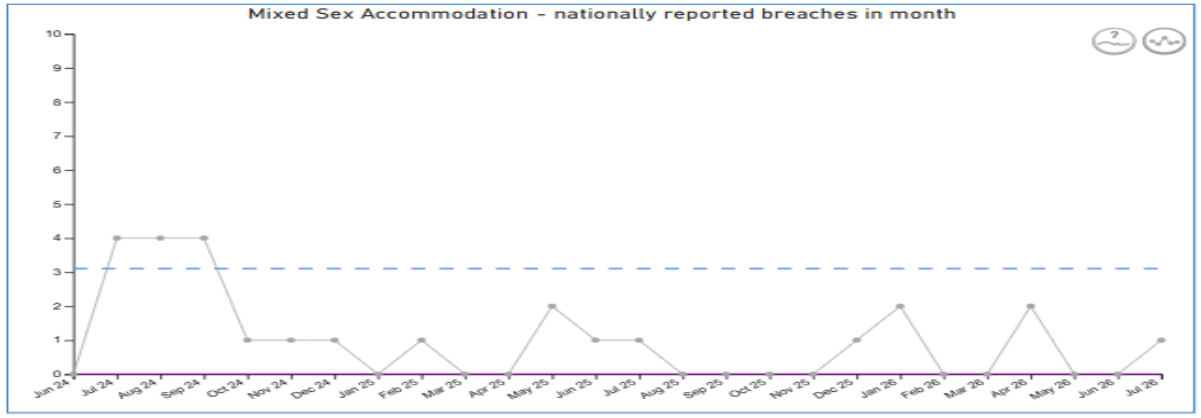
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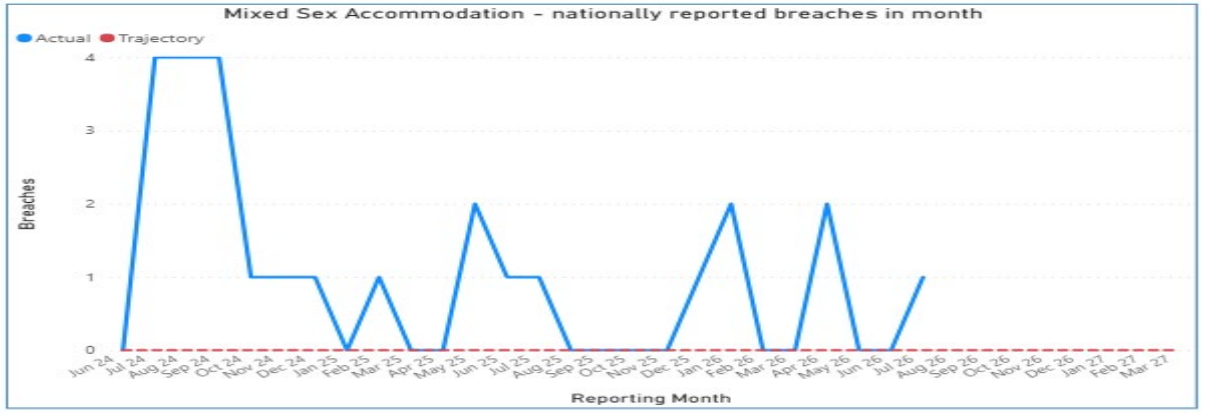
Risks

- **Process variation:** Inconsistent ward and discharge processes may limit improvement.
- **Partnership working:** effective discharge arrangements are reliant on timely access to care across acute, community and social care

Assurance report

Mixed sex accommodation breach





Understanding the performance

In July 2026, there was 1 mixed sex accommodation breach, against the plan of 0.

The breach occurred in month due to a delay in step down from critical care due to single room availability on the receiving ward.

Actions (SMART)

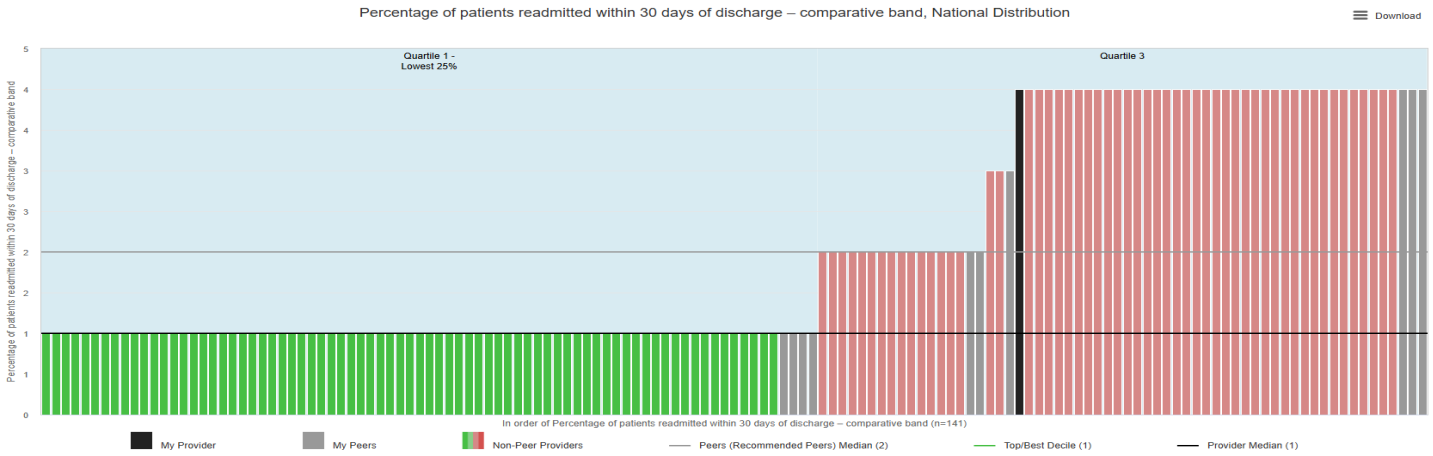
Trust wide escalation processes are in place with operational oversight through the capacity and flow meetings.

Risks

High bed occupancy and limited patient flow may have an adverse impact on mixed sex accommodation breaches

Assurance report

30 day readmission rate band



Understanding the performance

The percentage of patients readmitted to inpatient capacity within 30 days of being discharged is shown as a comparative banding compared with the national average. For the most recent reporting period 24/25, the Trust scored significantly higher than the national average at the 99.8% level, indicating a significant opportunity to improve discharge planning, admission avoidance and post-discharge support.

Actions (SMART)

- **Readmission review:** Complete a 30-day readmission deep dive by October 2026, identifying the main clinical and pathway drivers.
- **Admission avoidance**: Increase use of SDEC, virtual ward and community alternatives to reduce avoidable admissions and readmissions.
- **Post-discharge support**: Improve early discharge planning post-discharge review for patients identified as high risk, with a standardised process by December 2026.
- **Monitoring:** Establish a monthly readmission review, including readmissions by specialty, diagnosis, ward and discharge pathway by December 2026.

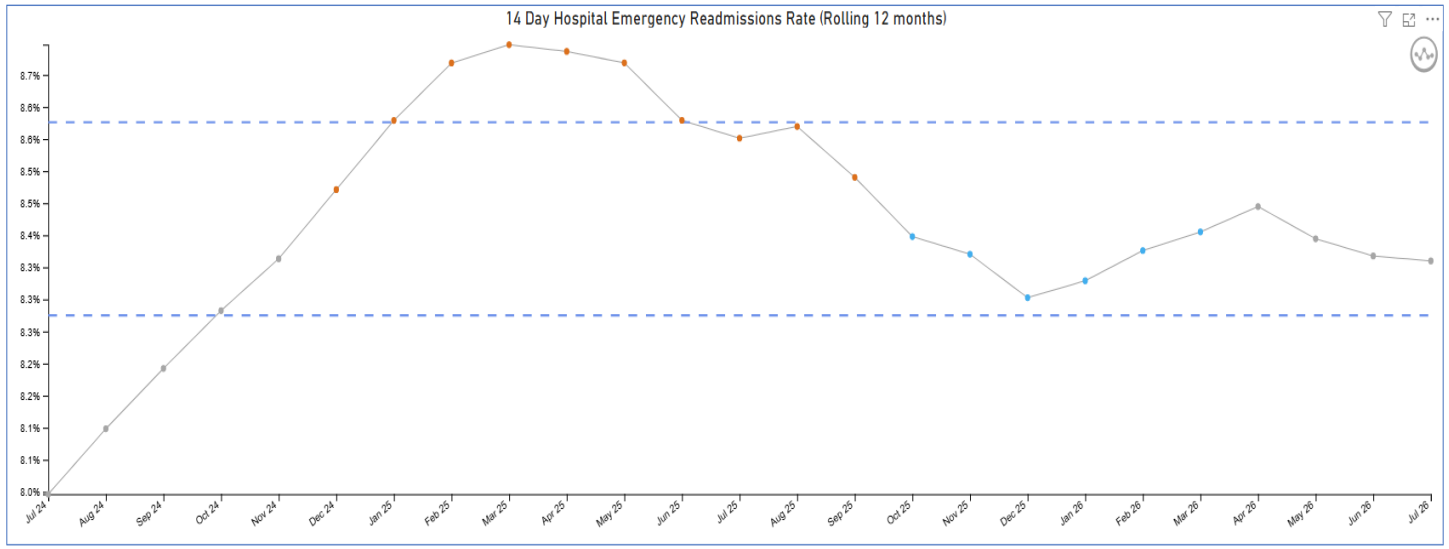
Risks

- **Patient complexity:** Higher clinical and social complexity may continue to drive readmissions.
- **Discharge quality:** Inconsistent discharge planning and follow-up may increase avoidable readmissions.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

14 day readmission rate



Understanding the performance

The 12-month rolling 14-day readmission rate was 8.3% in July 2026, slightly lower than June and 0.3 percentage points lower than July 2025.

High level variation analysis indicates that long-term conditions and associated acuity are the main contributors. Further review is required to identify avoidable readmissions, understand specialty and ward-level variation, and strengthen admission avoidance, discharge planning and post-discharge support.

Actions (SMART)

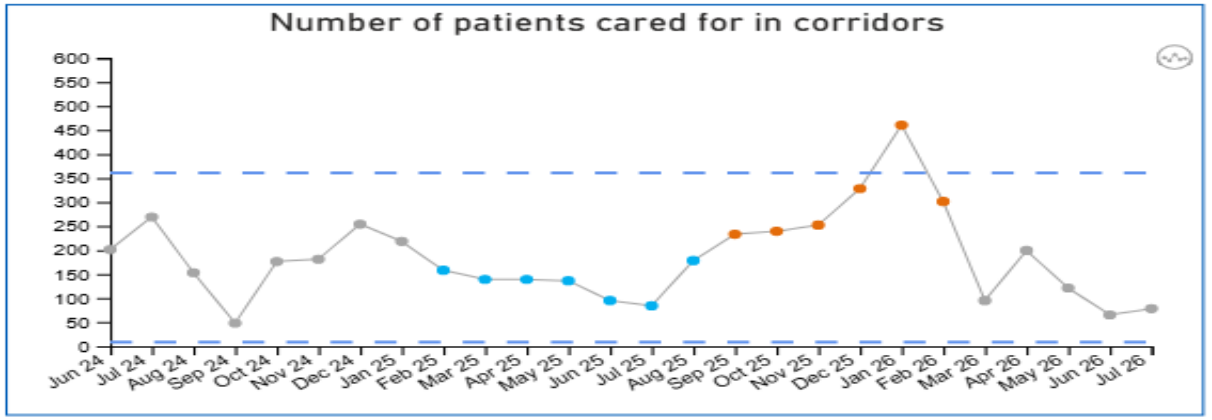
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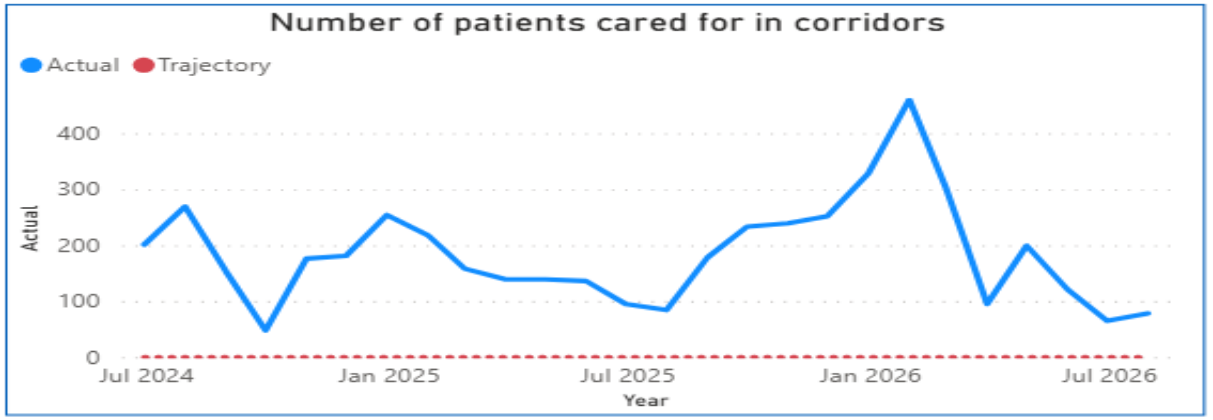
Risks

- **Patient complexity:** Higher clinical and social complexity may continue to drive readmissions.
- **Discharge quality:** Inconsistent discharge planning and follow-up may increase avoidable readmissions.

Assurance report

Number of patients cared for in corridors





Understanding the performance

In July 2026, 78 patients received 'corridor care' within the emergency department.

'Corridor care' in the emergency department is care that is delivered in an non designated clinical space for > 45 minutes.

At Doncaster and Bassetlaw, all emergency department patients are cared for within the department but some may not spend all of their stay within a designated cubicle space.

Actions (SMART)

- **EEMAC implementation**: Implement EEMAC at Bassetlaw by the end of Q2 to reduce ED crowding.
- **Admitted pathway**: Increase SDEC / admission avoidance to reduce admissions by 5 patients per day and improve admitted 4-hour performance by October 2026.
- **ED flow**: Strengthen admission, discharge and SDEC pathways to reduce ED occupancy.

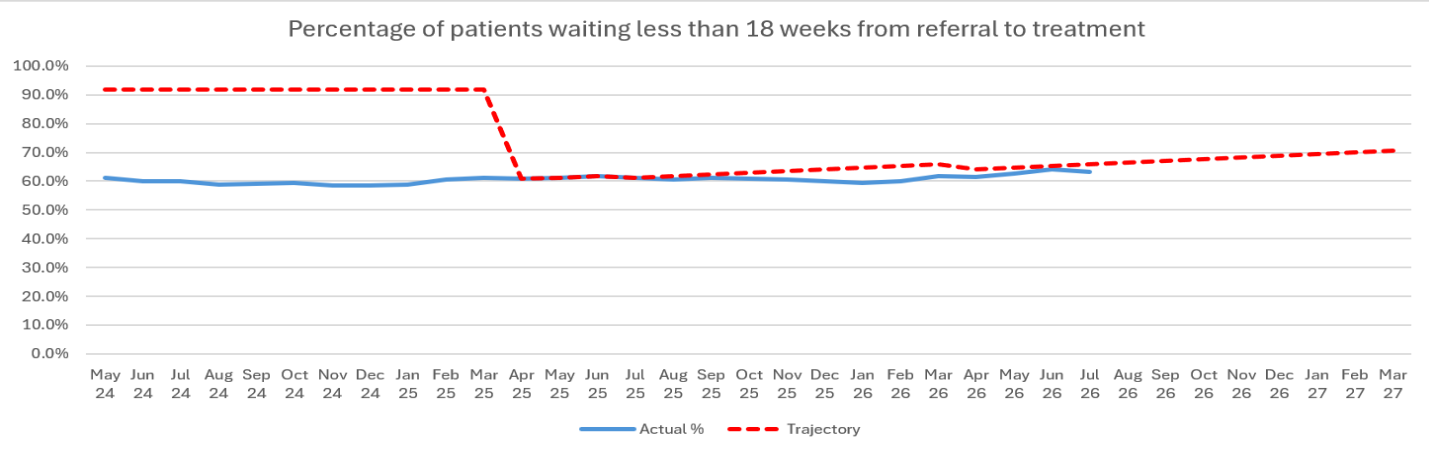
Risks

- **ED occupancy:** Continued high demand and limited flow out of ED may have an adverse impact on corridor care.
- **Inpatient capacity:** Bed constraints and prolonged LOS may restrict ED flow.
- **Non-admitted delays:** Specialty and ED review and discharge delays may limit capacity release.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patients waiting up to 18 weeks for care



Understanding the performance

- In July 2026, 63.3% (unvalidated) of started consultant led elective treatment within 18 weeks of a GP referral, against the plan of 65.9%.
- Referral to Treatment (RTT) performance varies significantly between admitted and non-admitted pathways. In July 2026, unvalidated performance was 38.8% for admitted pathways and 69.2% for non-admitted pathways.
- 30% of all patients waiting > 18 weeks are in Trauma & orthopaedics and a further 17% are in ENT.

Actions (SMART)

- Improve outpatient and theatre productivity through the improvement programmes for 2025/26
- Continue pathway validation, focussing on high volume specialties
- Speciality specific recovery plans for T&O and ENT

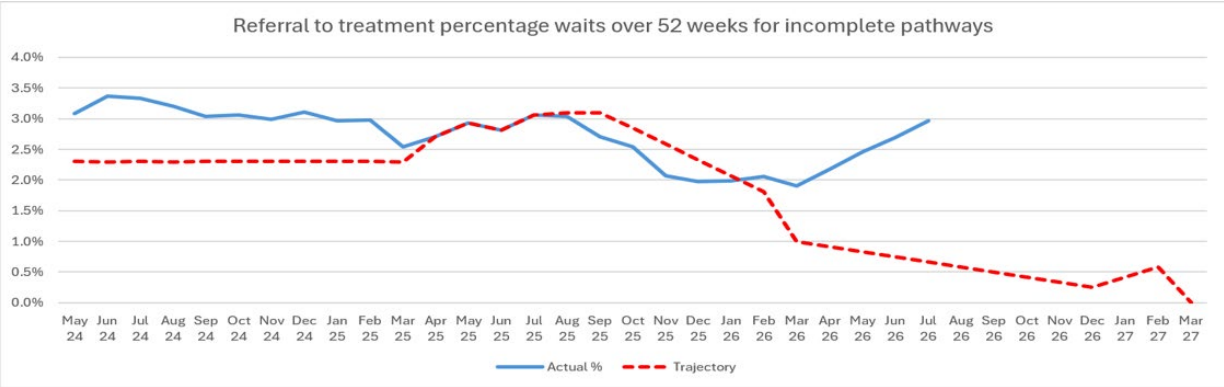
Risks

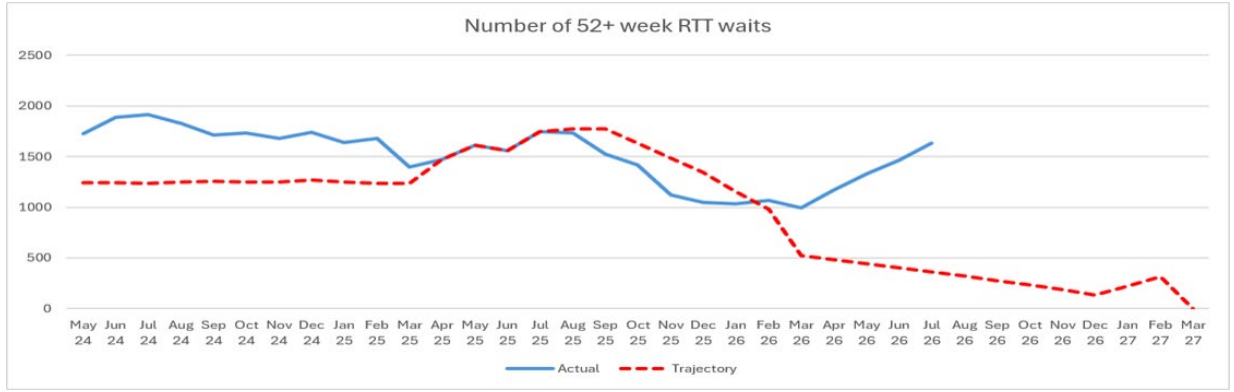
- T&O and ENT remain the key risks to overall delivery of the RTT trajectory for 2026/27.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patients waiting over 52 weeks for care





Understanding the performance

- In July 2026, 1,663 (3.0%) (unvalidated) patients were waiting > 52 weeks for treatment, against the plan of 362 (0.67%)
- Of the total number of patients waiting > 52 weeks, 1,229 (74%) were in T&O and 318 (19%) were in ENT.

Actions (SMART)

- Improve outpatient and theatre productivity through the improvement programmes for 2025/26
- Continue pathway validation, focussing on high volume specialties
- Speciality specific recovery plans for T&O and ENT

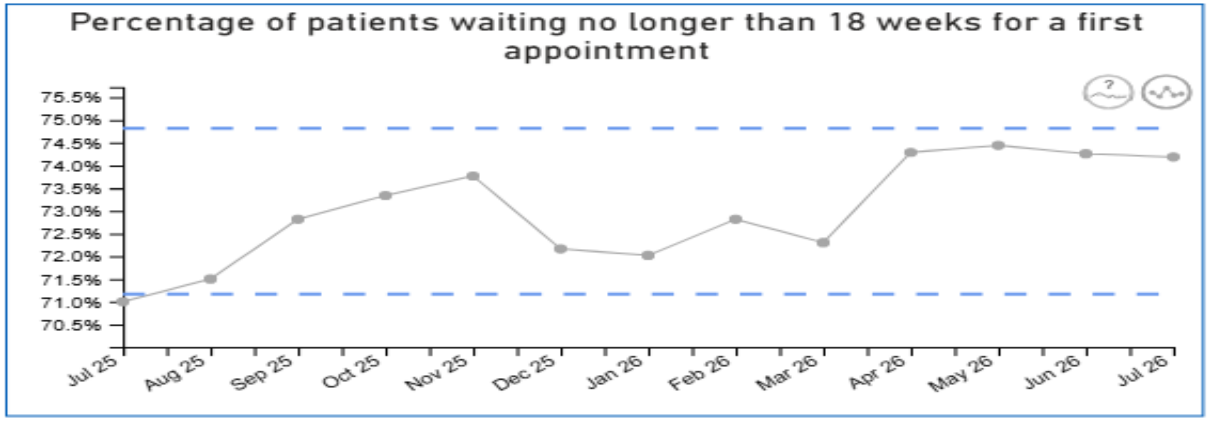
Risks

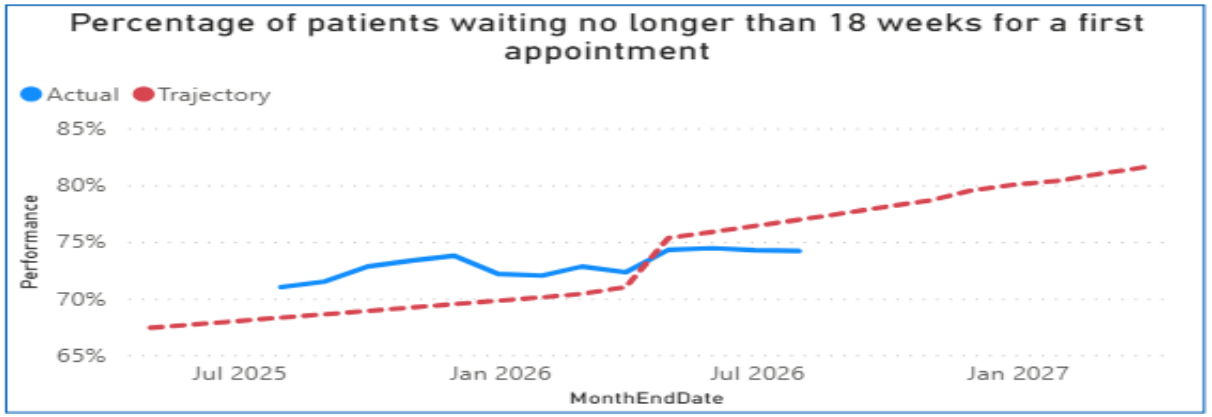
- T&O and ENT remain the key risks to overall delivery of the RTT trajectory for 2026/27.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patients waiting for a first appointment date that have been waiting less than 18 weeks





Understanding the performance

- In July 2026, 74.2% (unvalidated) of patients waited < 18 weeks for a first outpatient appointment, against the trajectory of 77%.

Actions (SMART)

Improve outpatient productivity through the improvement programmes for 2025/26 which includes:

- Embedding of OP 642 process
- Review of clinic templates / job plans by the end of August
- DNA deep dive to inform specialty specific action plans
- PIFU baseline assessment to be completed and priority pathways / specialties to be confirmed

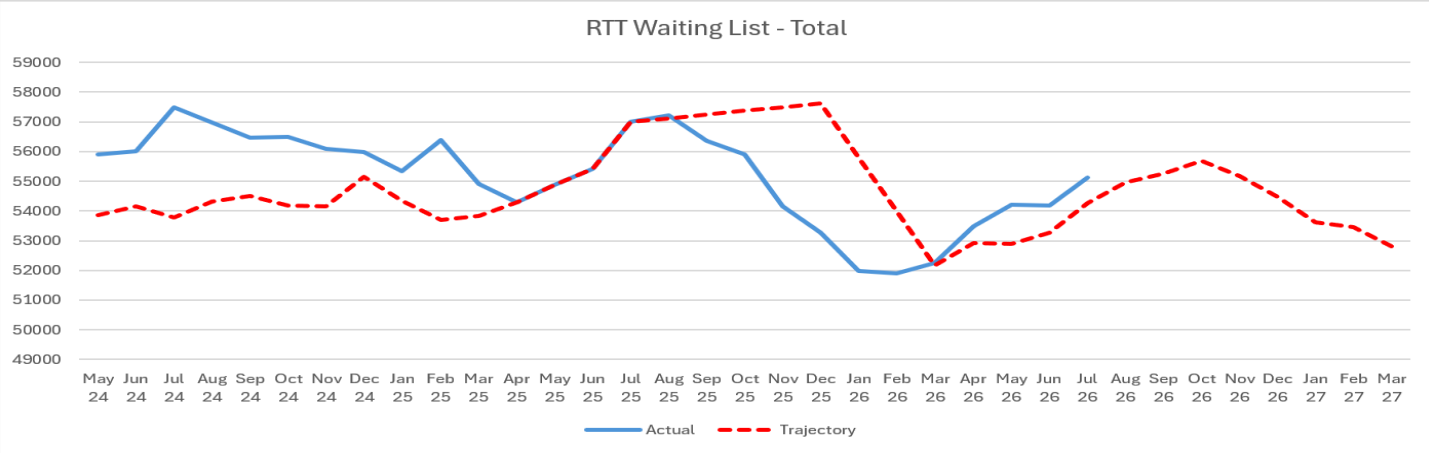
Risks

- Continued high DNA rates

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

RTT waiting list – total



Understanding the performance

- In July 2026, the total waiting list size was 55,132 (unvalidated) against the plan of 54,276.
- Trauma and Orthopaedics accounts for c. 25% of the total waiting list and ENT c. 12%.

Actions (SMART)

- Continued validation of pathways with a focus on the highest volume specialties.
- Continued implementation of advice and guidance

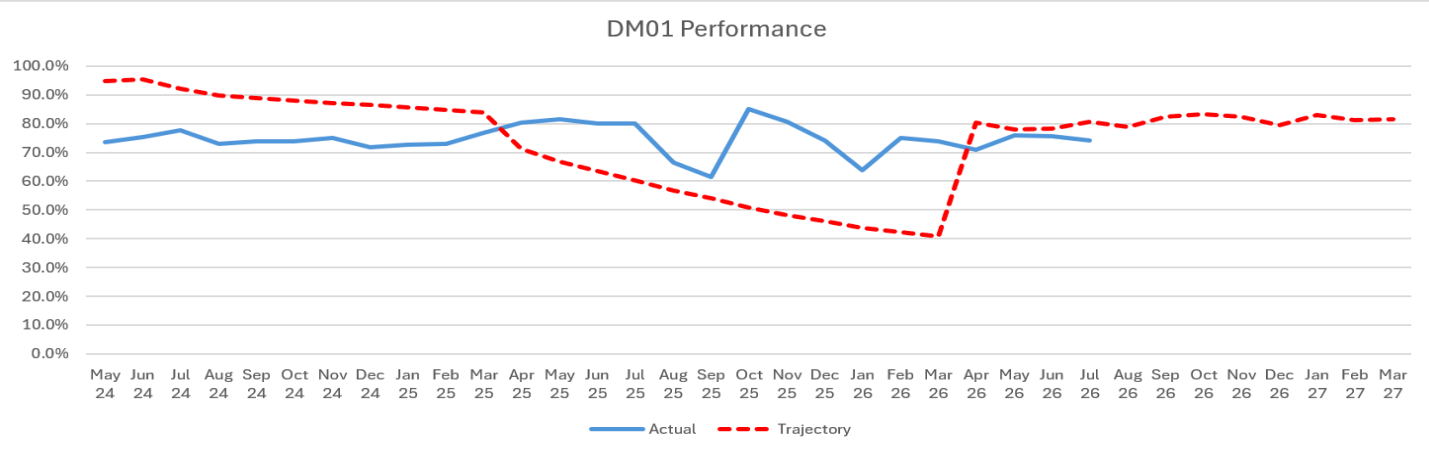
Risks

- Validation capacity may be a limiting factor in maximising all validation opportunities
- Maximising demand management opportunities across all specialties

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Diagnostic referrals waiting over 6 weeks



Understanding the performance

- In July 2026, diagnostic performance was 74.1% against the plan of 80.76%
- 3,676 patients were waiting > 6 weeks, of these 55% (2,006) were in MRI and 23% (1,031) were in Audiology

Actions (SMART)

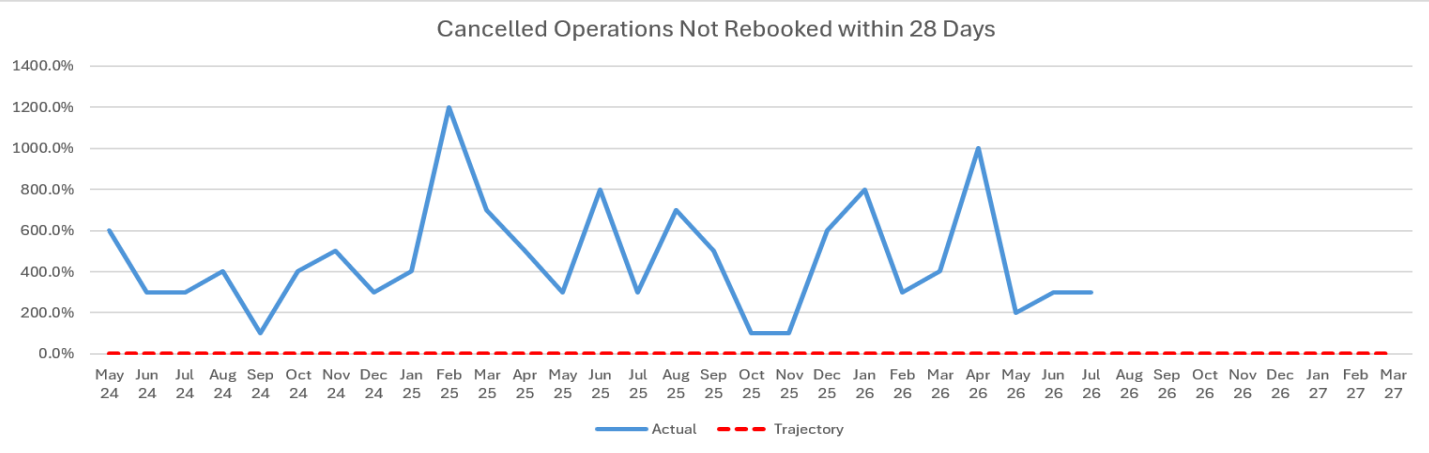
- Recovery plan developed for MR with actions to improve utilisation of current capacity and proposal to extend the use of mobile capacity.
- Insource, outsourced and mutual aid capacity remains in place to support Audiology recovery.

Risks

- Competing demand for MRI capacity for emergency. cancer and elective urgent long waiting patients.
- Limited paediatric Audiology capacity available across South Yorkshire.

Assurance report

28 day theatre cancellations



Understanding the performance

In July 2026 there were 3 breaches of the 28 day guarantee.

1 x T&O: cancelled due to consultant sickness. Procedure required DRI only and specific (part time) consultant. Revised date 6 Aug (complete)

1 x T&O: cancelled due to equipment availability (MEOC patient). Revised date 28 July (complete)

1 x Ophthalmology: cancelled due to list overrun. Specific consultant required to undertake and no capacity before the end of August.

Actions (SMART)

Maintain divisional oversight of cancellations and rebooking within 28 days

Risks

- Potential risk of capacity constraints to rebook within 28 days, particularly in specialties with high volume of long wait patients

NHS Oversight Framework 2026/27 KPIs - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Effectiveness & Experience

3 KPIs Mean Score: 2.31

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Avg Days Ready Date to Discharge (inc 0 day delays)	May 26	-	0.3			1.44
CQC inpatient survey satisfaction rate	2024	-	4.0			2.00
Summary Hospital Mortality Indicator	Feb 26	-	1.15			3.59

Patient Safety

4 KPIs Mean Score: 2.69

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Number of MRSA bacteraemia cases	Jun 26	0	**5**			3.13
Proportion of C-Difficile infections against threshold	Jun 26	1.00	**1.38**			3.47
Proportion of E-Coli bacteraemia against threshold	Jun 26	1.00	**1.10**			2.30
Staff Survey - Raising Concerns sub-score	2025	-	6.33			2.45

Key performance indicators - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling	26/27 NOF	Apr-26	100	114.42	114.42	114.42	14.42	100	114.42	114.42	114.42	14.42
Summary Hospital - Level Mortality Indicator (SHMI) - Monthly	26/27 NOF	Apr-26	100	110.99	110.99	110.99	10.99	100	110.99	110.99	110.99	10.99
Rate of pregnant women with a delayed planned induction per 1,000 deliveries	26/27 NOF	Q1 2026/27				12.8					12.8	
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month	26/27 NOF 26/27 Standard contract	Jul-26	0	0	0	0	0	0	1	1	1	1
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month	26/27 NOF 26/27 Standard contract	Jul-26	1	0	0	0	-1	4	3	3	3	-1
Escherichia coli	26/27 NOF	Jul-26	6	10	10	10	4	32	55	55	55	23
Number of Hospital and Community Onset Healthcare associated Clostridioides difficile cases in month	26/27 NOF 26/27 Standard contract	Jul-26	6	6	6	6	0	20	27	27	27	7
Klebsiella	26/27 Standard contract	Jul-26	1	4	4	4	3	10	16	16	16	6
Pseudomonas		Jul-26	2	3	3	3	1	7	12	12	12	5
Venous Thromboembolism - percentage of patients having a Risk Assessment	26/27 Standard contract	Jul-26	95%	8410	9608	87.5%	-7.5%	95%	33487	35533	94.2%	-0.8%
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	26/27 Standard contract	Jul-26	90%	106	194	54.6%	-35.4%	90%	474	917	51.7%	-38.3%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	26/27 Standard contract	Jul-26	90%	18	26	69.2%	-20.8%	90%	70	107	65.4%	-24.6%

Key performance indicators - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
CQC inpatient survey satisfaction rate	26/27 NOF	Qtr 4 25/26				4					4	
Duty of candour (Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations)	26/27 Standard contract	Jul-26		5	5	100.0%		22	25	88.0%		
Complaints Not Signed Off In Agreed Timeframe	Local	Jul-26	0	0	0	0	0	0	1	1	1	1
Planned Vs Actual Care hours per patient day (CHPPD) - Registered midwife	Local	Jul-26	90%	16249.65	19143.8	84.9%	-5.1%	90%	86415.66	78004.15	110.8%	20.8%
Planned Vs Actual Care hours per patient day (CHPPD) - Registered nurse	Local	Jul-26	90%	176669.47	181339.25	97.4%	7.4%	90%	701523.84	715831.75	98.0%	8.0%
Planned Vs Actual Care hours per patient day (CHPPD) - Total	Local	Jul-26	90%	192919.12	200483.05	96.2%	6.2%	90%	787939.5	793835.9	99.3%	9.3%
Patient Safety Incident Investigation (Psii) reported in month	Local	Jul-26	0	0	0	0	0	0	3	3	3	3

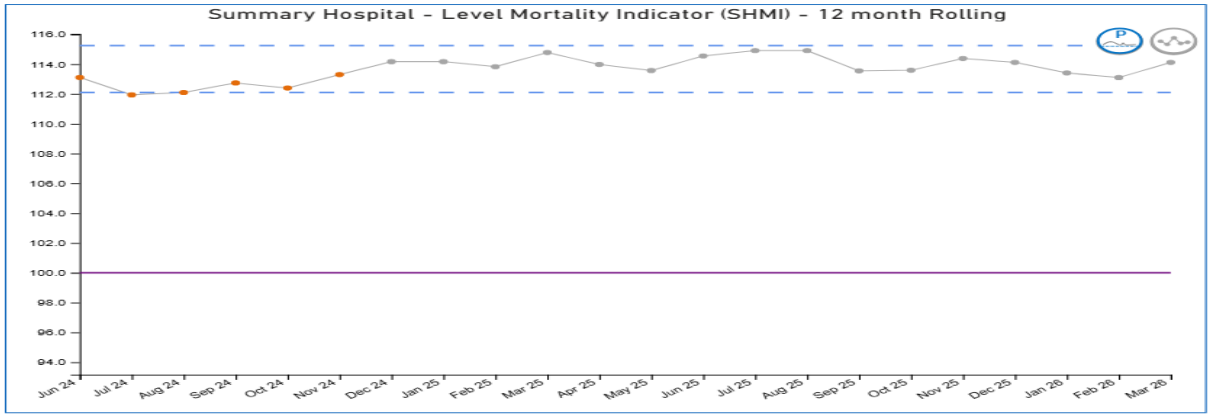
Our Quality domain matrix

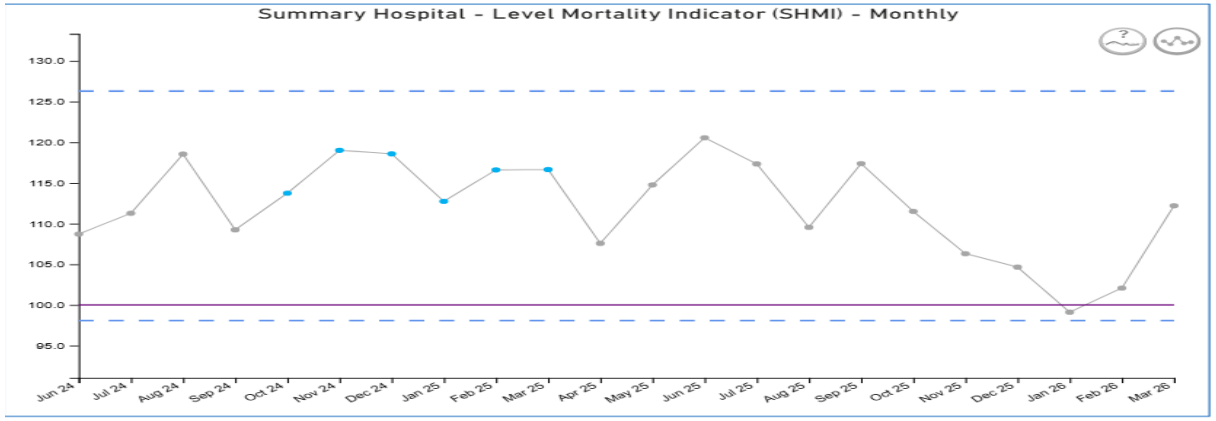
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

		Assurance			
	Icon				No Target
Variation				Complaints Not Signed Off In Agreed Timeframe	
					
		Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling Planned Vs Actual Care hours per patient day (CHPPD) - Registered nurse Planned Vs Actual Care hours per patient day (CHPPD) - Total	Summary Hospital - Level Mortality Indicator (SHMI) - Monthly Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month Patient Safety Incident Investigation (Psii) reported in month Escherichia coli Number of Hospital and Community Onset Healthcare associated Clostridioides difficile cases in month Klebsiella Pseudomonas Venous Thromboembolism - percentage of patients having a Risk Assessment Planned Vs Actual Care hours per patient day (CHPPD) - Registered midwife	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 Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	
					
					

Assurance report

Summary Hospital Mortality Indicator





Understanding the performance

The 12 month rolling Summary Hospital Mortality Indicator for April 2026 was **114.42.**
The monthly Summary Hospital Mortality Indicator for April 2026 was **110.99.**

Actions (SMART)

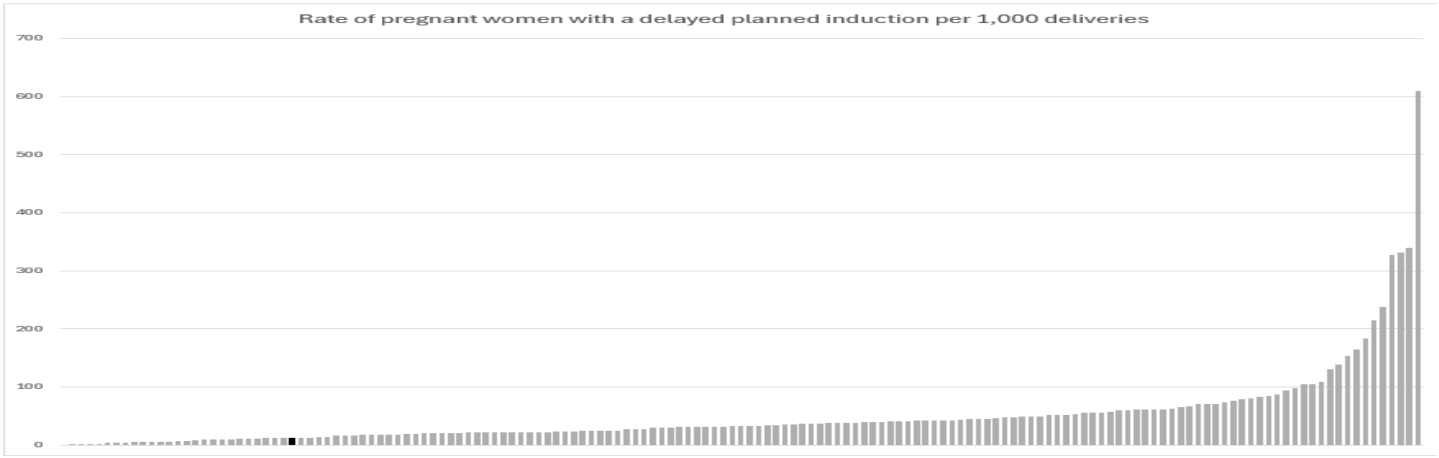
Strengthening the Learning from Deaths process.
Improving sepsis management.
Improving clinical care and escalation
Improving clinical coding
Mortality monitoring through governance structures
Investment in critical care and emergency capacity

Risks

Patient safety risk
Clinical governance
Regulatory
Reputational risk
Financial risk
Workforce
Medicolegal risk

Assurance report

Rate of pregnant women with a delayed planned induction per 1,000 deliveries



Understanding the performance

The rate of pregnant women with a delayed planned induction per 1,000 deliveries between 1/4/2026 and 30/6/2026 was 12.8.

Trusts are asked to provide the number of women whose commencement of induction of labour (IOL) is delayed >6 hours from point of admission for induction (from home or ward).

Number of delays is compared to number of deliveries (derived from a historic average) as reported in the Maternity Services Dataset.

Actions (SMART)

All IOL are managed by the manager of the day with oversight by the labour ward coordinators and obstetric consultants continuously.

All delayed IOL on ward rounds and handovers.
Proactive management using both sites for improve flow and workload.

IOLs commenced in order of clinical priority.
If clinical risk increasing mutual assistance requested to see if other units in the region can support.

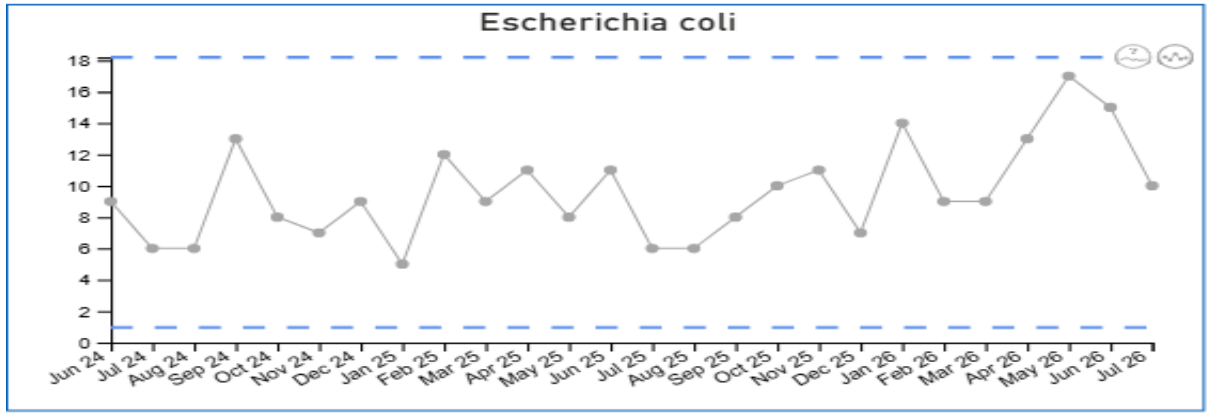
Risks

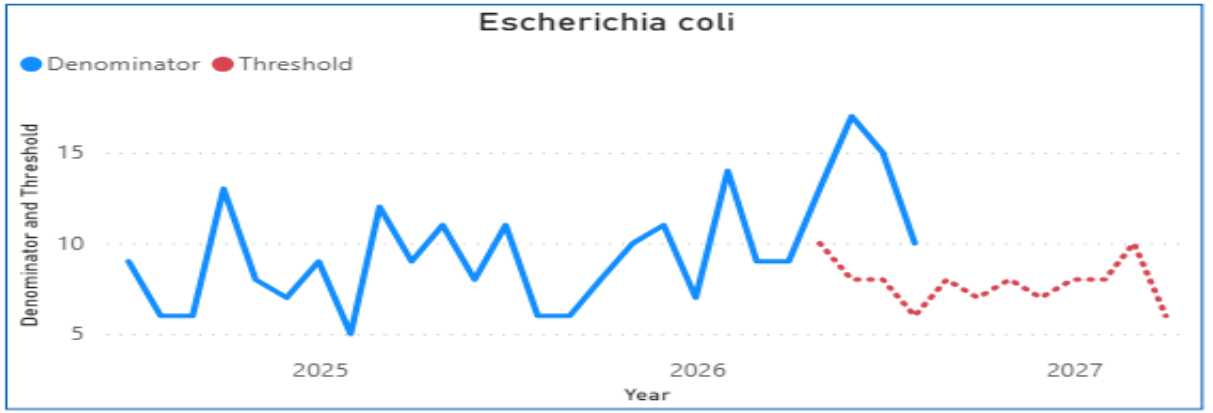
Because IOL workload is decided on clinical need, this can give a poorer service user experience for those women with lower risks because they are waiting longer.

Mutual aid is inconsistent depending on each organisation's risk appetite.

Assurance report

Rate of e-coli





Understanding the performance

In July 2026, there were **10** e-coli cases against a trajectory of 6. Although case numbers have reduced compared with preceding months, further improvement is required to achieve the annual objective. Robust review mechanisms are in place and targeted actions focusing on urinary tract infection prevention, device management and antimicrobial stewardship continue to support reduction strategies

Actions (SMART)

E.coli blood stream infections are reviewed by the Consultants in infection, identifying avoidable factors and learning themes and shared through governance processes

Focused audits of:

- Peripheral and PICC line surveillance reviewing device care.
- Promotion of Urinary catheter care principles - Catheter care audits completed by IPC team
- Reporting results through IPC governance meetings monthly (ICOG, TWIG) and through PSRG and PSAG

Continue antimicrobial stewardship ward rounds and monitor compliance with prescribing guidance, with quarterly feedback to clinical teams. Kurin lock trial in progress and showing positive results.(a single-use medical device designed to reduce skin-cell contamination during blood culture collection)

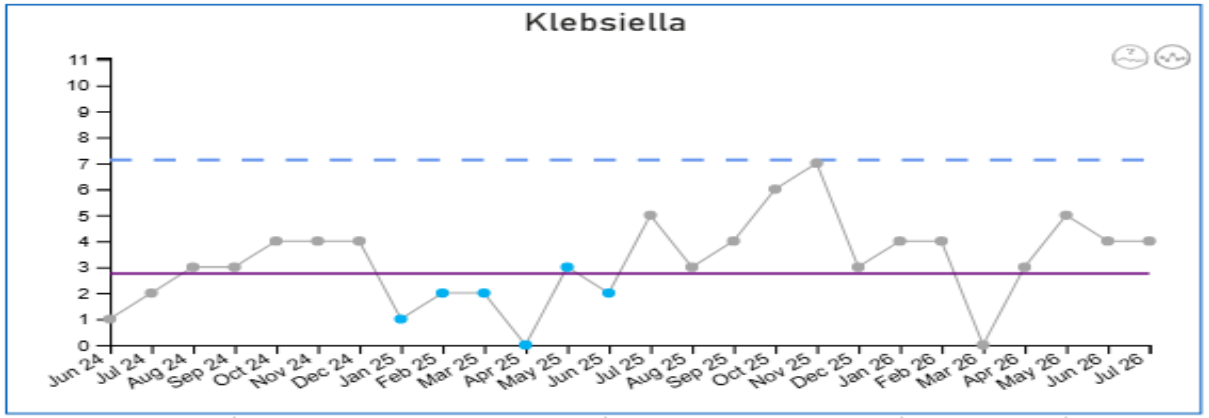
Risks

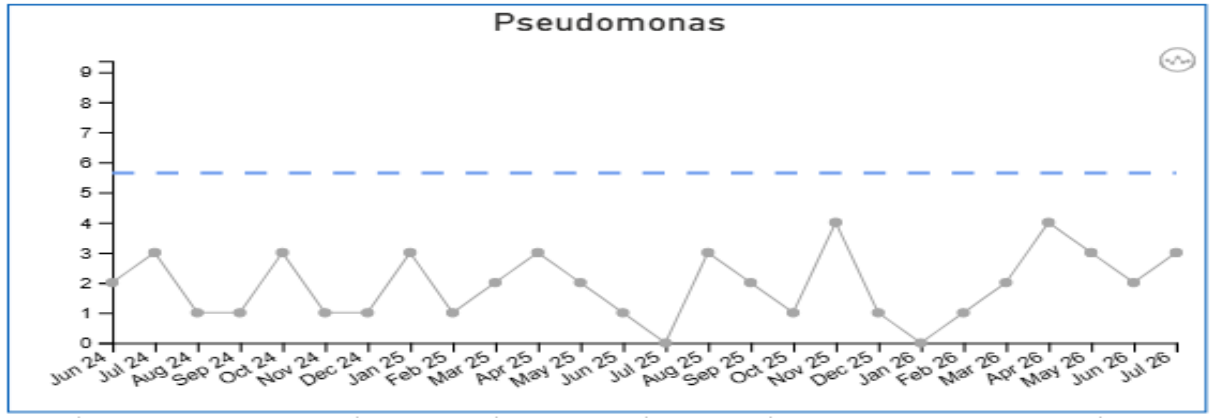
- E. coli bacteraemia numbers remain above trajectory and may impact achievement of the NHSE threshold
- Increasing patient acuity, frailty and co-morbidity continue to increase the risk of all gram negative bloodstream infections.
- Urinary catheter use remains a significant risk factor for healthcare-associated E. coli bacteraemia.
- Antimicrobial resistance may contribute to treatment complexity and increased risk of invasive infection.
- Workforce pressures and competing operational priorities may affect delivery of improvement actions and audit programmes.
- Seasonal variation in infection rates and increased healthcare demand may result in further fluctuations in performance.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Minimise gram-negative bloodstream infections (Klebsiella spp & P. aeruginosa)





Understanding the performance

In July 2026, there were **4** klebsiella cases against a trajectory of 1 and there were **3** pseudomonas cases against a trajectory of 2.

Performance for both Klebsiella and Pseudomonas bacteraemia exceeded trajectory during July 2026. Robust and targeted infection prevention and antimicrobial stewardship actions continue. Whilst no single systemic issue has been identified, ongoing focus is required to reduce Gram-negative bloodstream infections and achieve annual objectives.

Actions (SMART)

•Klebsiella and Pseudomonas bacteraemia are reviewed by the Consultants in infection, identifying avoidable factors and learning themes.
•Focused audits of:
- Peripheral and PICC line surveillance reviewing device care.
- Promotion of Urinary catheter care principles - Catheter care audits completed by IPC team
- Reporting results through IPC governance meetings monthly (ICOG, TWIG) and through PSRG and PSAG.
•Continue antimicrobial stewardship ward rounds and monitor compliance with prescribing guidance, with quarterly feedback to clinical teams. Kurin lock trial in progress and showing positive results.(a single-use medical device designed to reduce skin-cell contamination during blood culture collection.)

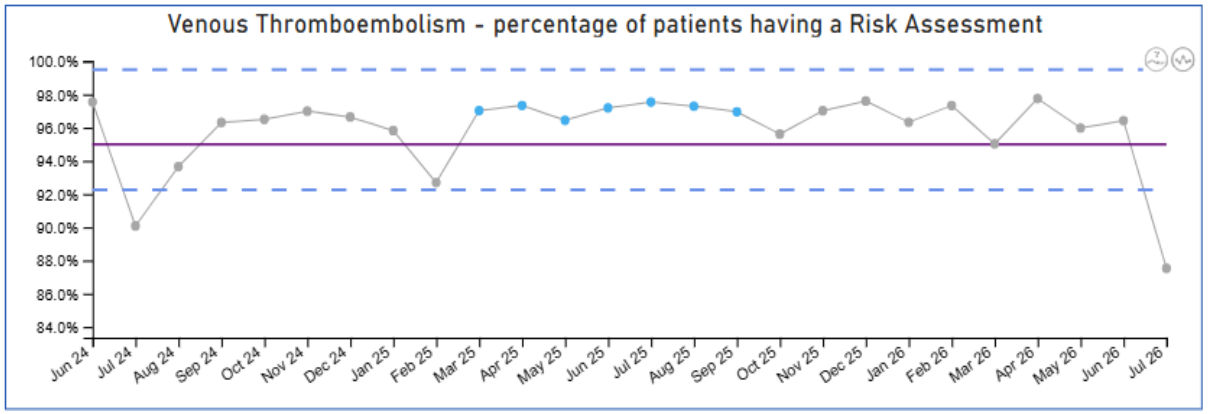
Risks

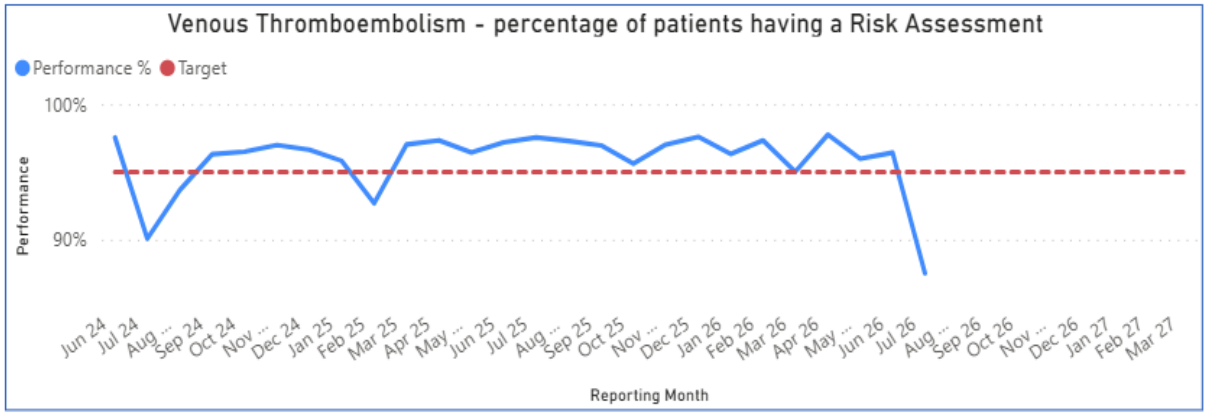
•Continued increases against the Klebsiella trajectory may affect achievement of the NHSE set thresholds.
•Increasing complexity and frailty of the patient population, with multiple comorbidities and repeated healthcare exposure, increases and extreme temperatures affect hydration and Gram-negative bacteraemia risk.
•High utilisation of invasive devices (urinary catheters and vascular access devices) remains a recognised risk factor.
•Antimicrobial resistance and recurrent infections may limit treatment options and increase the likelihood of bloodstream infections.
•Workforce pressures and competing operational priorities could impact timely implementation of improvement actions and audit programmes.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE





Understanding the performance

In July 2026, the percentage of patients undergoing a risk assessment for VTE was **87.5%** against a target of 95%

Actions (SMART)

Ensure VTE risk assessment is completed for every eligible inpatient on admission.
Complete the assessment within 14 hours of admission and preferably before the first consultant review
Embed VTE assessment into the admission/EPR workflow so that an admission cannot be completed without documenting the assessment
Introduce daily exception reporting
Use electronic alerts and escalation for overdue assessments
Audit compliance by ward and specialty, rather than relying only on Trust-wide performance

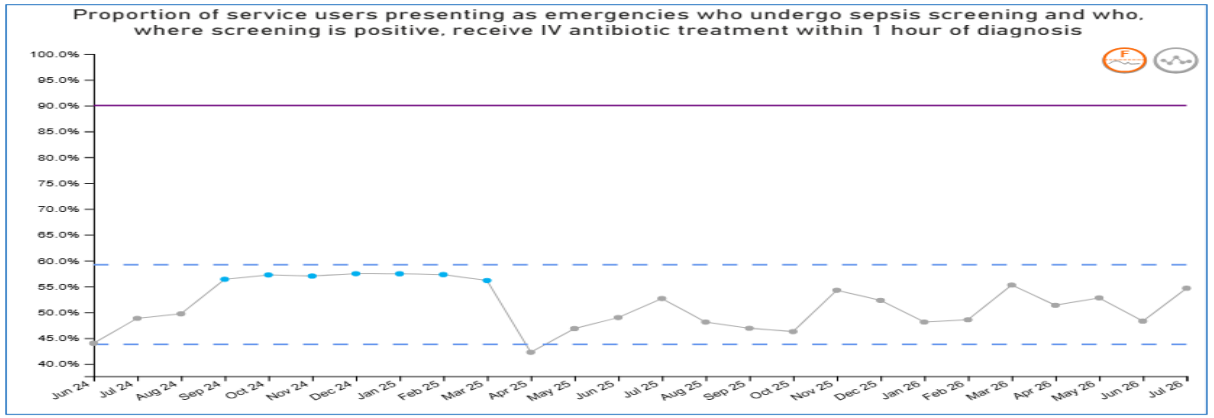
Risks

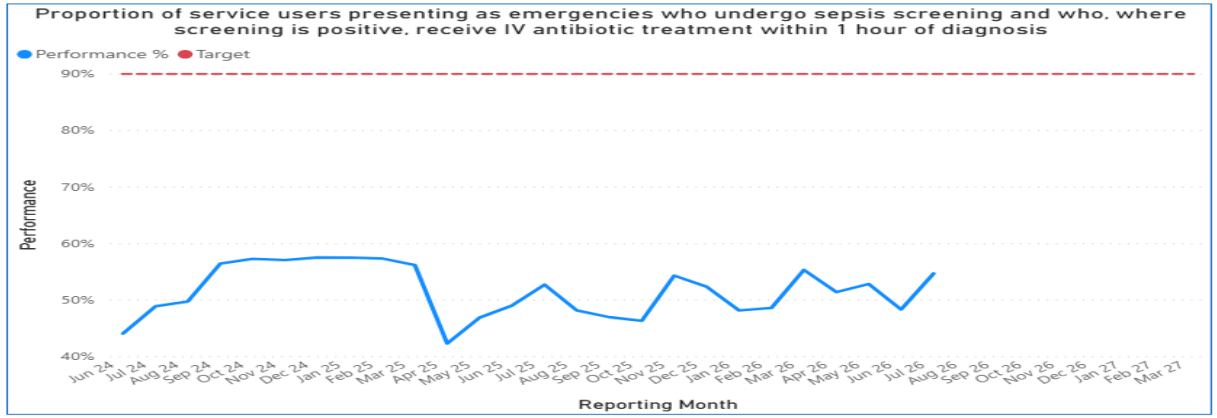
Patient safety risk
Risk of preventable harm
Increased hospital VTE risk
Medico legal risk
Reputational and Financial risk

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Proportion of Adult Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis





Understanding the performance

In July 2026, the proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was **54.6%** against a standard of 90%.

Actions (SMART)

Immediate review
Case note review
Process mapping
ED screening
Antibiotic availability
Real time monitoring
Improvement trajectory

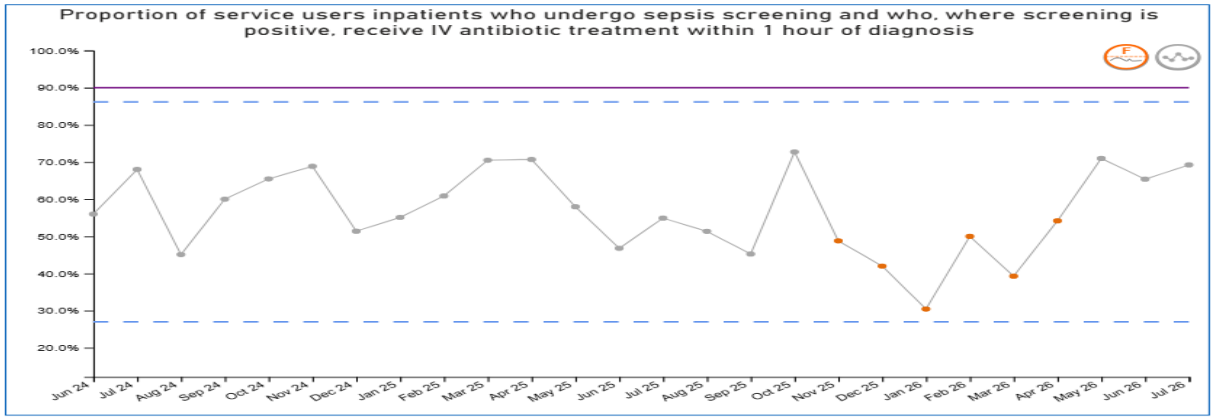
Risks

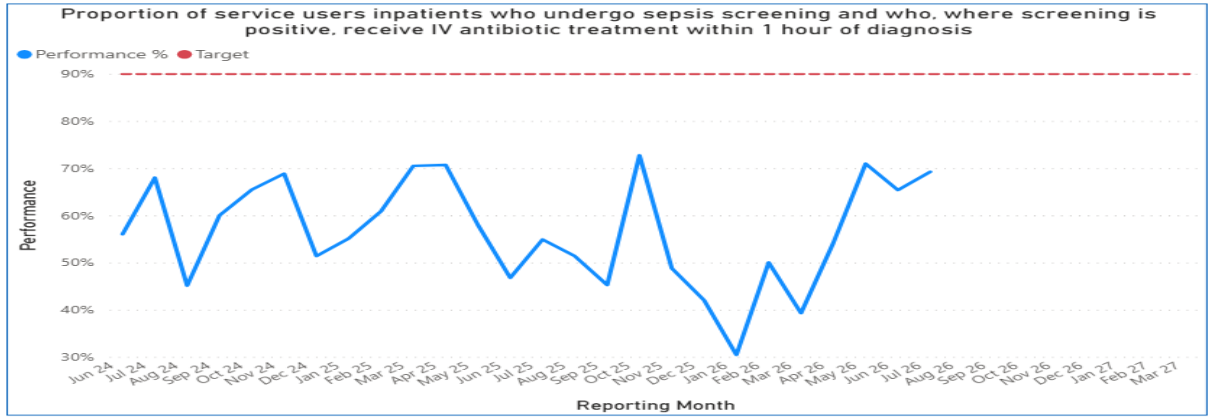
Reputational and Clinical Risk
Antimicrobial Stewardship Risk
Variation in clinical practice
Delayed recognition as well as delayed treatment
Data Quality Risk

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Proportion of Adult Service User inpatients who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis





Understanding the performance

In July 2026, the proportion of Adult Service User inpatients who undergo sepsis screening and who, where screening is positive for high risk of severe illness or death from sepsis, receive IV antibiotic treatment within one hour of diagnosis was **69.2%** against a target of 90%.

Actions (SMART)

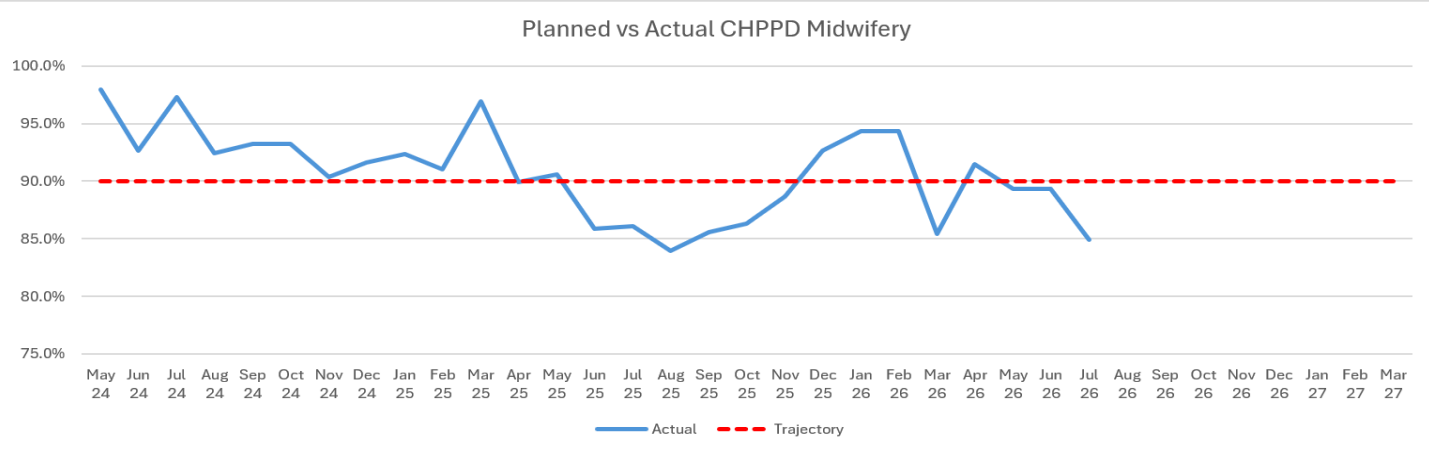
Immediate review
Case note review
Process mapping
ED screening
Antibiotic availability
Real time monitoring
Improvement trajectory

Risks

Reputational and Clinical Risk
Antimicrobial Stewardship Risk
Variation in clinical practice
Delayed recognition as well as delayed treatment
Data Quality Risk

Assurance report

Care hours per patient day (CHPPD)



Understanding the performance

In July 2026 the Planned Vs Actual Care hours per patient day (CHPPD) - Registered midwife was 84.9% against the standard of 90%.

Actions (SMART)

All staffing and rosters are reviewed at weekly operational managers meeting.
Midwives are moved to areas that have significant gaps
Managers working additional clinical shifts
Use of specialist midwives through the specialist escalation roster
NHSP used to cover where required

Risks

Delays in clinical care
Women diverted from one site to the other

NHS Oversight Framework 2026/27 KPIs - Finance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Finance & Productivity

4 KPIs Mean Score: 1.77

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Finance - Combined finance score	Q4 25/26	-	2			2.00
Finance - Planned surplus/deficit	Q4 25/26	0.0%	-2.8%			2.94
Finance - Variance year-to-date to financial plan	Q4 25/26	0.00%	0.00%			1.00
Productivity - Implied productivity level	Mar 26	-	11.4%			1.16

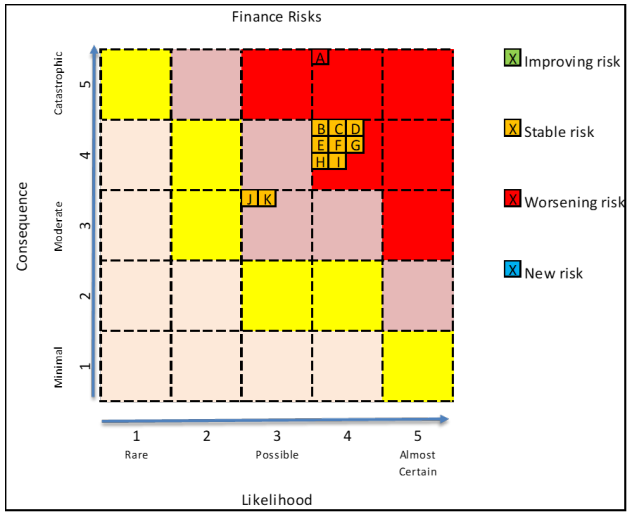
Assurance report - Finance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Planned surplus or deficit - Variance to plan year-to-date

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust M04 July 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	(646,166)	(54,312)	(55,721)	(1,409)	F	(215,219)	(211,751)	3,468	A
Pay	433,301	36,688	36,647	(40)	F	146,704	145,334	(1,371)	F
Non Pay	204,198	17,230	17,192	(39)	F	68,409	69,381	972	A
Financing Costs	9,455	788	642	(145)	F	3,152	2,378	(774)	F
(Surplus)/Deficit for the period	**787**	**394**	**(1,240)**	**(1,634)**	**F**	**3,046**	**5,342**	**2,296**	**A**
Donated Asset Adjustment	(787)	(66)	(67)	(2)	F	(262)	(273)	(11)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**0**	**328**	**(1,307)**	**(1,635)**	**F**	**2,784**	**5,068**	**2,285**	**A**
Remove Deficit Support Funding	***15,700***	***1,308***	***3,924***	*2,616*	***A***	***5,233***	***3,924***	*(1,309)*	***F***
Adjusted Financial Performance Excluding Deficit Support Funding	***15,700***	***1,637***	***2,617***	***980***	***A***	***8,017***	***8,992***	***975***	***A***

Income: Over-achieved F / Under-achieved A — Expenditure: Underspent F / Overspent A — **F** = Favourable **A** = Adverse



Key Risks	26/27 Plan	M2	M3	M4
	£'000	£'000	£'000	£'000
Efficiency risk	(32,659)	(24,463)	(18,635)	(18,640)
Commissioner Growth and clawback	(8,700)	(8,700)	(6,485)	(6,485)
Delays to acceleration of structural changes	(3,700)	(3,700)	0	0
Incremental drift	(500)	(500)	0	0
Potential error in estimation of revenue to capital transfer	(100)	(100)	0	0
Industrial Action	0	(680)	0	0
Total	**(45,659)**	**(38,143)**	**(25,120)**	**(25,125)**

Understanding the performance

The Trust is reporting a £5.1m year to date deficit, £2.3m adverse to plan, due to unachieved efficiencies (£1.7m) and Deficit Support Funding (DSF) not yet being received for month 4 (£1.3m), partly being offset by non recurrent technical benefits.

Income

- Income is adverse to plan YTD mainly due to Clinical Income £2.5m –; Deficit support funding of £1.3m, CDC activity £0.6m and ERF activity £0.5m driven by reduced activity in T&O, General Surgery. Operating income is adverse to plan £1.1m mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges.

Pay

- Pay is in line with plan in month and £1.4m favourable YTD mainly due to delays in spend for transformation funding/investments. Unachieved Pay CIP is £3.8m year to date.
- Bank/agency and additional medical sessions spend in month is £4.3m (previous month: £3.6m) due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

- Non-pay is in line with plan in month and £1m adverse YTD mainly due to clinical supplies additional activity, equipment hire and repairs, partially offset by the release of reserves.

Actions (SMART)

- Accelerate cash releasing savings - Reset/Local Savings
- CFO meetings with ICB regarding growth and rebasing block funding ongoing. Seeking to bring to a conclusion in September
- Reset Board – Has reviewed further opportunities at its meeting on 19th August and supported progressing these. Reviewing additional measures to support the financial recovery , review of current financial controls (NHSE and HFMA checklists) to ensure grip and control measures are maximised, reviewing service profile to ensure all services delivered are appropriately commissioned, rechecking all SLAs to ensure maximum recovery of income, re-reviewing supplier contracts to ensure best value.

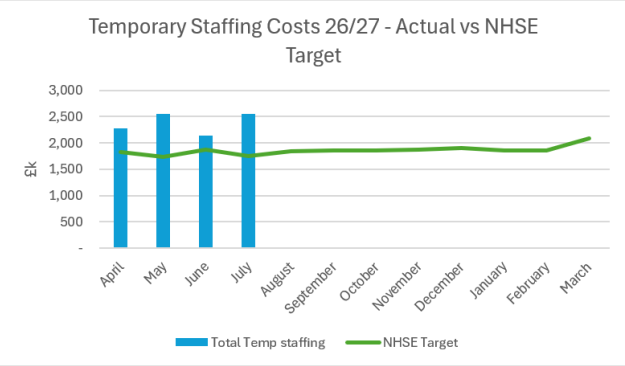
Risks

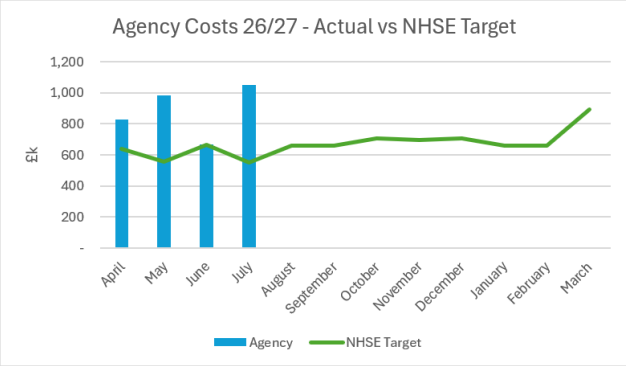
- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.
- There has been a £20.5m improvement in the gross risk profile (see above) since the plan was set.
- The key remaining risks are around efficiency delivery (£18.6M gross risk) and commissioner growth funding/clawback (£6.5M gross)

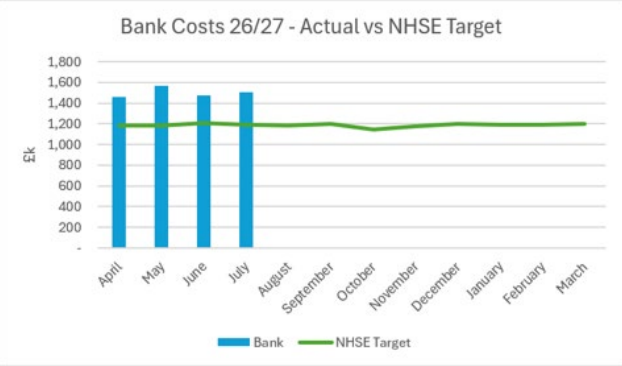
Assurance report - Finance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Temporary staffing cost







Understanding the performance

- The NHSE target is based on the plan submission to NHSE and meets the cap limit. Annual target for Agency is £8.0m Bank is £14.2m.
- Agency costs in month are £1.1m, above plan by £0.5m and £0.4m higher than the previous month mainly due Surgery and UEC due to vacancies and additional activity.
- Bank costs in month are £1.5m, above plan but are in line with 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.
- 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
- Temporary staffing cost relative band – 6.6% awaiting NHSE data on score

NHS Oversight Framework (NOF) temporary staffing	YTD Actual	Cap level	Forecast	Variance	Cap Compliance
Total employee benefits excluding capitalised costs	145,334				
Total agency costs excluding outsourced bank and capitalised agency costs	3,525	8,162	8,048	- 114	Yes
Total bank staff costs excluding capitalised bank staff costs	6,000	16,597	14,246	- 2,351	Yes
Trust YTD spend on agency as proportion of Trust YTD total paybill	2.4%				
Trust YTD spend on bank as proportion of Trust YTD total paybill	4.1%				
Trust YTD spend on agency and bank as proportion of Trust YTD total paybill	6.6%				

Actions (SMART)

- Maintaining tight vacancy control through weekly Executive panel.
- Improving attendance management. New Supporting Attendance at Work policy approved, planned for launch in September 2026 supported by training.
- 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. Audit work planned to ensure robustness of approval processes for temporary medical staffing spend.
- New approach to filling medical vacancies – review of hard to fill vacancies and engaging with Holt as master vendor for permanent recruitment.
- 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

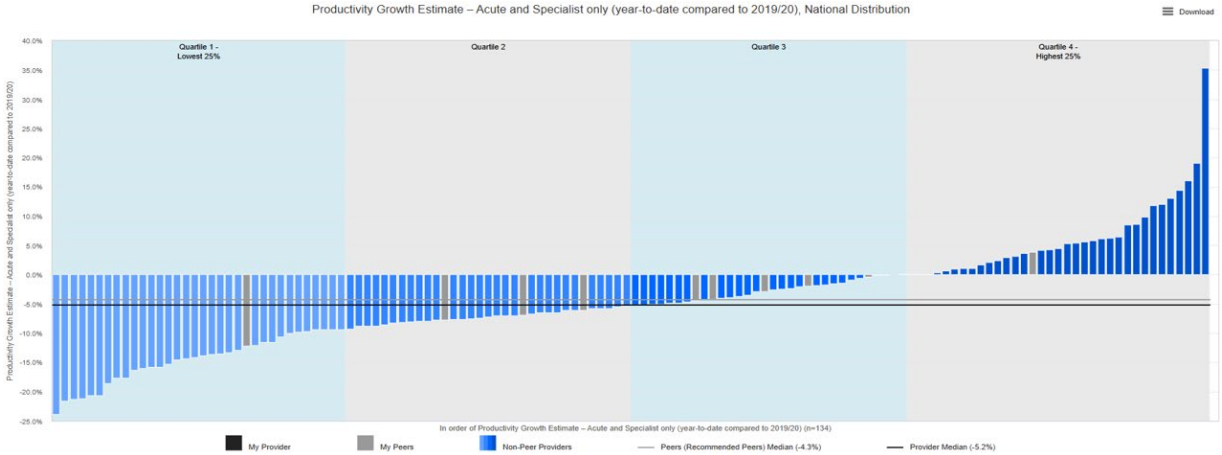
Risks

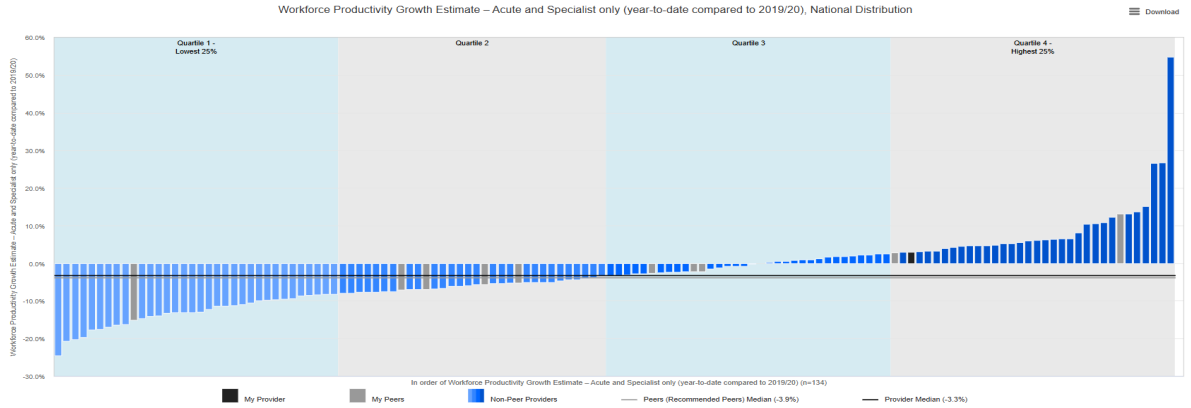
- Ongoing efficiency workplan throughout the year
- The Monthly Agency and Bank Workstream Steering Group contributes to the Workforce and Organisational Pillar, which in turn informs the Reset Board as a component of the Reset programme.
- Monthly tracking of all actions via Monday.com
- F&P monthly updates
- F&P Deep Dive (23/1/26) Feedback received and further deep dive planned for October 2026

Assurance report - Finance

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Implied productivity growth





Understanding the performance

- The most recently published data (full year 25/26) shows DBTH implied productivity is 0.2% **above** pre-covid (2019/20) levels (last month: -3.0%). This places the Trust in the top quartile of performers nationally and is better than both the national median (-5.2%) and the median of the group of peer Trusts selected by NHS England (-4.3%).

- The most recently published data (year to M12 25/26) shows DBTH implied workforce productivity is 2.9% **above** pre-covid (2019/20) levels (previously +1.1%). This places the Trust in the top quartile of performers nationally and is better than both the national median (-3.3%) and the median of the group of peer Trusts selected by NHS England (-3.9%).

Actions (SMART)

- **Agree growth funding with SYICB – End of September 2026**

Since April planning submission negotiations have continued with SYICB to agree the Income Gap of £6.485m. Side letter to contract approved, including various CFO meetings to agree growth with SYICB. Latest meeting 9th July with new SYICB CFO agreed further analysis/actions by end of Sep with monthly update meetings. Based on deconstructing block SYICB funding gap is £15m, however based on the NHSE 26/27 Finance and Contracting Guidance this is restricted to 2.5% of the annual recurrent contract value (£366m) equating to £9.15m - Current contract includes £1.8m of ERF growth.

- **Agree payment of MEOC risk share income – End of September 2026**
- MEOC Partnership agreement pending sign off. Local Trusts owe DBTH £1.3m - Invoices for risk share not paid since April 2024. CFO agreeing income with counterparts.

- **Counting and Coding – End of January 2027**

Recording of activity on systems non-PAS -e.g. RIS Ultrasounds, CVIS. Project team to review by end January

- **Overseas Patients – End of November 2026**

Income received during 25/26 £0.9m. However, this is provided as a 100% bad debt provision due to historic non-payment cumulatively £1.8m. Produce invest to save business case by November 2026. Review accounting policy for the bad debt provision

- **Review Month 5 Financial Position for Income – End of September 2026**

Month 5 finance report presented to Finance and Performance Committee

- **Develop revenue loan cash request – End of August 2026**

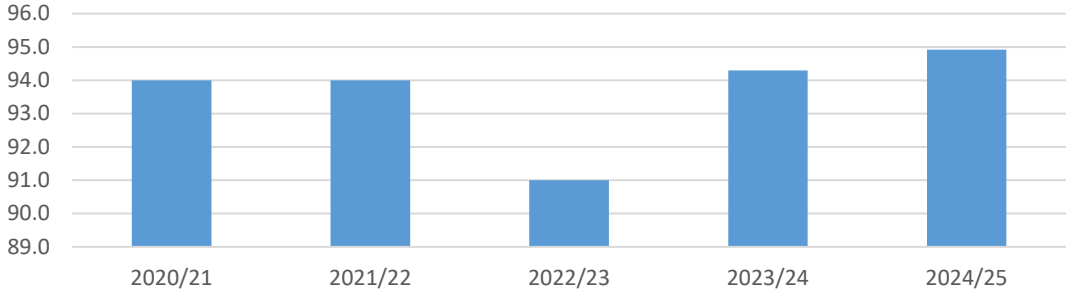
Prepare the loan request for submission to NHSE subject to cash releasing savings in line with plan

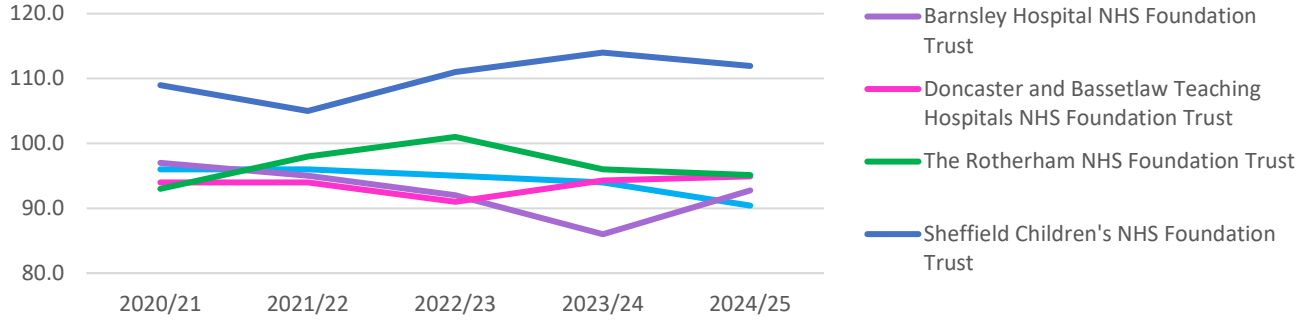
Risks

Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity

Assurance report - Finance

Relative cost difference (National Cost Collection Index) - Annual





Understanding the performance

The data shown in the tables relates to the 24/25 National Cost Collection Index (NCCI), published by NHS England on their website. This index shows the comparison of the Trust's costs to the national average and tells us that where national the average cost of services is £100, we spend £94.90.
The second graph shows the NCCI of the other trusts in our ICB for comparison.

Actions (SMART)

- National cost collection for 25/26 submitted on 26th June 2026
- Review Model Hospital data for 25/26 when published
- The costing processes are on the schedule for Internal Audit this year

Risks

NHS Oversight Framework 2026/27 KPIs - People

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

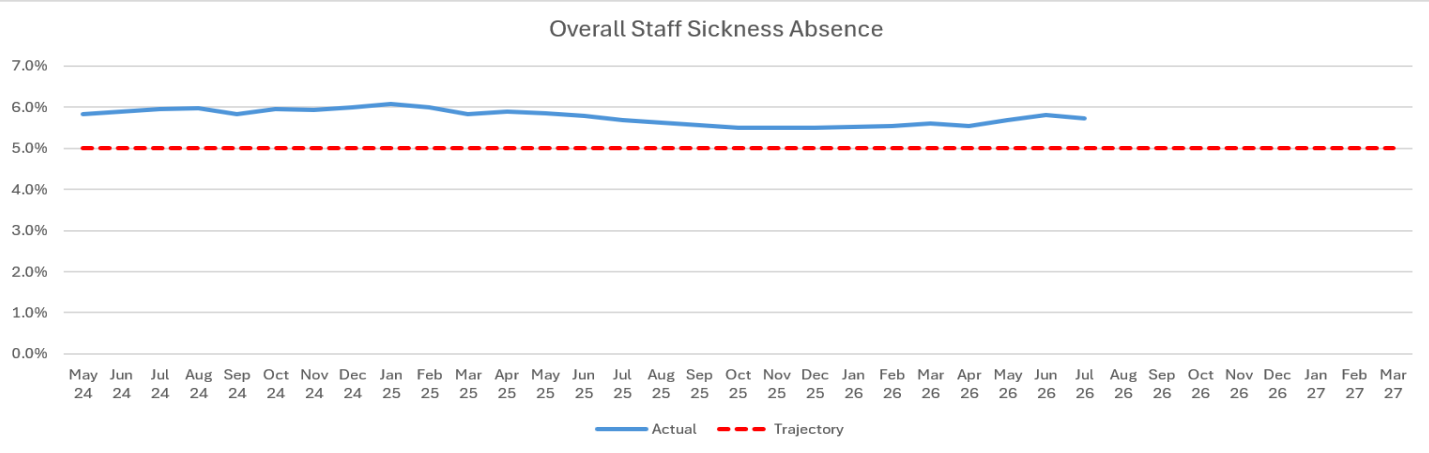
People & Workforce

2 KPIs Mean Score: 3.21

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Sickness Absence Rate QTD	Q1 26/27	-	5.66%			3.59
Staff Survey - Engagement Theme Score	2025	-	6.68			2.84

Assurance report

Sickness absence rate



Understanding the performance

The sickness absence rate for July 2026 was **5.7%** against a target of 5%.

Actions (SMART)

- New Supporting Attendance at Work policy approved late July 2026. Plan in place for launch and communication in September 2026, supported by refreshed training and guidance (Sept 26).
- Continuation of KPI clinics/workshops for managers with People & OD (monthly).
- Executive oversight of divisional sickness absence rates at Performance Review Meetings (PRMs).
- Improvement work ongoing supporting absence management for medical colleagues (Q2/3)
- Deep dives on sickness absence in targeted areas (Q3/4)

Risks

- Impact of wider pressures, external context and organisational change on colleague wellbeing and attendance.
- Increased sickness absence in some areas during summer holiday period, currently being reviewed.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Healthcare worker flu vaccination rate



Understanding the performance

The final performance for Healthcare worker flu vaccination rate in March 2026 was **45.6%**.

The chart above is taken from Public View and aligns with the national definition of healthcare worker for the vaccinations. Please note this is different to previously shared data from ESR which shows all colleagues.

Actions (SMART)

- Flu planning group and fortnightly meetings in place with representatives from across the Trust, including reviewing learning from last year's campaign (ongoing during Q2/3).
- Proposal supported at Executive Team in July 2026 for colleague vaccination delivery model for this year's campaign. This includes reducing Occupational Health clinics to focus on vaccinations (enact Q3).
- Flu vaccinations ordered to support timely commencement of the vaccination programme.
- Preparations underway to support accurate data recording (Q2).

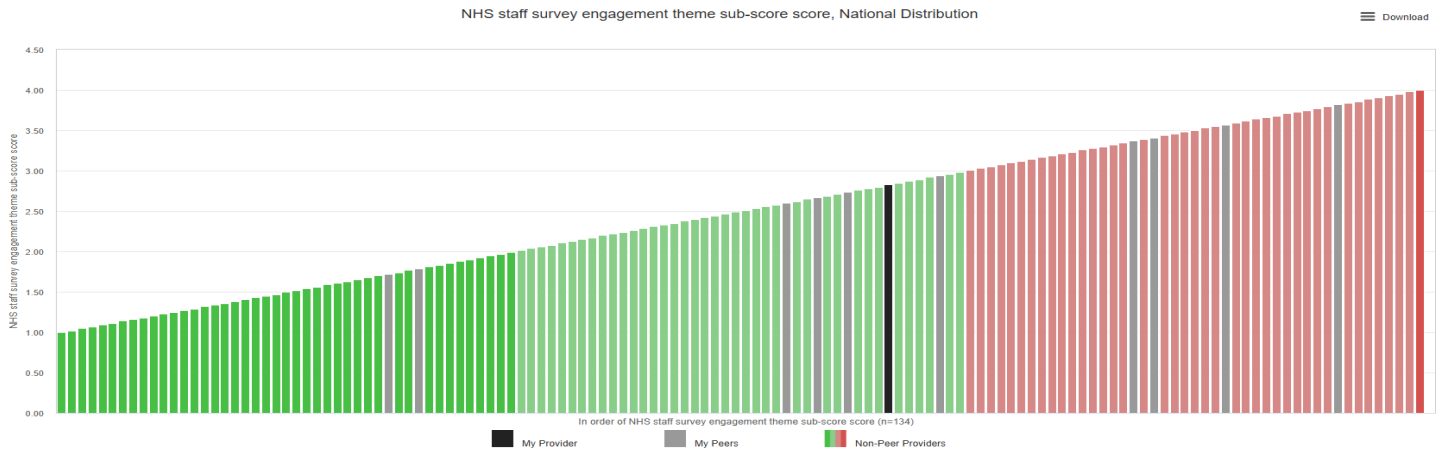
Risks

- Stretch target of 60% set in line with national guidance, with is ambitious based on performance in recent years.
- Potential impact of reduced Occupational Health clinics on other areas, e.g. supporting attendance at work.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NHS staff survey engagement theme score



Understanding the performance

The current NHS staff survey engagement theme score is 6.68 which benchmarked within the NOF is 2.83

Organisations scored between 1.00 and 4.00 based on percentage positive responses ranked high to low (Higher percentage is better).

Actions (SMART)

- Culture and Leadership pillar of Reset programme has wide programme of activities to support colleague engagement (throughout 2026/27)
- New Colleague Assembly launched Q2. Representatives from across the sites being sought currently and first meeting planned to take place by October 2026 (Q3)
- Preparations underway for launch of national staff survey late September 2026, with communications and engagement plan during survey period (Q2/Q3)

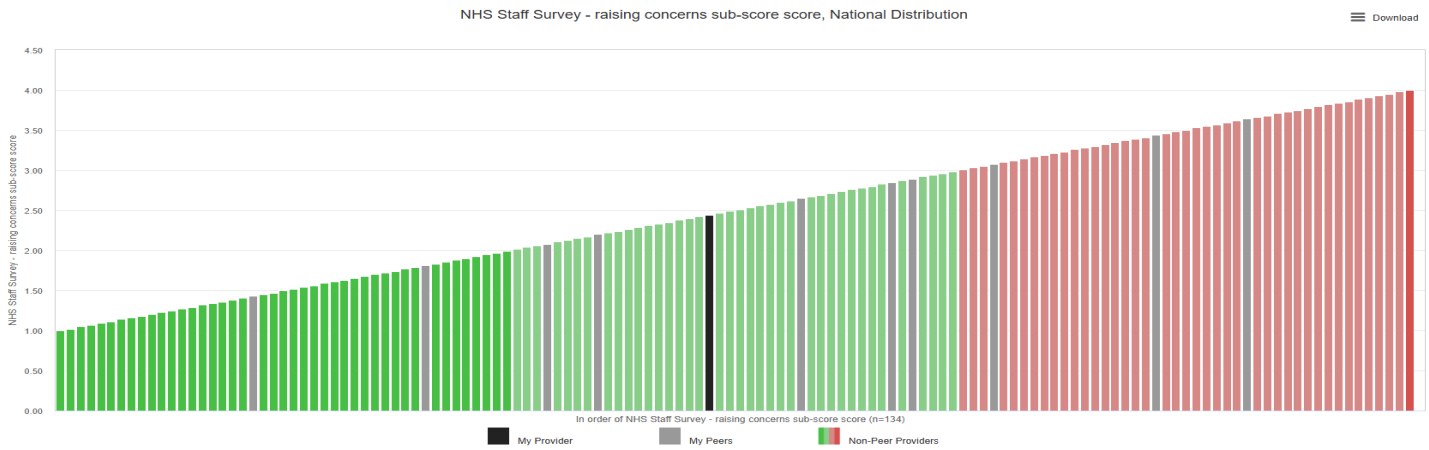
Risks

Impact of wider pressures, external context and organisational change on colleague mood, engagement and capacity.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NHS staff survey raising concerns sub-score



Understanding the performance

The current NHS staff survey raising concerns sub score is 6.33 which benchmarked within the NOF is 2.44

Organisations scored between 1.00 and 4.00 based on percentage positive responses ranked high to low (Higher percentage is better).

Actions (SMART)

- Alignment of Speaking Up activity with Culture & Leadership programme, e.g. Speaking Up for Patient Safety is one of the three focus behaviours for 2026/27 (through 26/27).
- Ongoing engagement following communication of FTSU peer review key themes and feedback (Q3).
- Preparations underway for FTSU month activities in October 2026 (August – October 2026).
- Preparations underway for launch of national staff survey late September 2026, with communications and engagement plan during survey period (Q2/Q3).

Risks

- Impact of wider pressures, external context and organisational change on colleague mood, engagement and capacity.

Metrics still to be included within the IPR

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

- % of patients waiting less than 18 weeks for community care – currently reviewing cohort of patients submitted to community return for accuracy
- No urgent operation should be cancelled for a second time – not currently collected, reviewing emergency theatre processes with Operational colleagues
- Inpatients making a supported quit attempt with an in-house tobacco dependence treatment service – reviewing data available to report on metric
- New to NOF for 26/27, awaiting technical specification/ Q1 data to be published via Model Health or Public View
  - % of safety incidents causing harm
  - Rate of inpatient falls that cause harm
  - % of inpatients to acquire a new grade 3 or 4 pressure ulcer
  - Breadth and depth of clinical audit outliers
  - NHS staff standards score

- The following metrics will be included next month as agreed with the Executive lead:
  - National education and training survey satisfaction rate
  - Clinical trials set up within 90 days
  - CQC inpatient satisfaction rate

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust



Finance And Activity Report

July 2026

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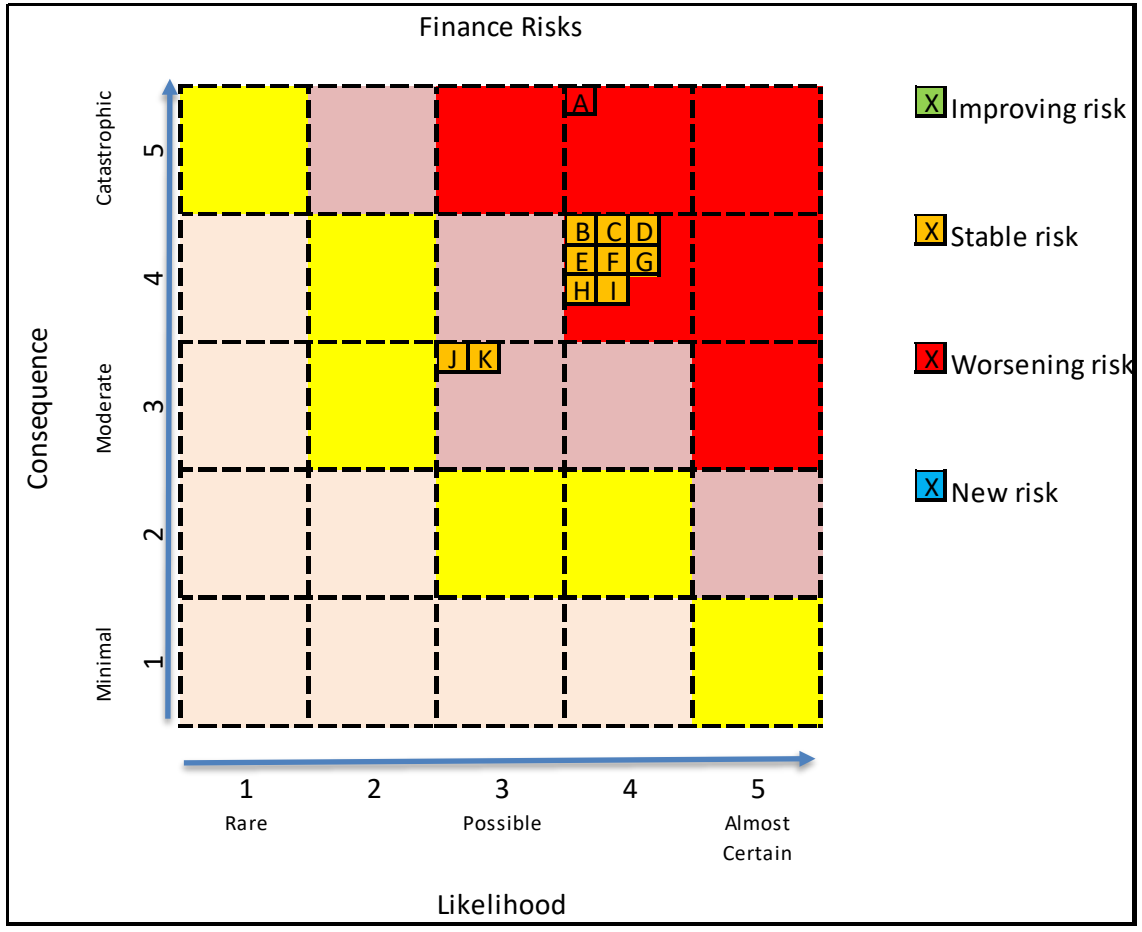
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SECTION 1
Financial Risks

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

•As a result of the efficiency programme adverse delivery compared to plan in month (and year to date), the risk associated with the development of fully developed recurrent schemes (A) has increased.

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

Underlying Deficit

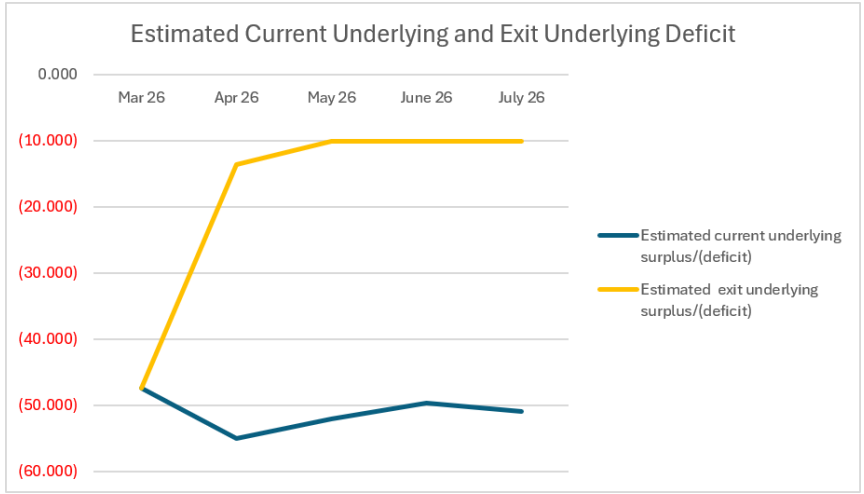
The analysis shows the current estimated underlying deficit as well as the estimated exit rate for each financial year.

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At month 4 the current underlying deficit is estimated at £51.0m 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.

Achievement of the recurrent efficiency schemes is key to allow the exit rate to be achieved.

The model is being reviewed following the submission of the new Provider Assurance Model (PAM) to incorporate the adjustments included in the PAM.



Estimated Underlying surplus/(deficit)	Mar 26	Apr 26	May 26	June 26	July 26
	£'m	£'m	£'m	£'m	£'m
YTD reported adjusted surplus/(deficit)	0.017	(1.189)	(4.260)	(6.375)	(5.069)
Less YTD DSF (£17M - 25/26, £15.7m, 26/27)	(17.000)	(1.308)	0.000	0.000	(3.924)
Less YTD NHSE 24/25 brokered support (£10m 25/26, £0m 26/27)	(9.986)	0.000	0.000	0.000	0.000
Less YTD CIP	(31.397)	(2.712)	(5.452)	(8.173)	(9.688)
Other Non-Recurrent Support/Pressures	(11.393)	0.000	(0.110)	(0.327)	(1.982)
Subtotal	**(69.760)**	**(5.209)**	**(9.822)**	**(14.875)**	**(20.663)**
Extrapolated to full year	(69.760)	(62.510)	(58.934)	(59.498)	(61.990)
Add Recurrent CIP FYE (implemented already)	22.300	7.400	6.800	12.300	11.000
Estimated current underlying surplus/(deficit)	**(47.460)**	**(55.110)**	**(52.134)**	**(49.692)**	**(50.990)**
Remove Recurrent CIP FYE (implemented already)	(22.300)	(7.400)	(6.800)	(12.300)	(11.000)
Add Recurrent CIP FYE (full year forecast)	22.300	48.829	48.829	51.906	51.906
Estimated exit underlying surplus/(deficit)	**(47.460)**	**(13.681)**	**(10.105)**	**(10.086)**	**(10.084)**

IDP Programme NB Includes both the Reset Programme and Local Schemes

In terms of recurrent full year effect:

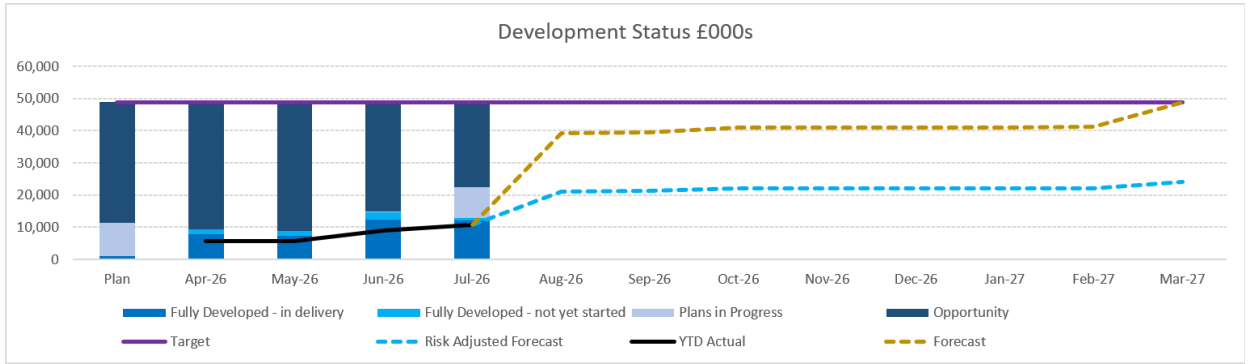
- Schemes implemented in the year to date will yield a recurrent full year effect of £10.6m (a reduction on month 3 following a workstream forecast review).
- Forecast delivery by the end of the year is in line with plan of £48.8m.
- The risk adjusted forecast stands at £24.1m, as at month 4 many schemes 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 4 we have delivered a recurrent reduction of 42.51 WTE (a reduction on month 3 following a workstream forecast review), this is forecast to rise to 502.0 WTE by the end of the year.

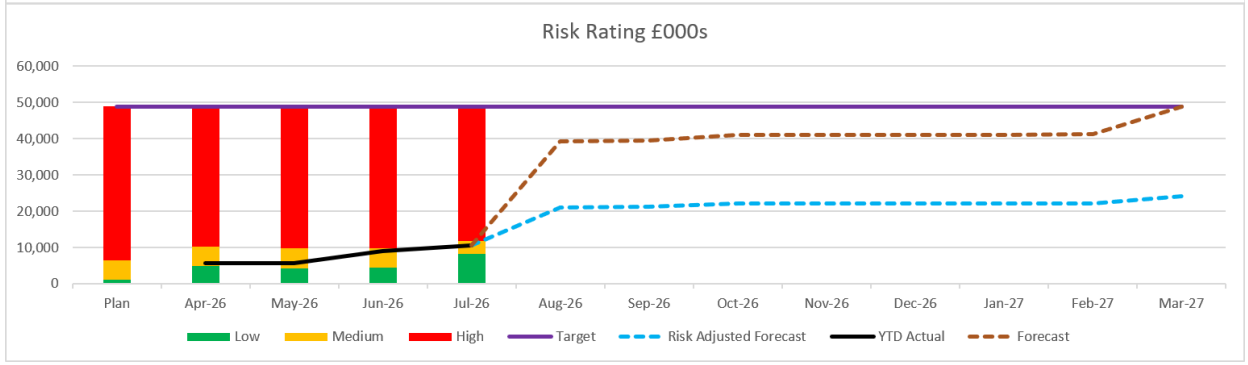
IDP Programme – Recurrent FYE (£)

Recurrent FYE £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
Fully Developed - in delivery	1,000	12,330	12,158	(171)
Fully Developed - not yet started	0	2,249	686	(1,563)
Plans in Progress	10,311	400	9,713	9,313
Opportunity	37,518	33,850	26,271	(7,579)
Unidentified	0	0	0	0
Total	**48,829**	**48,829**	**48,829**	**(0)**

Recurrent FYE £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
High	42,329	39,077	37,013	(2,064)
Medium	5,500	5,306	3,509	(1,796)
Low	1,000	4,446	8,306	3,861
Total	**48,829**	**48,829**	**48,829**	**0**

At the end of month 4 we have delivered a recurrent FYE of £10.6m and are forecasting delivery of £48.8m in line with plan by the end of the year. The risk adjusted forecast is £24.1m





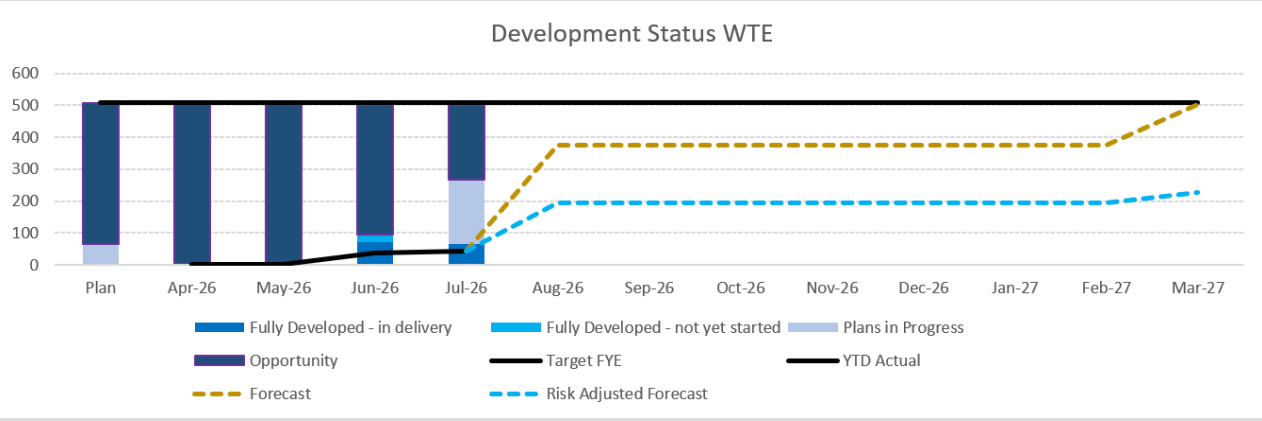
Workstream / Scheme	Movement from prior month FYE	Value £000's	Risk as per Month 3	Risk as per Month 4	Status as per Month 3	Status as per Month 4
Reset - Additional Sessions	Reduction in Forecast to more realistic levels	(3,279)	High	High	Opportunity	Opportunity
Reset - Agency & Bank	Reduction in Forecast to more realistic levels	(2,353)	High	High	Developed in Delivery	Developed in Delivery
Reset - Corporate Services	Increase in Forecast based on PRM discussions	(3,013)	High	High	Opportunity	Plans in Progress
Reset - Drug Cost Efficiency	Reduction in Forecast to more realistic levels	(1,500)	Medium	Medium	Developed in Delivery	Developed in Delivery
Reset - Theatres	Increase in forecast based on YTD delivery	463	Low	Low	Developed in Delivery	Developed in Delivery
Local - All	Forecast Review	9,682	High	High	Opportunity	Opportunity

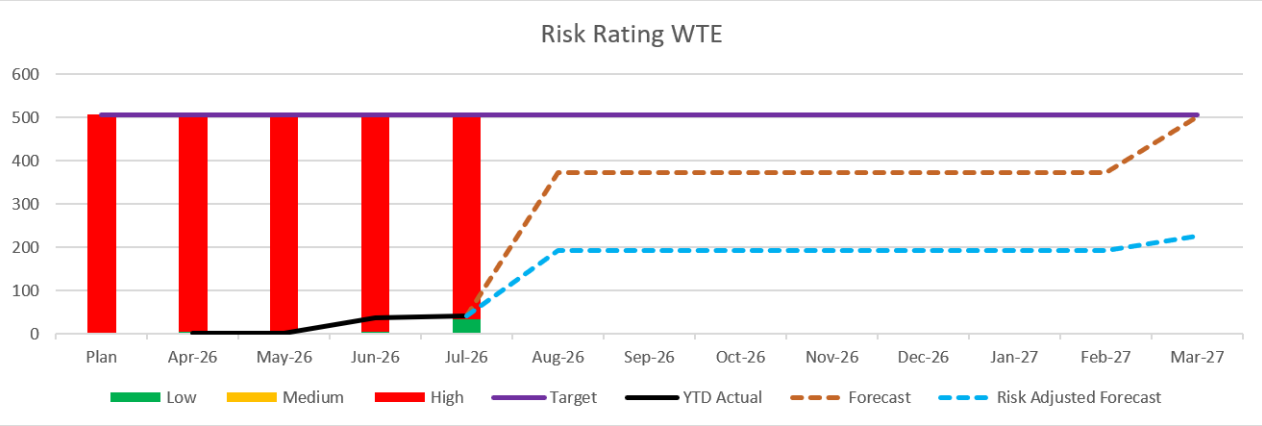
IDP Programme – Recurrent FYE (WTE reduction)

WTE - FYE	April Plan Submission	Month 3	Month 4	Increase (Decrease)
Fully Developed - in delivery	0.0	70.8	67.2	(3.6)
Fully Developed - not yet started	0.0	24.6	0.0	(24.6)
Plans in Progress	66.5	0.0	200.8	200.8
Opportunity	440.9	406.5	234.0	(172.6)
Unidentified	0.0	0.0	0.0	0.0
Total	**507.4**	**501.9**	**502.0**	**0.0**

WTE - FYE	April Plan Submission	Month 3	Month 4	Increase (Decrease)
High	507.4	497.6	468.0	(29.6)
Medium	0.0	0.0	0.0	0.0
Low	0.0	4.3	33.9	29.6
Total	**507.4**	**501.9**	**502.0**	**(0.0)**

Our committed plan is to reduce by 507.4 WTE recurrently in the year. At the end of month 4 we have delivered a recurrent FYE reduction of 42.5 WTE and are forecasting delivery of 502.0 WTE by the end of the year.





Workstream / Scheme	Movement	WTE	Risk as per Month 3	Risk as per Month 4	Status as per Month 3	Status as per Month 4
Reset - Agency & Bank	Reduction in Forecast to more realistic levels	(33.24)	High	High	Developed in Delivery	Developed in Delivery
Reset - Corporate Services	Increase in Forecast based on PRM discussions	(77.64)	High	High	Opportunity	Plans in Progress
Reset - Admin	Reduction in Forecast to more realistic levels	0.00	High	High	Opportunity	Plans in Progress
Reset - Ward Consolidation Ward 22	Following development of project plans	(7.80)	Low	Low	Developed not yet started	Developed in Delivery
Reset - Ward Consolidation MMH	Following development of project plans	0.00	High	High	Opportunity	Plans in Progress
Local - All	Forecast Review	118.70	High	High	Opportunity	Opportunity

SECTION 3
Delivering the 2026/27 committed plan

Executive Summary

In month surplus/deficit (July 2026)
The Trust is reporting a £5.1m year to date deficit, £2.3m adverse to plan, due to unachieved efficiencies (£1.7m) and Deficit Support Funding (DSF) not yet being earned for month 4 (£1.3m), these being partially offset by non recurrent technical benefits.

Activity
Outpatient new, outpatient follow up, and daycase were below plan in July. Elective is above plan mainly due to maternity admissions, however ERF activity is below plan. Year to date, outpatient new and outpatient follow up are behind plan and daycase and elective are above plan.

Efficiencies
Schemes implemented in the year will yield recurrent full year savings of £10.6m. Year to date in-year savings (which also include non-recurrent) are £9.7m (adverse to plan by £1.7m). The full year forecast for in-year savings remains in line with plan at £46.3m.

Implied Productivity
The most recently published data (full year 25/26) shows DBTH implied productivity is 0.2% **above** pre-covid (2019/20) levels (last month: -3.0%). This places the Trust in the top quartile of performers nationally and is better than both the national median (-5.2%) and the median of the group of peer Trusts selected by NHS England (-4.3%).

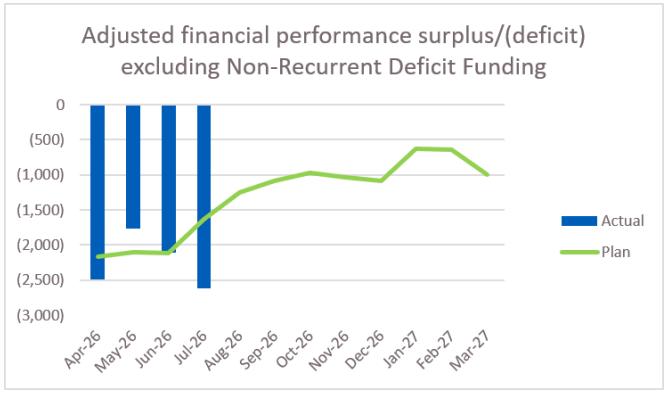
Cash
The cash balance is £12m and has increased by £3.9m as a result of the receipt of quarterly Education monies. Revenue cash support from NHSE is in the process of being requested to support the cash position.

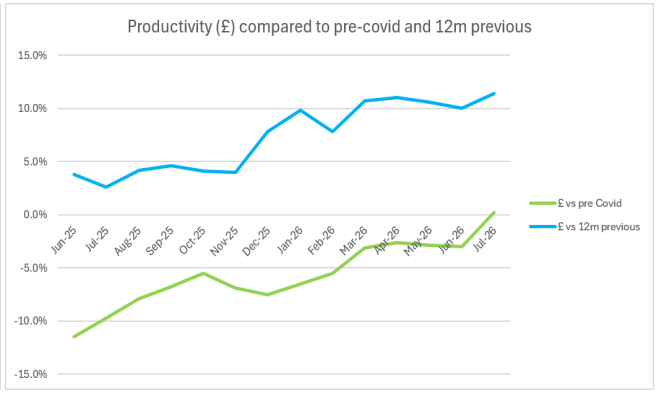
Capital
Capital expenditure (excluding charitable funds) is £0.3m in month against a plan of £2.2m and year to date is £1.0m against a plan of £6.4m.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
M04 July 2026
Income and Expenditure vs. Budget

Performance Indicator	Annual budget £'000	Monthly Performance Budget £'000	Actual £'000	Variance to budget £'000		YTD Performance YTD Budget £'000	YTD Actual £'000	Variance to budget £'000	
Income	(646,166)	(54,312)	(55,721)	(1,409)	F	(215,219)	(211,751)	3,468	A
Pay	433,301	36,688	36,647	(40)	F	146,704	145,334	(1,371)	F
Non Pay	204,198	17,230	17,192	(39)	F	68,409	69,381	972	A
Financing Costs	9,455	788	642	(145)	F	3,152	2,378	(774)	F
(Surplus)/Deficit for the period	**787**	**394**	**(1,240)**	**(1,634)**	**F**	**3,046**	**5,342**	**2,296**	**A**
Donated Asset Adjustment	(787)	(66)	(67)	(2)	F	(262)	(273)	(11)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**0**	**328**	**(1,307)**	**(1,635)**	**F**	**2,784**	**5,068**	**2,285**	**A**
Remove Deficit Support Funding	***15,700***	***1,308***	***3,924***	*2,616*	***A***	***5,233***	***3,924***	*(1,309)*	***F***
Adjusted Financial Performance Excluding Deficit Support Funding	***15,700***	***1,637***	***2,617***	***980***	***A***	***8,017***	***8,992***	***975***	***A***

Income: Over-achieved F; Under-achieved A
Expenditure: Underspent F; Overspent A
F = Favourable **A** = Adverse





Deficit Support Funding

NHSE North-East & Yorkshire region have confirmed their decision to:
(1) Award Q1 funding for the Trust in recognition of the progress made to date; and
(2) Withhold Q2 funding for the Trust until further progress is demonstrated on de-risking the delivery of the plan (including CIP delivery).

Eligibility for Q2 DSF, along with any decision to award Q3 DSF, will be re-assessed later in the year using month 5 results and will be required to be determined by region by 30th September.

To qualify for further DSF funding, the requirements are that the Trust must demonstrate 100% of the value of CIP is fully developed and being implemented, with the Trusts internal risk adjusted forecast demonstrating confidence in delivery of forecast (as independently reviewed by region), supported by Board assurance from the Chair and CEO.

At the month 4 reporting point £19.5m (42.1%) of the £46.3m in-year CIP programme is categorised within the fully-developed categories.

Key Risks and Mitigations to Delivery of In-Year Plan

Key Risks	Risks (R)				
	26/27 Plan	M2	M3	M4	(Increase) Decrease
	£'000	£'000	£'000	£'000	£'000
Efficiency risk	(32,659)	(24,463)	(18,635)	(18,640)	(5)
Commissioner Growth and clawback	(8,700)	(8,700)	(6,485)	(6,485)	0
Delays to acceleration of structural changes	(3,700)	(3,700)	0	0	0
Incremental drift	(500)	(500)	0	0	0
Potential error in estimation of revenue to capital transfer	(100)	(100)	0	0	0
Industrial Action	0	(680)	0	0	0
Total	**(45,659)**	**(38,143)**	**(25,120)**	**(25,125)**	**(5)**

Key Mitigations	Mitigations (M)				
	26/27 Plan	M2	M3	M4	Increase (Decrease)
	£'000	£'000	£'000	£'000	£'000
Reset programme	6,786	6,786	6,786	6,786	0
Negotiation with SY ICB / NHSE CDC allocation	0	6,525	6,485	6,485	0
Reset Programme	0	1,850	0	0	0
Non Recurrent technical	0	500	0	0	0
Non Recurrent technical	0	100	0	0	0
Non Recurrent technical	0	680	0	0	0
Total	**6,786**	**16,441**	**13,271**	**13,271**	**0**

26/27 Plan Net Risk	M4 Net Risk	(Increase) Decrease in month
£'000	£'000	£'000
(25,873)	(11,854)	(5)
(8,700)	0	0
(3,700)	0	0
(500)	0	0
(100)	0	0
0	0	0
(38,873)	**(11,854)**	**(5)**

- 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 £20.5m improvement in the gross risk profile since the plan was set.
- Mitigations have improved by £6.5m (£6.8m to £13.3m) since the plan submission.
- The net risk has reduced by £27m since plan submission to £11.9m.

Surplus/Deficit – Graphs M04

In month/Year to Date

- In month £1.3m deficit, a £1.6m favourable to plan mainly due to Deficit Support Funding (DSF) being received for Q1 £3.9m.
- Year to date (YTD) £5.1m deficit, £2.3m adverse to plan mainly due to the DSF not being achieved for Month 4, (£1.3m) unachieved efficiencies (£1.7m), offset by non recurrent technical benefits.
- As per NHSE guidance, the Trust is only able to recognise Deficit Support Funding when paid.

Income

- Income is adverse to plan YTD mainly due to Clinical Income £2.5m; Deficit support funding of £1.3m, CDC activity £0.6m and ERF activity of £0.5m. Operating income is adverse to plan £1.1m mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges.

Pay

- Pay is in line with plan in month and £1.4m favourable YTD mainly due to delays in spend for transformation funding/investments. Unachieved CIP is £3.8m year to date.
- Bank/agency and additional medical sessions spend in month is £4.3m (previous month: £3.6m) due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

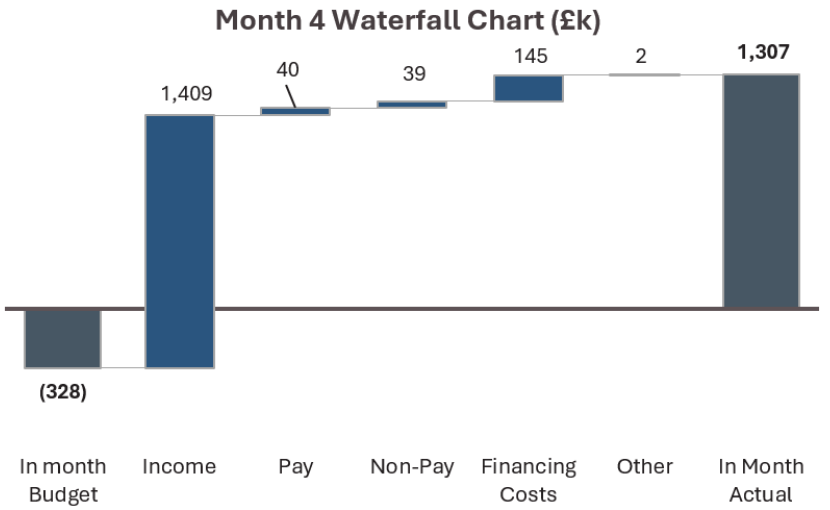
- Non-pay is in line with plan in month and £1m adverse YTD mainly due to clinical supplies additional activity, equipment hire and repairs, partially offset by the release of reserves.

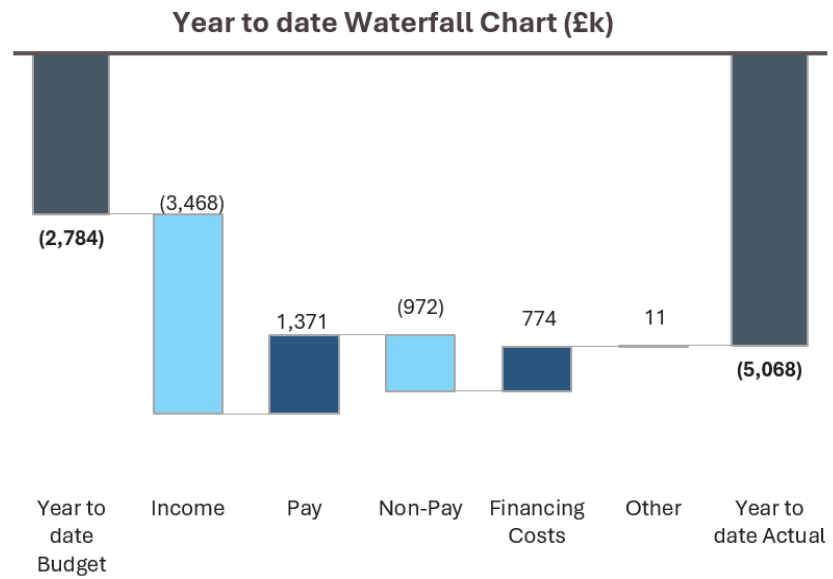
Other

- Adjustments for donated assets are broadly in line with plan.

Financing Costs

- Higher interest rates than planned has increased interest income.





Financial Performance – Income

Clinical Income Position Month 4

	Annual Plan	Plan - M4 YTD	Actuals - M4 YTD	Variance
	£'000	£'000	£'000	£'000
ICB				
NHS South Yorkshire ICB	(398,429)	(133,090)	(132,104)	986
NHS Nottingham and Nottinghamshire ICB	(120,844)	(40,281)	(40,480)	(198)
NHS Humber and North Yorkshire ICB	(9,043)	(3,014)	(2,976)	38
NHS Derby and Derbyshire ICB	(6,307)	(2,102)	(2,150)	(47)
NHS West Yorkshire ICB	(4,123)	(1,374)	(1,370)	4
NHS Lincolnshire ICB	(2,290)	(763)	(762)	1
LVA	(1,348)	(449)	(449)	(0)
ERF	0	0	525	525
CDC	0	0	555	555
UEC	0	0	(220)	(220)
Excluded drugs (ICB)	1,011	1,011	1,012	0
ICB sub total	**(541,373)**	**(180,063)**	**(178,418)**	**1,645**
NHS England				
Deficit Support Funding	(15,700)	(5,233)	(3,924)	1,309
Armed Forces / Retained Block	0	0	(41)	(41)
Drugs and Devices	(10,561)	(3,365)	(3,492)	(127)
Offender Health	(1,657)	(552)	(562)	(10)
Public Health	(4,678)	(1,559)	(1,573)	(14)
NHS England sub total	**(32,596)**	**(10,710)**	**(9,591)**	**1,118**
Other Clinical Income	(142)	(231)	(471)	(240)
Grand Total	**(574,112)**	**(191,004)**	**(188,481)**	**2,523**
other income - RTAs, PPs, OSV, CIP	(6,013)	(2,004)	(2,073)	(69)
	(580,125)	(193,008)	(190,554)	2,454

Month 4

The Clinical Income position is showing an adverse variance to plan of £2.5m due to Deficit Support Funding (£1.3m), CDC activity (£0.6m) ERF Activity (£0.5m) and non recurrent transformation income. This has been offset by UEC income, depreciation funding, cancer alliance monies and other clinical income. Operating income is adverse to plan (£1.1m) mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges. Deficit support funding has been assumed in the year-to-date position as per the NHSE guidance up to Month 3, as 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 4 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying ERF performance.

ICB	ERF	Plan M4	Actual M4	Variance	Notes
South Yorkshire	(91,652)	(31,813)	(31,255)	558	No variance transacted
Nottinghamshire	(31,100)	(10,795)	(10,218)	577	
Lincolnshire	(758)	(263)	(237)	26	
Derbyshire	(1,036)	(359)	(353)	6	
West Yorkshire	(749)	(260)	(330)	(70)	
Humber & North Yorkshire	(1,911)	(663)	(677)	(14)	
Total	(127,206)	(44,154)	(43,070)	525	

Financial Performance – UEC Position

Urgent and Emergency Care Income Position Month 4

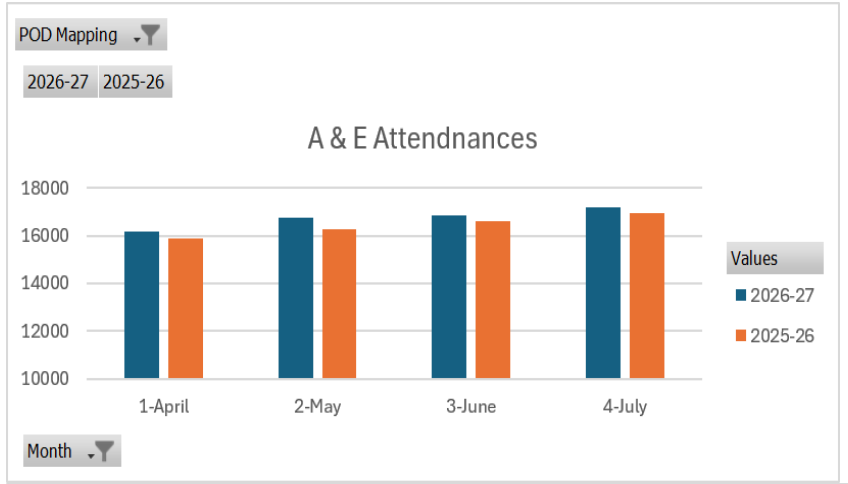
Change in Commissioning Approach 2026-27

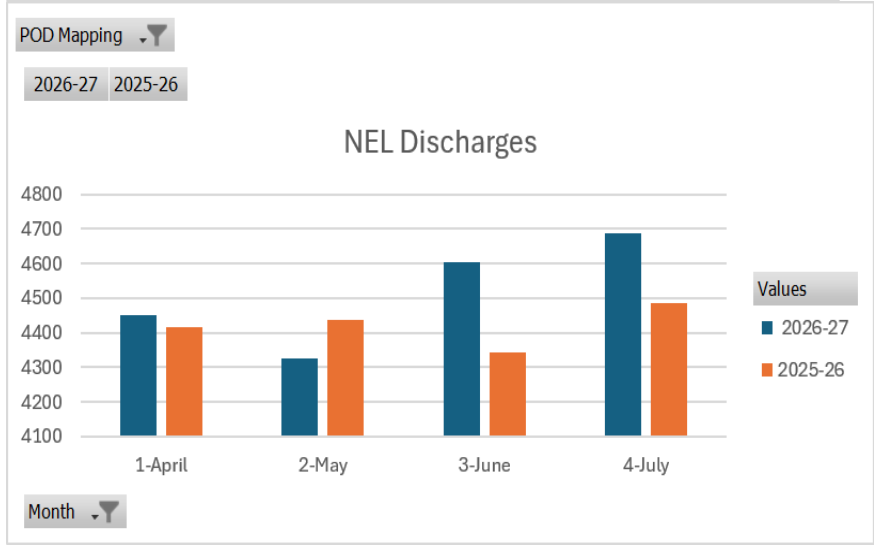
For 2026/27, urgent and emergency care (UEC) activity is commissioned and reimbursed through the NHS Payment Scheme using the Aligned Payment and Incentive (API) model. Under this approach, providers receive a fixed annual payment alongside an activity-based adjustment for emergency care services.

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 4 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying UEC performance. For the associates, the YTD month 3 performance was £0.1m favourable after applying the marginal rate. SY ICB is monitoring in shadow form by agreement in a side letter to the contract, whereas the other commissioners are implementing it fully.

ICB	UEC	Plan M4	Actual M4	Variance	UEC Marginal Rate	Notes
South Yorkshire	(144,180)	(47,581)	(49,602)	(2,022)	(404)	No variance transacted
Nottinghamshire	(54,295)	(17,956)	(19,060)	(1,105)	(221)	
Lincolnshire	(408)	(135)	(189)	(54)	(11)	
Derbyshire	(3,020)	(997)	(858)	139	28	
West Yorkshire	(1,589)	(524)	(544)	(19)	(4)	
Humber & North Yorkshire	(4,552)	(1,502)	(1,564)	(61)	(12)	
Total	(208,044)	(68,694)	(71,817)	(1,101)	(220)	





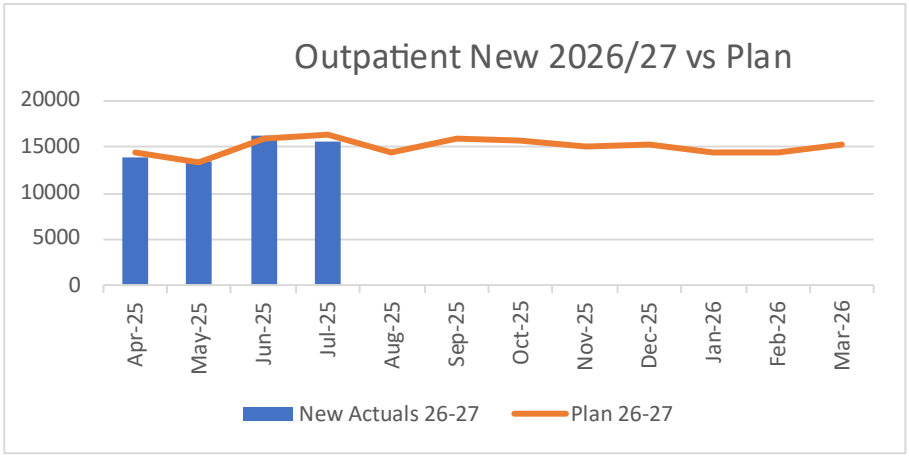
Activity Against Plan 2026/27

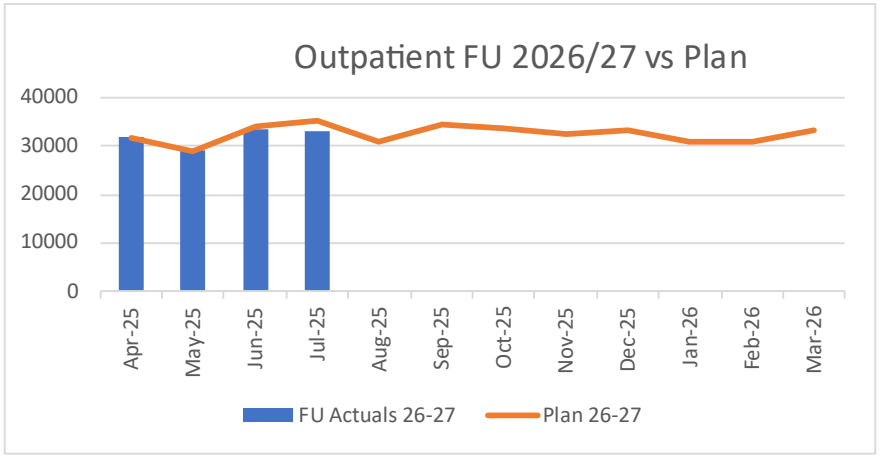
Data as at 04/08/2026

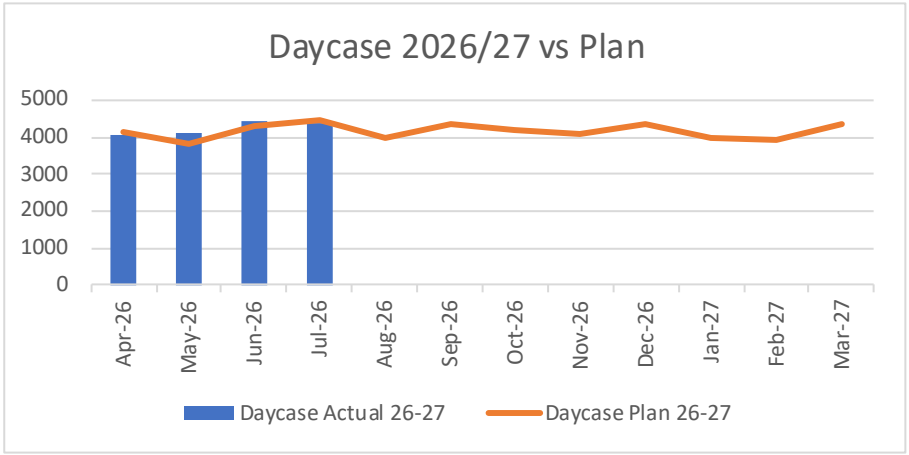
Point of Delivery	Activity vs Plan (July 2026)
Outpatients New	95.0%
Outpatient Follow up	93.5%
Daycase, excluding MEOC	98.8%
Elective, excluding MEOC	103.5%

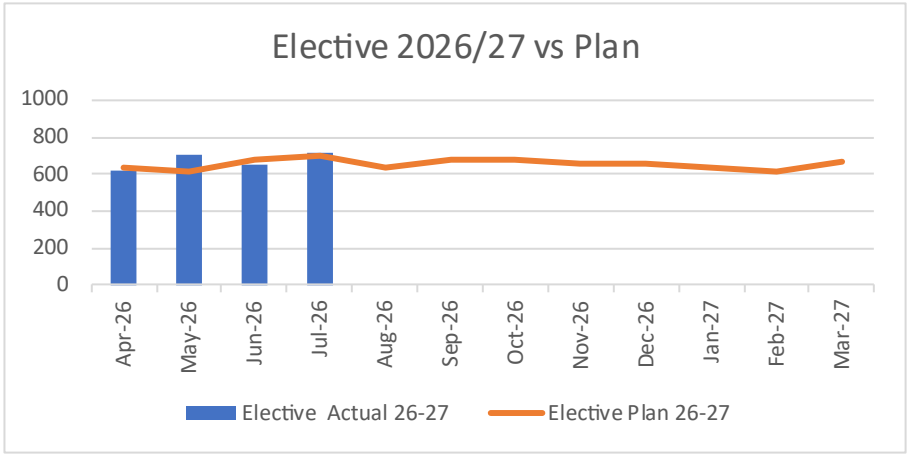
- Outpatient New, Outpatient Follow up, and daycase were below plan in July. Elective was above plan.
- Outpatient New were -813 below plan in month and -1119 below plan YTD (98.1%).
- Outpatient Follow up were -2296 below plan in month and -2327 below plan YTD (98.2%)
- Daycases were -55 below plan cases in month and 363 cases above plan YTD (102.2%)
- Electives were 24 cases above plan in month and above by 103 cases YTD (104.0%)

Comparison to ERF – Please note that these graphs show all activity from all commissioners. This is not a direct comparison with the calculated ERF position which is only based on SY ICB and associate activity. ERF is also reliant on the case mix of the patients seen and doesn't include any maternity related activity which is 93 of the YTD elective overperformance.







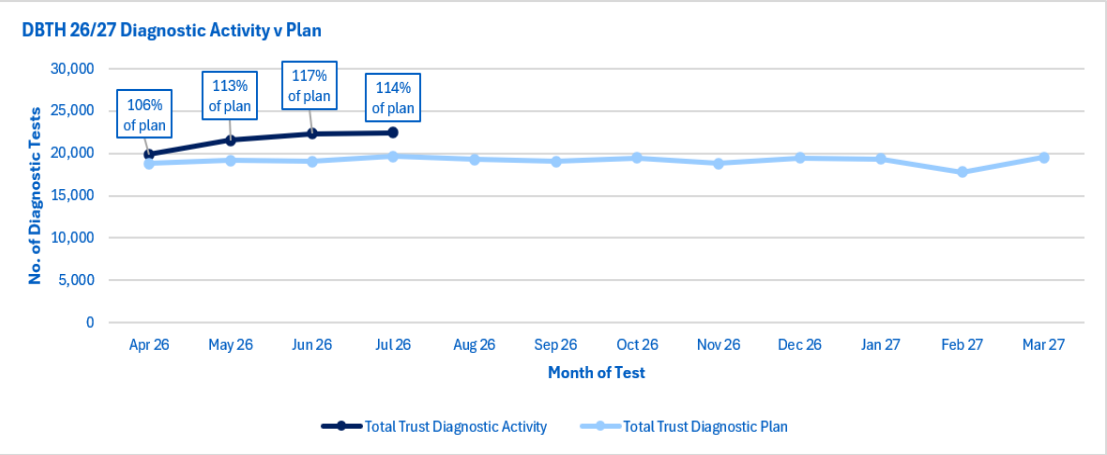


Please note that the performance is expected to improve as further clinics are reconciled after the data was extracted for this reporting period

Diagnostic Activity Against Plan 26/27

Data as at 06/08/2026

- Diagnostic activity in July (22,428) was the highest monthly total so far this year and was 114% of the diagnostic plan for July (19,633), taking the YTD activity delivery (86,127) to 112% of plan (76,597).
- NOUS had the largest over delivery of plan in terms of activity numbers (1,334 exams above plan in July) but the highest activity as a percentage of plan figure in July was in Cystoscopy, where activity in July represented 142% of plan.
- Audiology was behind plan in month by 402 and the lowest percentage of plan delivered (38% in July).



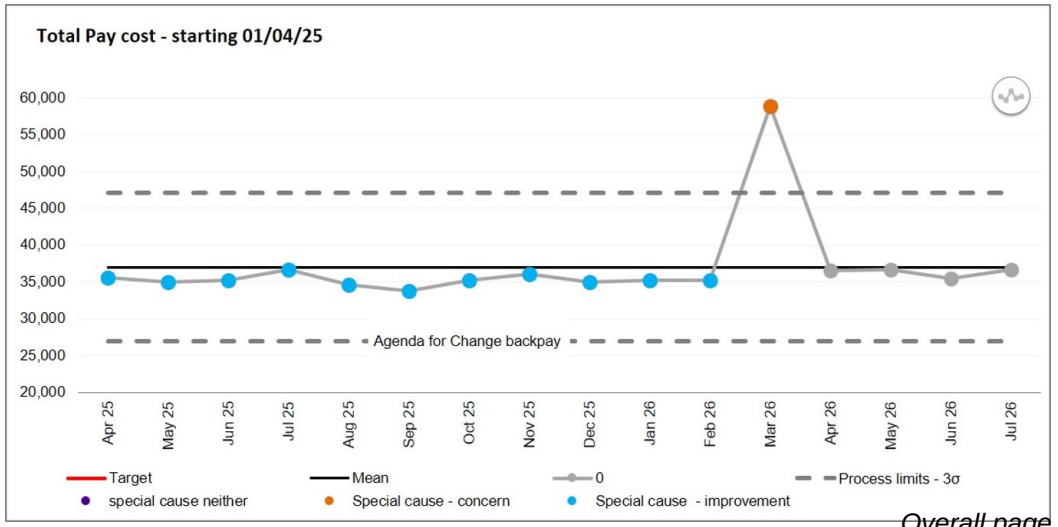
Please note: *the activity numbers above are taken from the DM01 Diagnostic Reconciliation file and the plan numbers are taken from the Trust's Plan Submission. The plan specified the 'number of diagnostic tests or procedures carried out' and so therefore the activity numbers do not include interventional activity; the activity numbers also exclude the two Barium Enema exams that have taken place this year as the submission did not include Barium Enema activity.*

Financial Performance - Pay

In Month – In line with plan in month and £1.4m favourable YTD.

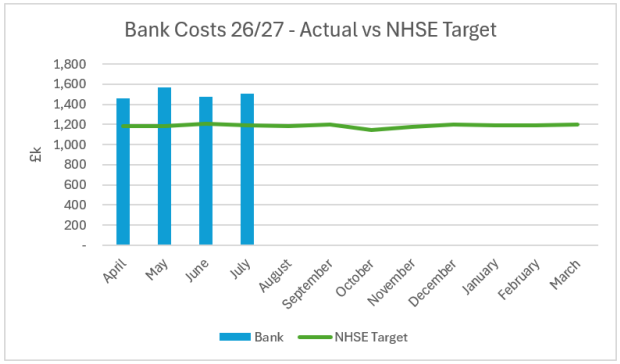
- Pay is £1.4m favourable YTD mainly due to delays in spend for transformation funding/investments.
- Bank/agency and additional medical sessions spend in month is £4.3m (previous month: £3.6m) due to operational pressures, cover for vacant posts and sickness cover.
- Additional sessions increased by £0.3m, mainly within UEC.
- Bank spend remained in line with previous months
- Agency spend increased by £0.4m, mainly in UEC and Surgery, linked to additional activity and cover for vacancies.

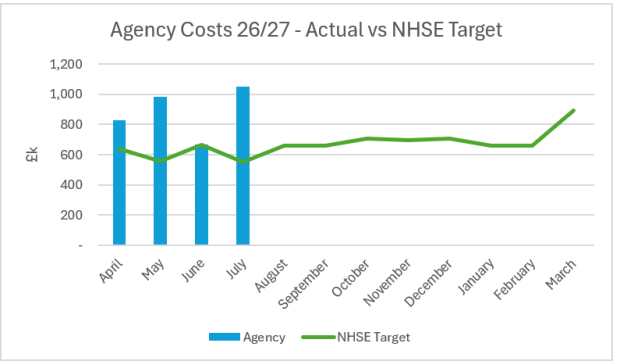
Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,755	6,281	-475	F	-1,909	F
Ambulance staff						
Apprenticeship Levy	135	136	1	A	-14	F
Allied health professionals	3,124	3,073	-51	F	-206	F
Healthcare science staff	23	32	9	A	37	A
Medical and dental	11,469	12,599	1,130	A	3,622	A
Non Medical Non Clinical				A		A
Nursing & midwifery	13,838	13,681	-157	F	42	A
Comprising:						
Registered nursing	*10,619*	*10,015*	*-604*	*F*	*-1,750*	*F*
Unregistered nursing	*3,219*	*3,655*	*436*	*A*	*1,765*	*A*
Scientific, therapeutic and tech	890	865	-25	F	-100	F
Reserves & Technical Adjustments	453	-19	-473	F	-2,842	F
Total Trust	**36,688**	**36,647**	**-40**	**F**	**-1,371**	**F**



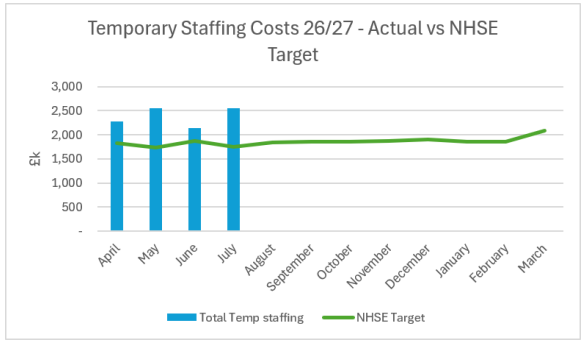
Financial Performance – Bank & Agency

In Month: Bank, £1.5m & Agency, £1.1m
Previous Month: Bank, £1.5m & Agency, £0.7m





- The NHSE target is based on the plan submission to NHSE and meets the cap limit.
- Agency costs in month are £1.1m, above plan by £0.5m and £0.4m higher than the previous month mainly due Surgery and UEC due to vacancies and additional activity.
- Bank costs in month are £1.5m, above plan but are in line with 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.

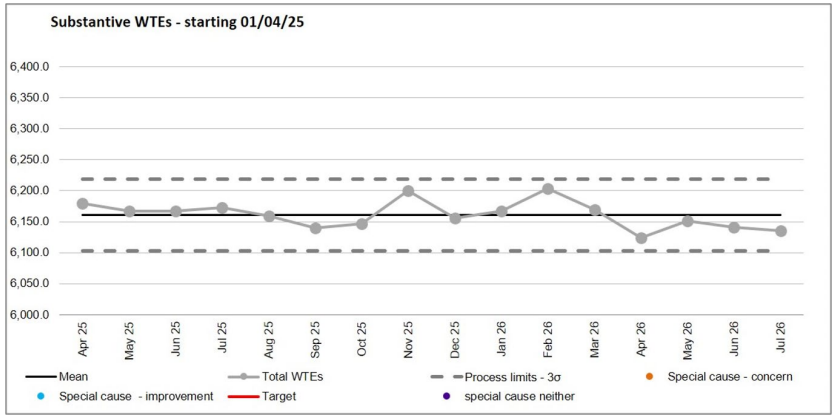


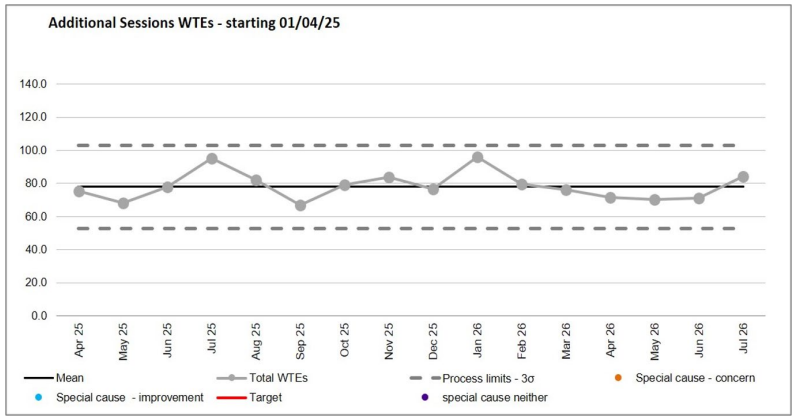
Temporary Staffing	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	YTD % of Total Pay
Bank - Actual	1,458	1,566	1,471	1,504									2.5%
Bank - Target	1,183	1,181	1,204	1,194	1,181	1,198	1,148	1,172	1,200	1,193	1,193	1,199	
Variance	**275**	**385**	**267**	**310**									
Agency - Actual	826	981	665	1,052									3.4%
Agency - Target	640	556	666	553	657	661	706	698	704	659	658	890	
Variance	**186**	**425**	**- 1**	**499**									**5.9%**

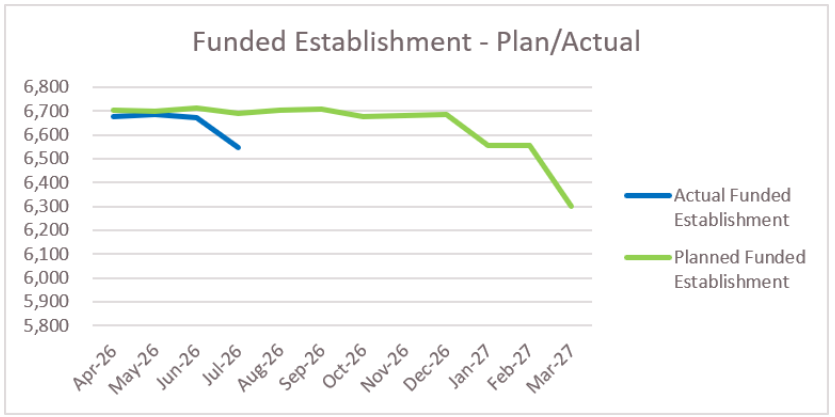
Financial Performance – Worked WTE

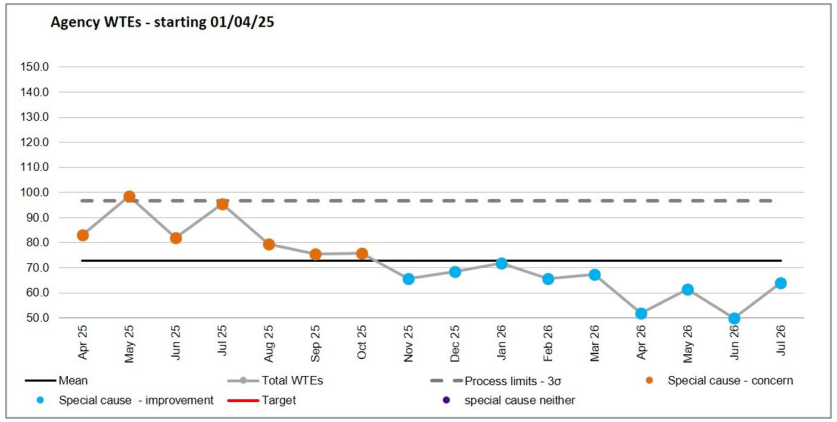
Workforce	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Additional Sessions	Total Temporary WTE	Total Worked WTE	Variance
Current Month	6,526.6	6,135.5	326.6	64.1	84.37	475.1	6,610.6	84.0
Previous Month	6,671.8	6,140.8	322.4	50.0	71.23	443.7	6,584.5	-87.3
Movement	-145.1	-5.2	4.2	14.1	13.1	31.4	26.2	171.3

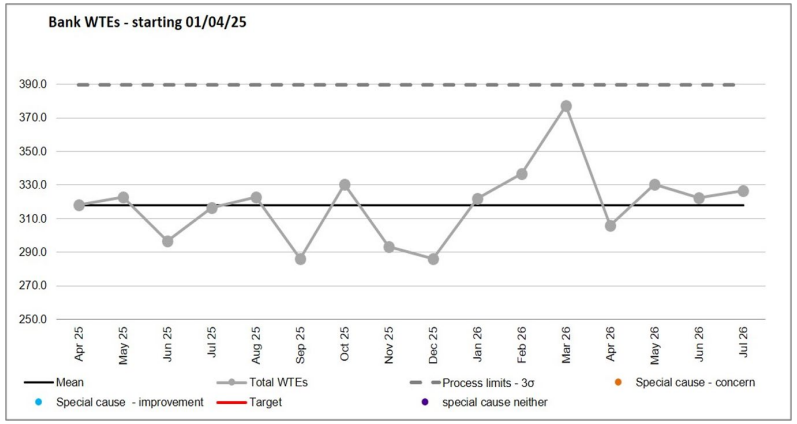
- The WTE's reported are worked WTE which are derived from the actual hours paid and worked.
- Funded Establishment – WTE Contracted and Plan Graph the WTEs for Additional Sessions, Bank and Agency are the worked WTE as we do not have any contracted wte for temporary staffing.
- Funded WTE have reduced by 145.1 mainly due to the profile of CIP savings (122.3) and skills mix in CSS.
- Substantive staff have reduced slightly in month due to vacancies
- Bank WTE increase mainly in UEC due to a response to CQC.
- Additional sessions have increased in UEC due to increased vacancies and backdated claims for prior periods.
- Agency has increased mainly in Surgery and UEC due to vacancies and additional activity.

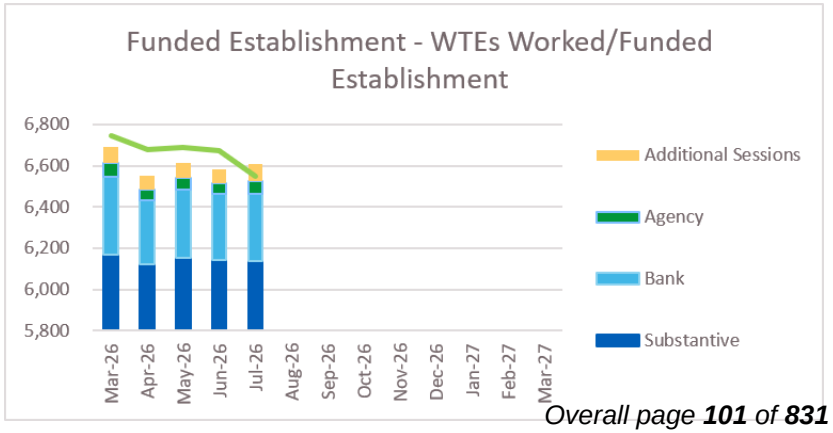








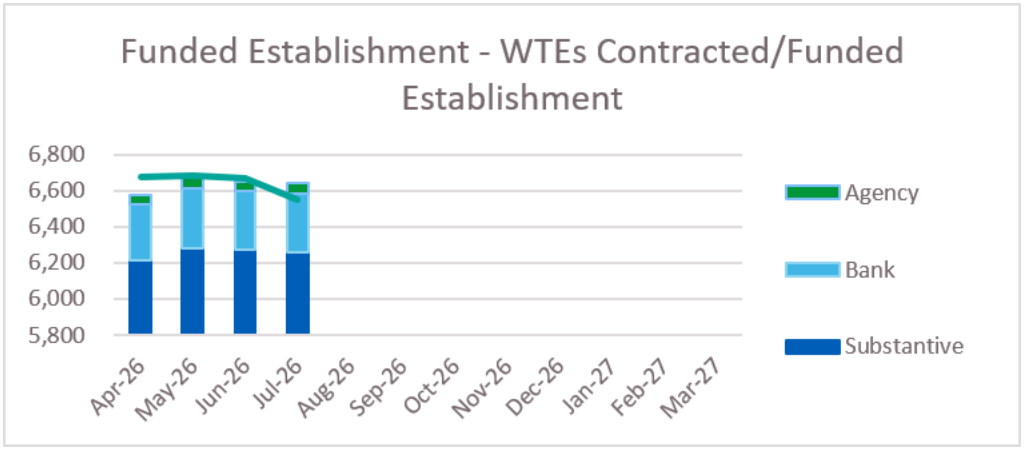




Financial Performance – Contracted WTE

Table 1 – Budget WTE

	2026/27 Budget WTE				
Total Pay WTE by Cost Type	Apr-26	May-26	Jun-26	Jul-26	Movement
2a. Substantive	6,739.82	6,768.70	6,769.99	6,651.92	(118.07)
2b. Bank	1.39	1.31	1.31	1.31	0.00
2c. Agency	44.62	27.19	30.21	30.21	0.00
2d. Reserves - Pay	(108.27)	(111.03)	(129.73)	(156.81)	(27.08)
Total	**6,677.56**	**6,686.17**	**6,671.78**	**6,526.63**	**(145.15)**



Reserves – Relates to planned Reset Savings not yet fully developed

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	6,526.63	6,253.26	273.37	4.2%	326.63	64.10	0.00	390.73	6,643.99	(117.36)	(1.8%)
Previous Month	6,671.78	6,276.63	395.15	5.9%	322.43	50.03	0.00	372.46	6,649.09	22.69	0.3%
Movement	(145.15)	(23.37)	(121.78)	(1.7%)	4.20	14.07	0.00	18.27	(5.10)	(140.05)	(2.1%)

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 reduced by 145.15 Whole Time Equivalents (WTE) in month 4, mainly due to CIP retractions. Based on the number of contracted staff, there is a 'vacancy' rate of 4.2% gross (5.9% last month) and a 1.8% over-establishment net of temporary staffing (0.3% vacancy rate last month).

Additional sessions WTE are excluded as they are not contracted WTE's.

Financial Performance – Non-Pay

In Month – in line with budget
YTD - £1.0m adverse to budget

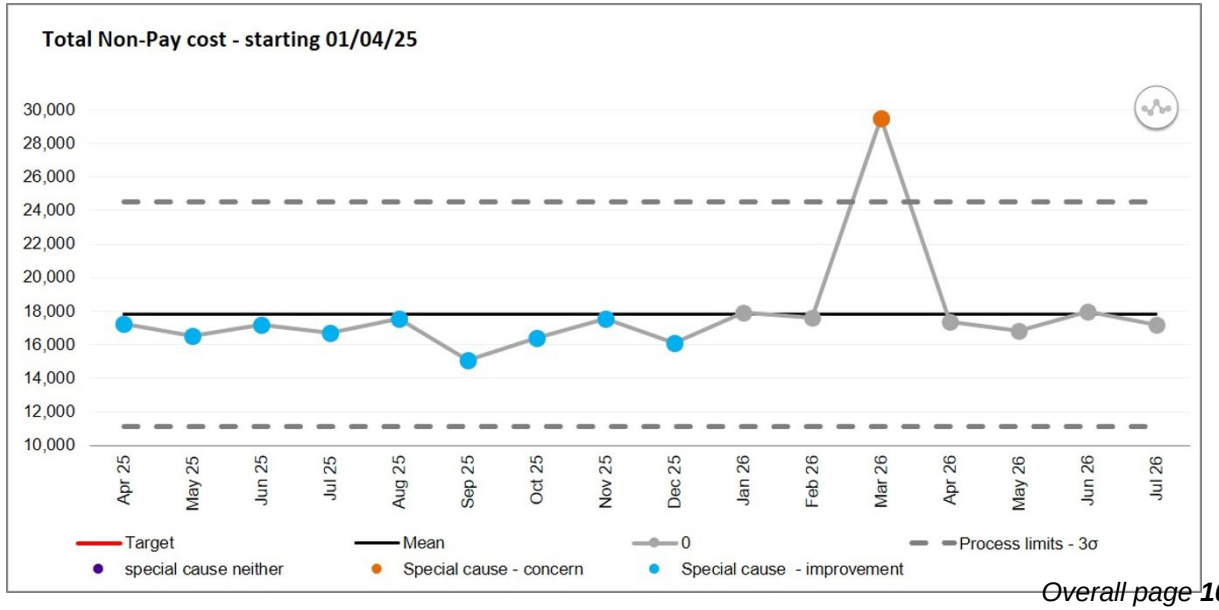
The main reasons for the adverse YTD variance is due to:

- £0.4m Drugs expenditure – inflation has been allocated, activity increases are being reviewed by Divisions
- £1.4m – Clinical supplies; £0.6m additional activity, £0.8m equipment contract hire and repairs
- £1.1m - Other costs - unachieved CIP
- £0.2m - depreciation

Offset by:

- Non pay reserves of £1.5m 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)	1,609	1,935	326	A	532	A
Drugs (non PBR)	1,734	1,709	(26)	F	(88)	F
Clinical Supplies and Services	3,607	3,915	308	A	1,464	A
Other costs	7,800	7,449	(350)	F	407	A
Non-Executive Directors	16	13	(3)	F	(13)	F
Depreciation	1,658	1,738	80	A	225	A
Reserves & Technical Adjustments	(1,081)	(1,448)	(366)	F	(1,533)	F
Recharges	1,848	1,846	(2)	F	(2)	F
Parkhill	40	33	(7)	F	(20)	F
Total Trust	**17,230**	**17,192**	**(39)**	**F**	**972**	**A**



IDP Programme NB Includes both the Reset Programme and Local Schemes

In terms of 2026/27 in-year impact:

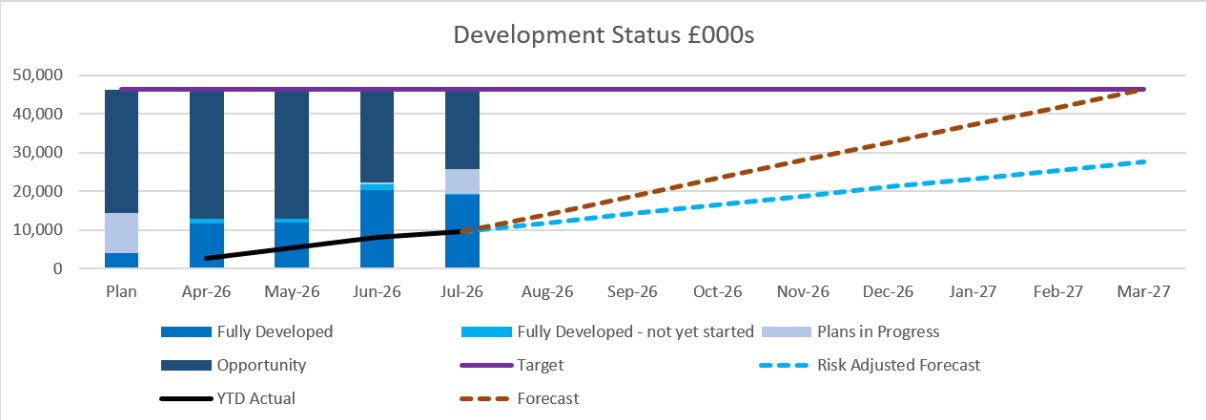
- In month 4 the Trust delivered £1.5m of savings vs a plan of £3.2m. This includes non-recurrent savings of £0.4m.
- Forecast in-year savings are £46.3m in line with plan, with a risk adjusted forecast of £27.7m.
- The committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction as at month 4 is 97.7 WTE, of which 60.93 WTE is driven by pay underspends in the year to date. There is forecast to be an average reduction of 351.0 WTE across the full year.

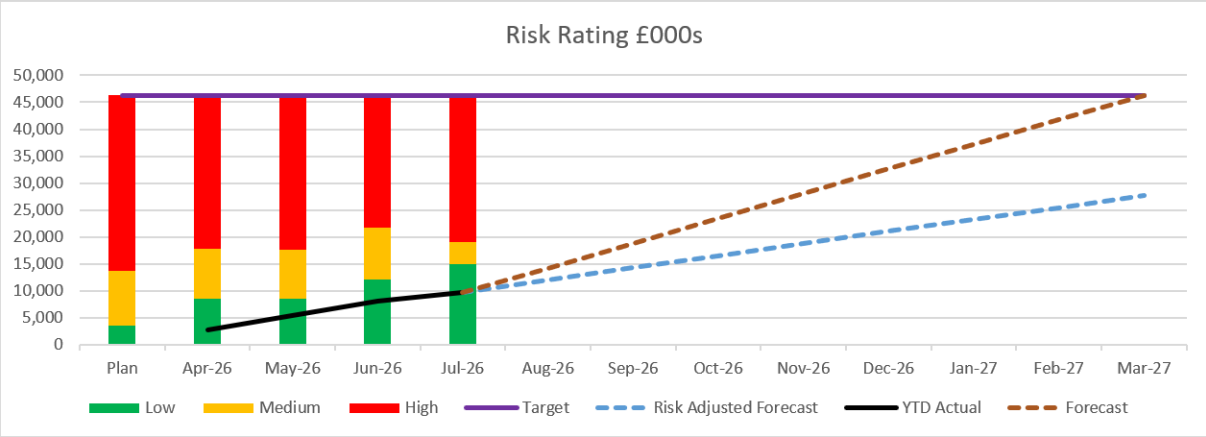
IDP Programme – 2026/27 In Year Savings (£)

Efficiency Plan Status £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
Fully Developed - in delivery	4,077	20,319	19,034	(1,285)
Fully Developed - not yet started	0	1,487	437	(1,050)
Plans in Progress	10,311	400	6,335	5,935
Opportunity	31,902	24,084	20,484	(3,601)
Unidentified	0	0	0	0
Total	**46,290**	**46,290**	**46,290**	**(0)**

Efficiency Plan Risk £000's	April Plan Submission	Month 3	Month 4	Increase (Decrease)
High	32,657	24,606	27,174	2,568
Medium	10,072	9,535	4,183	(5,353)
Low	3,561	12,149	14,934	2,785
Total	**46,290**	**46,290**	**46,290**	**(0)**

The committed plan is to deliver £46.3m of in-year savings during 2026/27. As at month 4 we have delivered £9.7m of savings (21% of the full year plan). This is behind plan by £1.7m plan and includes non-recurrent savings. Forecast delivery for the full year is £46.3m and the risk adjusted forecast is £27.7m.





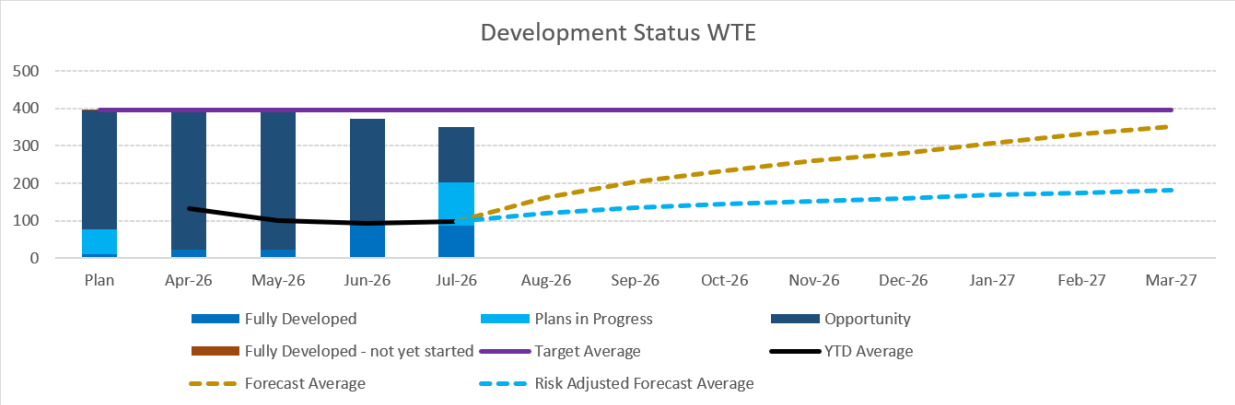
Workstream / Scheme	Movement	Value £000's	Risk as per Month 3	Risk as per Month 4	Status as per Month 3	Status as per Month 4
Reset - Theatres	Increase in forecast based on YTD delivery	463	Low	Low	Developed in Delivery	Developed in Delivery
Reset - Diagnostics	Reduction in Forecast to more realistic levels	(750)	High	High	Opportunity	Opportunity
Reset - Agency & Bank	Reduction in Forecast to more realistic levels	(2,353)	High	High	Developed in Delivery	Developed in Delivery
Reset - Medical Workforce	Following development of project plans	0	High	High	Opportunity	Plans in Progress
Reset - Corporate Services	Increase in Forecast based on PRM discussions	515	High	High	Opportunity	Plans in Progress
Reset - Admin	Reduction in Forecast to more realistic levels	(656)	High	High	Opportunity	Plans in Progress
Reset - Bassetlaw Service Review	Reduction in Forecast to more realistic levels	(443)	High	High	Opportunity	Opportunity
Reset - HoH, Service Rationalisation and Acute Partnership	Reduction in Forecast to more realistic levels	(1,473)	High	High	Opportunity	Opportunity
Reset - Ward Consolidation Ward 22	Following development of project plans	0	Low	Low	Developed not yet started	Developed in Delivery
Reset - Ward Consolidation MMH	Following development of project plans	0	High	High	Opportunity	Plans in Progress
Reset - Additional Sessions	Reduction in Forecast to more realistic levels	(3,279)	High	High	Opportunity	Opportunity
Reset - Drug Cost Efficiency	Reduction in Forecast to more realistic levels	(1,500)	Medium	Medium	Developed in Delivery	Developed in Delivery
Local - All	Forecast Review	9,476	High	High	Opportunity	Opportunity

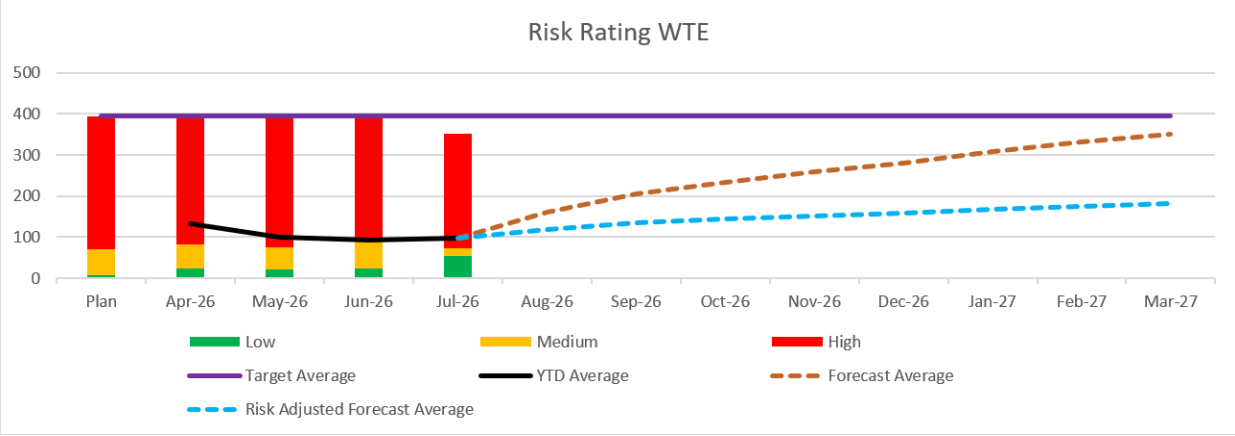
IDP Programme – 2026/27 In-Year (WTE reduction)

WTE - in year	April Plan Submission	Month 3	Month 4	Increase (Decrease)
Fully Developed - in delivery	9.3	90.6	85.4	(5.2)
Fully Developed - not yet started	0.0	16.4	-	(16.4)
Plans in Progress	66.5	0.0	117.0	117.0
Opportunity	319.4	282.9	148.6	(134.3)
Unidentified	0.0	0.0	-	0.0
Total	**395.1**	**389.9**	**351.0**	**(38.9)**

WTE - in year	April Plan Submission	Month 3	Month 4	Increase (Decrease)
High	323.9	301.4	277.3	(24.0)
Medium	64.9	64.1	18.9	(45.2)
Low	6.3	24.5	54.8	30.4
Total	**395.1**	**389.9**	**351.0**	**(38.9)**

Our committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction as at month 4 is 97.7 WTE and the forecast average reduction across the full year is currently 351.0 WTE.





Workstream / Scheme	Movement	WTE	Risk as per Month 3	Risk as per Month 4	Status as per Month 3	Status as per Month 4
Reset - Agency & Bank	Reduction in Forecast to more realistic levels	(35.88)	High	High	Developed in Delivery	Developed in Delivery
Reset - Corporate Services	Increase in Forecast based on PRM discussions	(61.96)	High	High	Opportunity	Plans in Progress
Reset - Admin	Reduction in Forecast to more realistic levels	(16.82)	High	High	Opportunity	Plans in Progress
Reset - Bassetlaw Service Review	Reduction in Forecast to more realistic levels	(6.54)	High	High	Opportunity	Opportunity
Reset - HoH, Service Rationalisation and Acute Partnership	Reduction in Forecast to more realistic levels	(25.43)	High	High	Opportunity	Opportunity
Local - All	Forecast Review	108.35	High	High	Opportunity	Opportunity

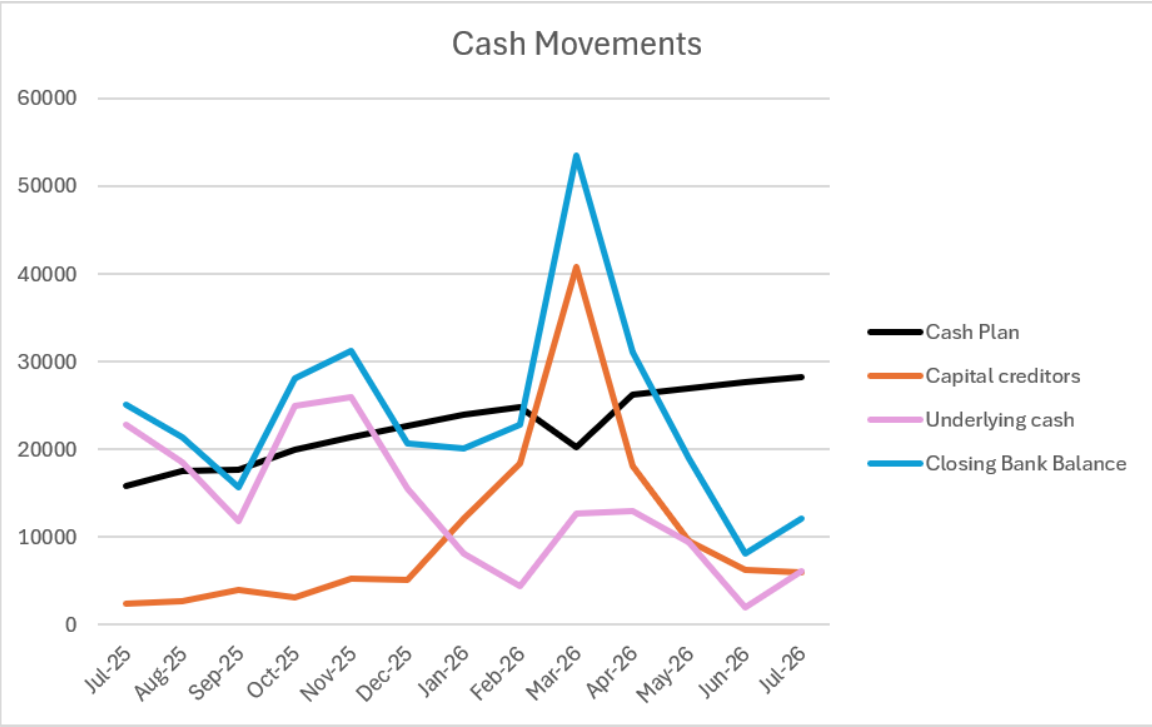
IDP Programme – Reset/Local

	In Year - Year to Date £000s			In Year - Full Year £000s			In Year - Year to Date WTE			In Year - Full Year WTE		
Pillar	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	500	-	(500)	3,416	1,500	(1,916)	0.00	0.00	0.00	31.96	0.00	(31.96)
Workforce & Organisational Design	2,489	506	(1,983)	11,980	6,572	(5,408)	137.51	7.05	(130.46)	252.98	138.32	(114.66)
Access & Flow	2,022	630	(1,392)	7,634	4,068	(3,566)	6.29	6.32	0.04	36.06	30.32	(5.74)
Productivity & Financial Reset	4,029	5,140	1,111	9,577	10,211	634	25.15	18.39	(6.76)	9.27	9.17	(0.10)
Total Reset	**9,040**	**6,276**	**(2,764)**	**32,607**	**22,351**	**(10,257)**	**168.94**	**31.76**	**(137.19)**	**330.27**	**177.80**	**(152.46)**
Local	2,338	1,903	(434)	13,683	8,405	(5,278)	64.86	65.97	1.11	64.86	67.10	2.24
Reserves Support	-	1,509	1,509	-	1,509	1,509	-	-	0.00	-	-	0.00
Total Local	**2,338**	**3,412**	**1,074**	**13,683**	**9,913**	**(3,769)**	**64.86**	**65.97**	**1.11**	**64.86**	**67.10**	**2.24**
Total Reset & Local	**11,378**	**9,688**	**(1,690)**	**46,290**	**32,264**	**(14,026)**	**233.80**	**97.73**	**(136.08)**	**395.13**	**244.91**	**(150.22)**
Local - Opportunity	-	-	0	-	14,026	14,026	-	-	0.00	-	106.11	106.11
Grand Total	**11,378**	**9,688**	**(1,690)**	**46,290**	**46,290**	**(0)**	**233.80**	**97.73**	**(136.08)**	**395.13**	**351.02**	**(44.11)**

	Recurrent FYE - Year to Date £000s			Recurrent FYE - Full Year £000s			Recurrent FYE - Year to Date WTE			Recurrent FYE - Full Year WTE		
Pillar	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	1,500	-	(1,500)	9,165	9,165	0	0.00	0.00	0.00	127.85	127.85	0.00
Workforce & Organisational Design	14,439	844	(13,595)	14,594	7,696	(6,898)	317.17	33.24	(283.93)	320.00	208.93	(111.07)
Access & Flow	7,120	3,523	(3,597)	8,763	5,947	(2,816)	25.15	1.96	(23.19)	59.54	51.75	(7.80)
Productivity & Financial Reset	6,500	3,675	(2,825)	6,500	5,000	(1,500)	0.00	2.68	2.68	0.00	2.68	2.68
Total Reset	**29,559**	**8,043**	**(21,516)**	**39,022**	**27,808**	**(11,214)**	**342.32**	**37.88**	**(304.44)**	**507.40**	**391.20**	**(116.19)**
Local	-	1,094	1,094	9,807	7,827	(1,980)	-	4.63	4.63	-	4.63	4.63
Reserves Support	-	1,509	1,509	-	1,509	1,509	-	-	0.00	-	-	0.00
Total Local	**0**	**2,603**	**2,603**	**9,807**	**9,336**	**(471)**	**0.00**	**4.63**	**4.63**	**0.00**	**4.63**	**4.63**
Total Reset & Local	**29,559**	**10,646**	**(18,913)**	**48,829**	**37,144**	**(11,685)**	**342.32**	**42.51**	**(299.81)**	**507.40**	**395.83**	**(111.56)**
Local - Opportunity	-	-	0	-	11,685	11,685	-	-	0.00	-	106.11	106.11
Grand Total	**29,559**	**10,646**	**(18,913)**	**48,829**	**48,829**	**(0)**	**342.32**	**42.51**	**(299.81)**	**507.40**	**501.94**	**(5.45)**

Cash, Receivables and Payables

Cash increased by £3.9m in month as a result of quarterly education monies being received in month. The adverse variance to plan is as a result of non recurrent benefits (£4.3m) Deficit Support Funding monies not yet received (£1.3m), non-cash releasing efficiency schemes (£1.7m), MEOC partner invoices awaiting payment (£1.5m), SYICB growth funding not being received (£2.2m) and timing of capital creditors (£5m).



Invoice Turnaround

Average days	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	YTD
Between date of invoice and date available on system	16.3	18	16.7	12.5	11.8	17.3	14.5
Between being available on system and approval	25.7	12.7	8	8.1	6.4	6.7	7.3
Between approved date and payment date	18.6	18.9	24.1	21.1	22.1	22.1	22.3
Total	60.6	49.6	48.8	41.7	40.3	46.1	44.1
Total that the Trust has control over	**44.3**	**31.6**	**32.1**	**29.2**	**28.5**	**28.8**	**29.6**
Number of invoices	*7,474*	*9,726*	*8,981*	*7,645*	*9,663*	*7,939*	*8,557*

Better Payment Practice Code (In month)

Average days	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	YTD
NHS - %age based on invoice count	86.61%	90.34%	63.89%	86.96%	90.27%	80.11%	80.31%
NHS - %age based on invoice value	88.02%	86.94%	77.26%	84.89%	90.40%	87.78%	85.08%
Non NHS - %age based on invoice count	34.95%	39.08%	35.99%	31.80%	36.05%	31.34%	33.80%
Non NHS - %age based on invoice value	78.77%	79.04%	75.08%	69.76%	82.95%	68.92%	74.18%
Overall - %age based on invoice count	36.50%	40.15%	37.25%	32.87%	37.55%	32.26%	34.98%
Overall - %age based on invoice value	79.92%	79.63%	75.31%	70.69%	84.02%	71.01%	75.26%

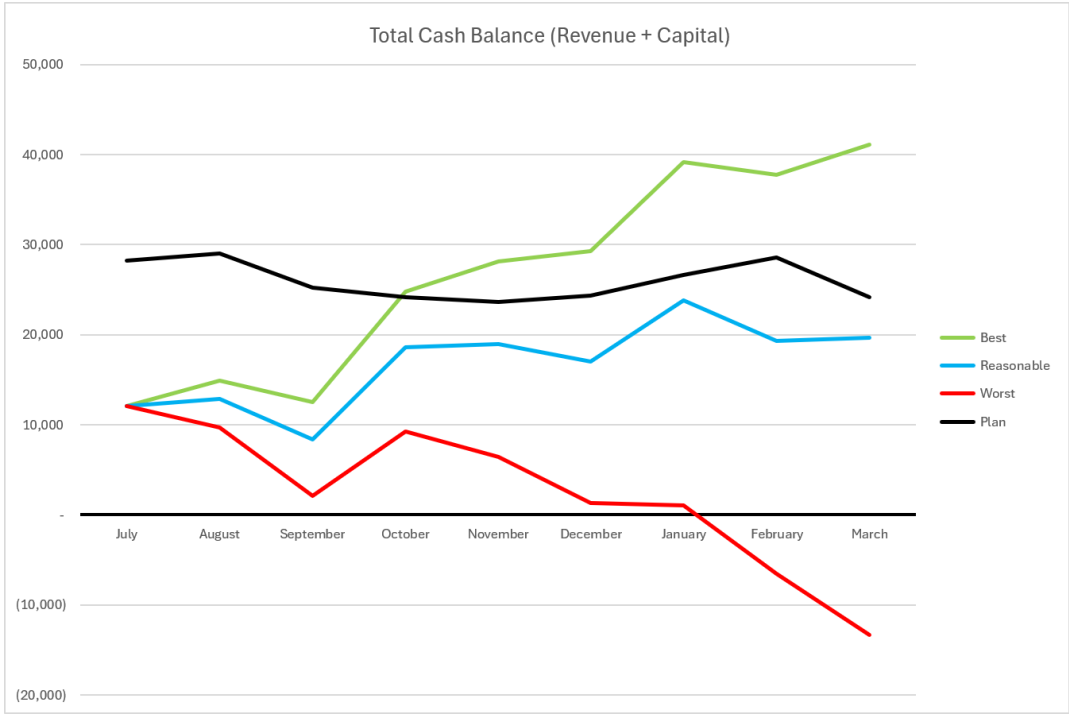
Cash Projections

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. Cash levels are projected to exceed plan at the end of the year in both the reasonable and best case scenarios.

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 worst case the Trust will require overall cash support in September 2026, although this position will be supported by capital creditors. As such, an application is in the process of being submitted to NHSE for cash support.

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 13)	Total mitigations of £16.4m	Risks and mitigations offset to nil	Total risks of £25.1m
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

Capital spend in month is £0.3m, £1.9m below plan.

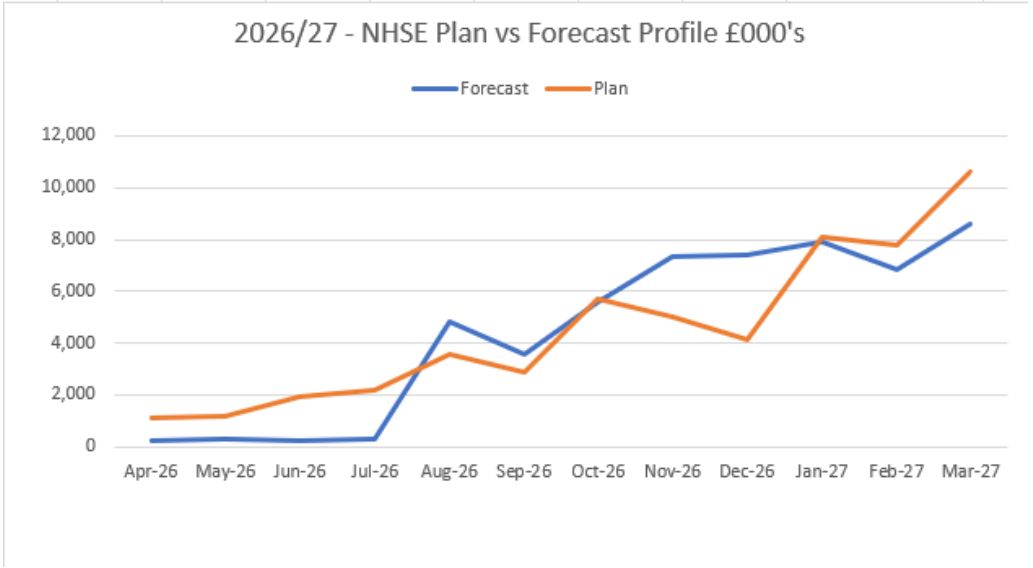
	In Month Plan (£'000)	In Month Forecast (£'000)	In Month Spend (£'000)	In Month Variance (£'000)	In Month Variance to Forecast (£'000)	YTD Plan (£'000)	YTD Forecast (£'000)	YTD Spend (£'000)	YTD Variance (£'000)	YTD Revised Variance to Forecast (£'000)	Annual Plan (£'000)
Estates Projects	1,394	469	313	(1,081)	(156)	3,066	972	816	(2,249)	(156)	30,315
Medical Equipment	0	0	(5)	(5)	(5)	0	106	101	101	(5)	5,951
Digital Transformation Projects	610	709	152	(458)	(557)	3,023	1,023	466	(2,557)	(557)	15,074
Central Capital	171	83	(184)	(355)	(267)	281	(111)	(378)	(659)	(267)	2,697
IFRS16 Leases	0	0	0	0	0	0	0	0	0	0	0
Total Capital Spend	**2,175**	**1,261**	**276**	**(1,899)**	**(985)**	**6,369**	**1,991**	**1,006**	**(5,363)**	**(985)**	**54,036**
Charitable Funds/Donated Assets	0	0	0	0	0	0	0	0	0	0	295
Total Capital Spend inc Charitable Funds/Donated Assets	**2,175**	**1,261**	**276**	**(1,899)**	**(985)**	**6,369**	**1,991**	**1,006**	**(5,363)**	**(985)**	**54,331**

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.

The variance to plan is predominantly driven by EPR and Estates delays which are expected to be recovered in the later months. Forecast reviews are taking place with capital sub-groups to monitor the delivery of the plan and expected cash outflow.



2609 - D PATIENTS

10:25

2609 - Q4 2025/26 LEARNING FROM DEATHS REPORT

Discussion Item

Dr Joseph John, Medical Director for Operational Stability and Optimisation

10 minutes

REFERENCES

Only PDFs are attached

D1 - Q4 2025-26 Learning from Deaths.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Learning from Deaths Report Q4 - 2025/26**			
Sponsor:	Dr Nick Mallaband, Chief Medical Officer			
Authors:	Mandy Cumberbatch, Interim Learning from Deaths Manager			
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 is asked to take Significant Assurance that robust mortality governance processes remain in place across the Trust, with 100% of in-hospital deaths subject to Medical Examiner scrutiny and appropriate escalation through established pathways (including coroner referral, PSIRF and SJR processes).			
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

As noted above this report will provide substantial assurance that we have robust mortality governance processes in place to ensure that 100% of in-hospital deaths are scrutinised by a Medical Examiner, enabling appropriate escalation and triangulation through other established pathways as identified below:

- 100% of all in hospital deaths have been scrutinised by a Medical Examiner.
- 132 deaths were reported to HM Coroner
- 10 Structured Judgement Reviews (SJRs) were requested by the Medical Examiner office
- 10 cases were referred to the "Learn from patient safety events panel" (LFPSE).
- 44 inquests have been opened.
- 66 further SJR's have been requested for cases where either sepsis appeared as a contribution to the cause of death or the case is highlighted within SHMI as an outlier under the diagnostic code of "fluid and electrolyte disorder". This is a total of 76 SJRs requested (14% of deaths)

There was a 7.7% decrease in the number of inpatient deaths during Q4 when compared to Q3 (461 in-patient deaths at the Trust during the quarter and 65 in the Emergency Department. Total = 526), with 1 death occurring following an elective admission, and six deaths were of patients with a learning disability.

The Summary Hospital Level Mortality Indicator (SHMI) rolling 12-month figure is currently 113.09, although this is a slightly elevated position, it is remaining relatively stable over time.

Although substantial assurance has been noted in terms of being able to evidence the robustness of our mortality governance processes, an overall rating of significant assurance has been given as work is being undertaken to improve the consistency of reviewing mortality and demonstrating how learning is contextualised across the Divisions.

Recommendations

Note the content of the report and take significant assurance.

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, timelier, 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 15.5.26 Effective Assurance Group 1.7.26 Quality Committee 6.8.26
Any outcomes/next steps / time scales	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

LEARNING FROM DEATHS REPORT 2025/26 - Quarter 4

1. Introduction

This report provides a quarterly overview of the Trust-level mortality data. 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 **Q4 (1st January– 31st March 2026)** 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 and other patient safety and governance processes.

2. Key Points.

- There have been 461 in-patient deaths at the Trust during the quarter and 65 in the Emergency Department. Total = 526. This is a 7.7% decrease from Q3
- One death occurred following an elective admission, and six deaths were of patients with a learning disability.
- 132 deaths were reported to HM Coroner
- 44 inquests have been opened.
- 10 Structured Judgement Reviews (SJRs) were requested by the Medical Examiner office
- 66 further SJR's have been requested for cases where either sepsis appeared as a contribution to the cause of death or the case is highlighted within SHMI as an outlier under the diagnostic code of "fluid and electrolyte disorder". This is a total of 76 SJRs requested (14% of deaths)
- 10 cases were referred to the "Learn from patient safety events panel" (LFPSE).
- The Summary Hospital Level Mortality Indicator (SHMI) rolling 12-month figure is currently 113.09
- 100% of all in hospital deaths have been scrutinised by a Medical Examiner.

Learning points from the completed SJRs are:

- Check allergy status prior to prescribing antibiotics.
- Do not chart medication before it has been administered
- Ensure timely referral to the Learning disability team when a patient with a learning disability is admitted.
- Ensure the comprehensive monitoring of blood glucose levels and timely escalation in cases of persistent "hypo" and "hyper" findings. Document times of escalation and times of response including all management and treatment plans.
- Encourage prompt discussions with a microbiologist re the choice of anti-biotics.
- Timely prescribing and administration of first dose of appropriate antibiotics.
- Blood culture sampling in cases of possible sepsis is essential.

Deaths by month- Crude Mortality January 2026 - 31 March 2026

3.1 There were a total of 461 in-patient deaths in Doncaster & Bassetlaw Teaching Hospital Foundation Trust (DBHFT) in the 3 months between January 1st 2026 and 31st March 2026 and 65 in the emergency department. Total deaths = 526 (Source: Information services) This is a 7.7% decrease on numbers from last quarter. There were 562 total deaths in the same quarter last year (Jan – March 2025).

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

Chart 1

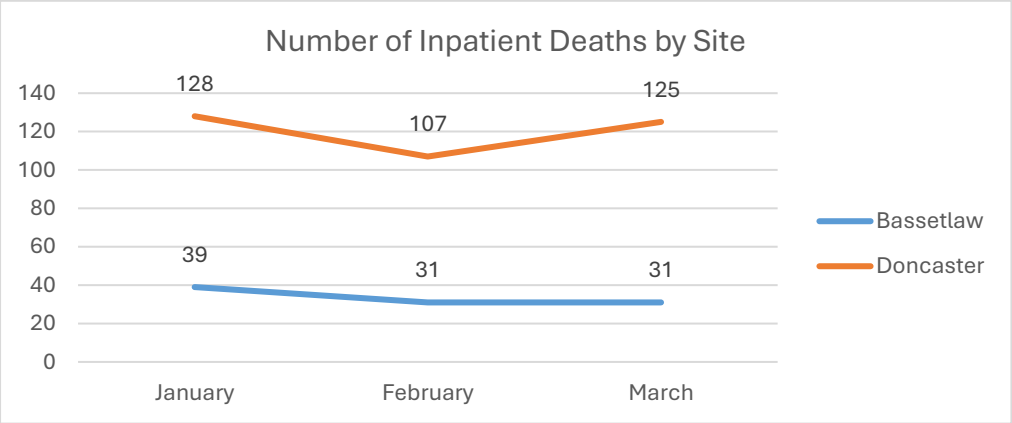


Chart 2.

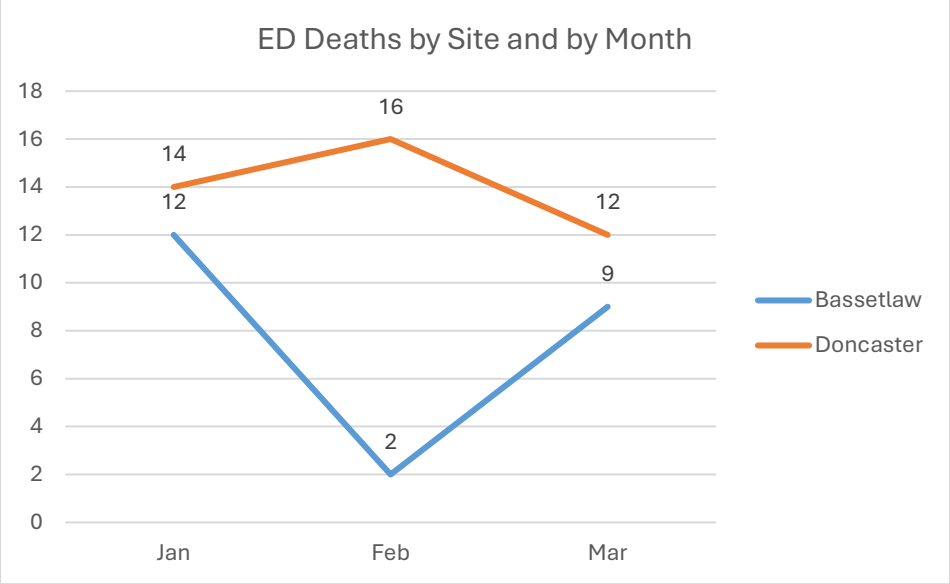
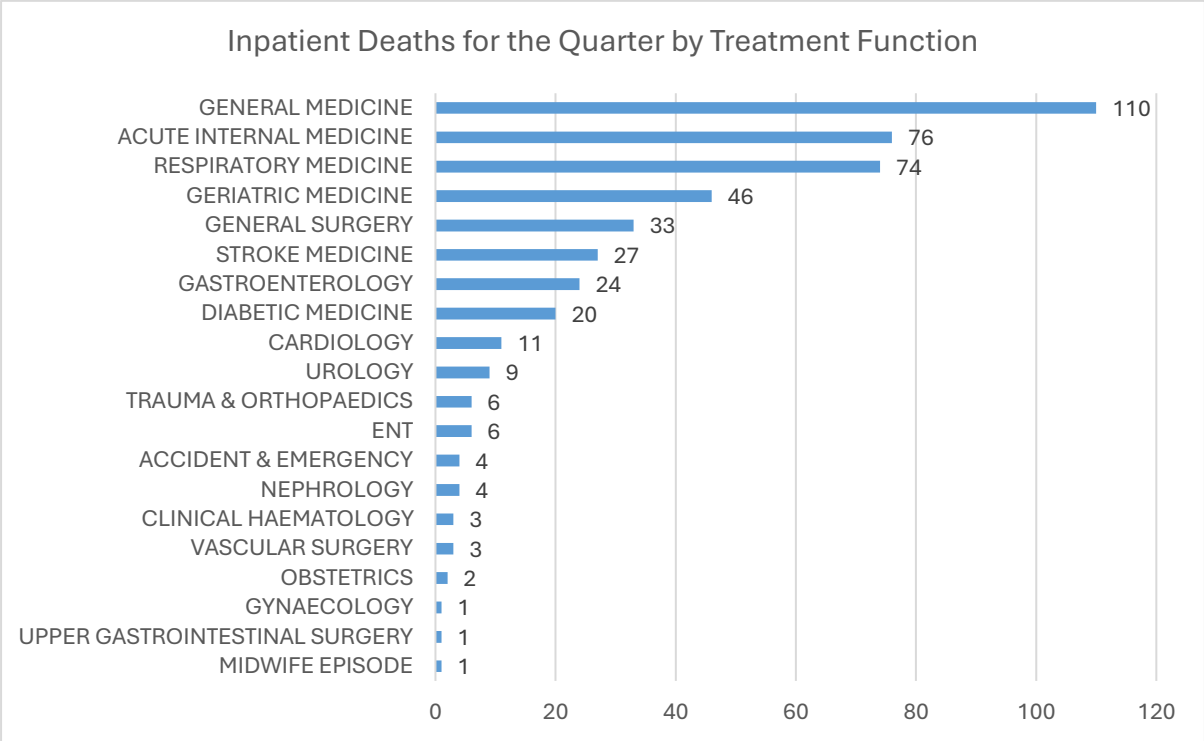


Chart 3.



3.3. Elective admissions resulting in death

One patient was initially reported as having been admitted electively and died. This case was reviewed within the Mortality Governance Group meeting. The conclusion was that this haematology patient had been admitted as an emergency. The issue of ensuring that the type of admission of a patient (elective or non-elective)is classified correctly, has been discussed at length and a standard operating procedure has now been drafted. This is being taken through the general manager meetings for consultation, agreement sought from the deputy medical director and will then be taken back to the Mortality Governance meeting for final approval.

3.4 LeDeR : (Learning from deaths review programme of people with Learning disabilities/autism/significant mental health issues

There were six patients recorded as having a Learning Disability who died this quarter. All of these cases were referred to LeDeR and SJRs were requested. At the point of reporting, five of these have been completed. The sixth one has been chased for completion. Four of the reviews concluded good care, one case identified issues with escalation, delays in involving microbiology and poor documentation of skin integrity findings. This case has been forwarded to the divisional governance team for further review, action and learning.

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. It should be noted that SHMI is an alerting indicator and not a direct quality of care score. In addition, 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. This will help to ensure earlier conversations can happen should any unexpected anomalies occur prior to any national data being published.

Chart 4 shows the rolling SHMI score compared to our peers, accurate as of the end of November 2025. There is always a delay of at least 6 months in assessing the SHMI value. Although the graph demonstrates an elevated position, it has remained relatively stable over time, indicating an underlying issue rather than episodes of short-term volatility, as can be seen in some of the peer groups. It should also be noted that the trust consistently records emergency department activity, whereas other trusts have not been recording this way and we await all trusts falling into line and what impact this may have.

Chart 4.

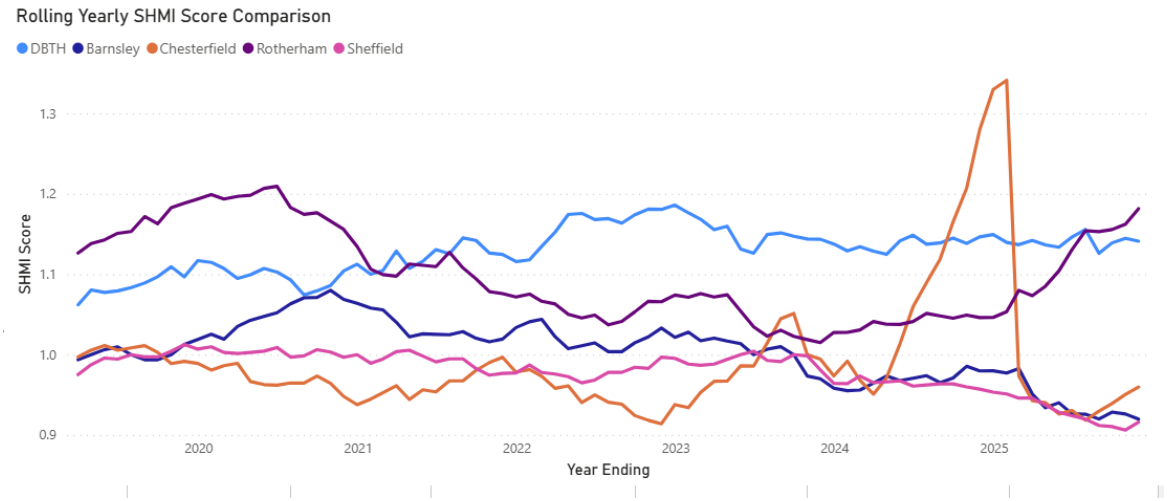


Table 1 below, is ordered to show statistically, those diagnosis groups where a higher-than-expected level of deaths has occurred. It is a selection of these cases that are being reviewed to understand if any learning can be identified. Last quarter "Anaemia" appeared in this list, and a sample of those deaths were reviewed. The findings of these reviews can be seen in **section 6** of the report. A sample of the "fluid and electrolyte disorder" cases have also been reviewed this quarter.

Table 1: Diagnostic group descriptions with outlier deaths

Latest 12 Months

Group Description	Total Spells	Predicted Deaths	LowerLimit	UpperLimit	Actual Deaths	SHMI banding	SHMI Score	StdDevs from Expected
Pulmonary heart disease	268	15.8	8.4	23.2	28	Higher than expected	1.77	3.2
Fluid and electrolyte disorders	683	38.8	27.1	50.4	57	Higher than expected	1.47	3.1
Cardiac dysrhythmias	1173	16.3	8.6	24.1	27	Higher than expected	1.65	2.7
Paralysis, Late effects of cerebrovascular disease	34	0.8	-0.9	2.5	3	Higher than expected	3.84	2.6
Pleurisy; pneumothorax; pulmonary collapse	262	19.7	11.6	27.7	30	Higher than expected	1.53	2.5
Diseases of white blood cells	27	0.5	-0.8	1.8	2	Higher than expected	4.32	2.3
Cancer of bone, thyroid and malignant neoplasm	48	13.1	8.0	18.2	19	Higher than expected	1.45	2.3
Regional enteritis and ulcerative colitis	176	1.4	-0.9	3.7	4	Higher than expected	2.82	2.2
Total	**79680**	**2,411.8**	**2,324.1**	**2,499.5**	**2541**	**Higher than expected**	**1.05**	**2.9**

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

5.1 A team of 20 trained senior medical and nursing staff undertake reviews on selected cases each month. These include those referred from the medical examiner team, cases where "sepsis" has contributed to the death and a further selection from the diagnostic groups which appear as outliers within the SHMI data.

In **table 2** below you can see that 76 SJRs have been requested which is 14% of all deaths. As of 12/5/26, 56 have been returned and the others will continue to be actively chased.

Table 2 : Deaths and percentage of SJRs requested and completed.

Reporting period	Total Deaths	SJRs requested	SJRs completed within 6 weeks of request
2024/25 (Q1-4)	**2,151**	**163 (7.5%)**	**163 (7.5%)**
2025/26 : Q1	478	49 (10%)	49 (10%)
2025/26 : Q2	459	33 (7%)	33 (7%)
2025/26 : Q3	570	67 (11.5%)	57 (10%)
2025/26 : Q4	**526**	**76 (14.%)**	**56 (10.6%)**

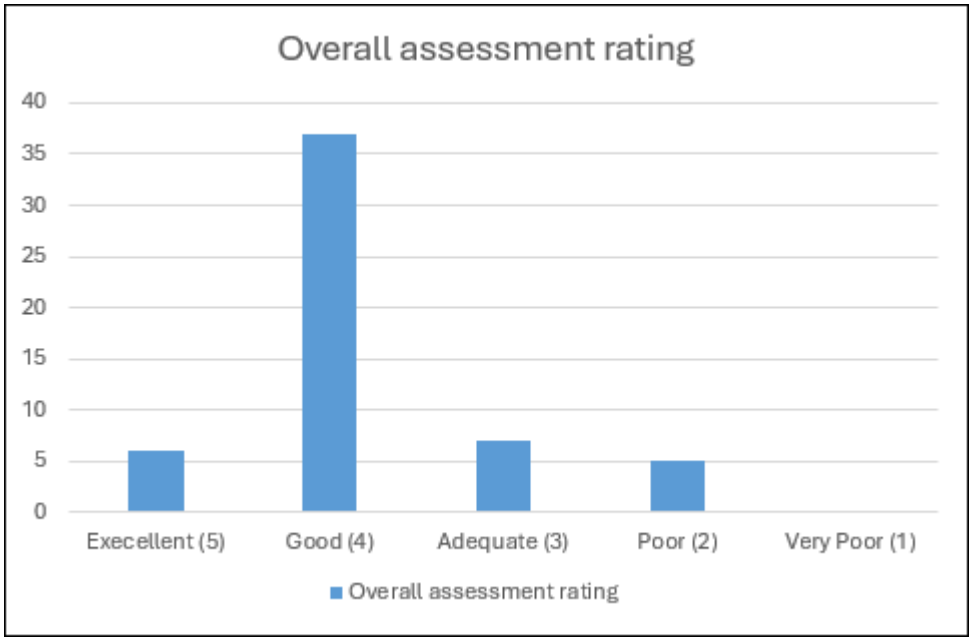
Several factors contribute to the timely completion of the reviews:

- Reviewers need to access several electronic systems to obtain the information needed to complete a review, and in some cases, paper records also have to be accessed, this adds to the time spent undertaking a review quite considerably. This situation has been observed at a regional level too, being discussed at some length in a recent regional mortality meeting.
- During this quarter the SJR plus application was taken out of commission and the trust needed to build up an inhouse electronic form with some speed to maintain the momentum. The digital transformation team completed this and the form went "live" via the clinical portal on April 13th. As with all new systems, there have been a few "teething problems" and in addition the two-week Easter holiday. Both of these factors have contributed to a slight delay in the return of SJRs.

6. Learning from SJR.

6.1 An important aspect of the SJR process is that it highlights excellent and 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 and explicit comment to support the score for the "overall assessment" of care. See **chart 5**.

Chart 5 : Overall assessment scores



The majority of cases reviewed have recorded "good" and "excellent" in the overall assessment. Frequently seen explicit judgement comments to support examples of good or excellent care can be seen below:

- Family recognised deterioration 1 day before deterioration in NEWS2. Demonstrates the importance of recognising that those who know the patient best are often best placed to notice subtle signs of early deterioration and allow early intervention.
- Patient wishes were considered as she declined surgical intervention with stoma and discharged with fast track to care home.
- Good initial recognition and management of infection including review of recent microbiology and source control. Sepsis recognised and prompt sepsis treatment given.
- Excellent nursing documentation and use of assessment tools.
- Good assessment and recognition of sepsis. Sepsis treatment given within 1 hour target.
- Good escalation of treatment and senior clinician involvement.
- Timely appropriate and holistic assessment in ED and on medical wards
- Early recognition of the appropriate ceiling of care, with timely initiation of end-of-life care measures. Referral to the end-of-life care team was made promptly, ensuring ongoing support for both the patient and family throughout the patient's care.

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 in the five cases referred have been:

- Lack of escalation or discussion with a microbiologist as it suggests in the hospital infection control policy.
- Despite the operation note being available for the doctor admitting the patient to Critical Care, no antibiotics to cover the post-operative period were prescribed.
- Significant delay in antibiotic prescription and administration.
- IV fluids not given and urine output not recorded when indicated

General learning includes:

- Check allergy status prior to prescribing antibiotics.
- Do not chart medication before it has been administered
- Ensure timely referral to the Learning disability team when a patient with a learning disability is admitted.
- Ensure the comprehensive monitoring of blood glucose levels and timely escalation in cases of persistent “hypo” and “hyper” findings. Document times of escalation and times of response including all management and treatment plans.

6.2 Sepsis

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

- Lack of escalation or prompt discussions with microbiologist re choice of anti-biotic
- Timely prescribing and administration of first dose of appropriate antibiotics
- Poor compliance with blood cultures was noted in two of the cases.

6.3 Anaemia

13 reviews were 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 and the main condition treated within the episode of care. The clinical coding of all these cases has been reviewed by the clinical coding manager. The coding was concluded to be correct in 11 of the cases. Two of the cases were concluded to have been incorrect and the coding manager has provided feedback to the coders.

6.4 Fluid and electrolyte disorders

This group description within the SHMI data has consistently appeared throughout this quarter as higher than expected deaths occurring. 38.8 predicted deaths with an actual figure of 57 being reported.

12 of these cases have had SJRs requested and to date, six of these have been completed.

Initial findings of five of these is that their care was judged to have "Good" or "Excellent" and generally these are patients admitted with multiple co-morbidities, often elderly and/or in the final stages of their life. One case has been rated as "poor" in the overall care with issues around blood glucose monitoring/escalation and escalation of GI issues. However, the admission phase and end of life phase was "good"

Further work on this SHMI outlier diagnosis will continue into the next quarter.

7. Medical Examiner Team.

7.1 100% of all hospital and community deaths have been scrutinised by a medical examiner.

7.2 Medical examiners and their officers attempt to communicate with all families following the death of their loved one, to discuss any issues they may have had with treatment/management and to discuss the proposed cause of death. There were only nine families this quarter where this interaction did not take place

7.3 The ME team have introduced a form to use when they identify a case where clear learning is identified following either scrutiny or feedback from families. This is sent directly to the Divisional Quality, Assurance and Compliance Lead (DQAC) so that they can have divisional discussions at their governance meetings and direct the learning with immediate effect to clinical areas.

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

This quarter there have been **132** referrals to the coroner. 44 inquests have been opened and 15 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 9 such requests this quarter and a total of 41 since the process was introduced.

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

There has been 1 PFDR received this quarter. The issues raised were:

- Failure to complete the inpatient post fall review
- No clear plan for frequency of neurological observations and duration of the same and associated lack of clear direction from the attending doctor following the fall
- The efficiency of the nerve centre system escalations in that any triggers must be followed up and properly completed on the system to be fully effective.

Summary of actions:

1. **Documentation and Training:**

Targeted multidisciplinary training is being delivered and reinforced to promote accurate, complete and contemporaneous clinical documentation, with particular emphasis on post-fall documentation and neurological observations. Documentation standards remain a core component of Patient Safety Team training, with additional sessions delivered by the Trust's Solicitor/Legal Manager and further education planned on an ongoing basis.

2. **Post-Fall Medical Direction and Neurological Observations:**

The Trust is reinforcing the requirement that, following an inpatient fall, the attending doctor must document a clear, individualised plan for neurological observations, including frequency, duration, review and escalation criteria. This expectation is being embedded through strengthened post-fall documentation standards and targeted multidisciplinary education.

3. **Nerve Centre Escalations:**

Use of the Nerve Centre system is being reinforced to ensure that all escalation triggers are actioned, followed up and fully completed, including clear documentation of the name and role of the clinician to whom escalation is made. Targeted training and renewed emphasis on accurate system documentation are being implemented to improve reliability, assurance and patient safety.

10. 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, 12 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*: Discharged too early, delay in diagnosis and lack of privacy and dignity.*

11. Patient Safety Incident Response Framework (PSIRF) investigations

10 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 with a resulting after action review. The following are examples of actions highlighted following after-action reviews and these are all monitored via Datix by the responsible governance teams:

- When a patient is being seen by Mental Health team and requires supervision – to ensure good communication between the 2 teams to ensure clear identification of who is nominated to carry out the supervision. A positive to flag is the cross Trust working to support learning to improve safety. This was a joint review with RDASH
- Clear and effective access to senior surgical medical input for emergency review is essential.
- Accurate and consistent communication is essential during clinical handover of all administered anaesthetic medications.
- Improve the completeness, accuracy, and timeliness of nursing and medical documentation for all inpatients. Ensure appropriate escalation as necessary.
- Ensure that all required components of the Chest Trauma IPOC are completed, documented, and reviewed within expected timeframes.
- Ensure early and timely referral to LD nurse.
- LD nurse to complete LD care bundle in conjunction with ward staff.
- Launch of new chest IPOC within General Surgery.
- Explore options to increase junior doctor overnight staffing (FY1 and SHO level)

12. Conclusion

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

13. 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 & approved by the Mortality Governance Group : 15th May 2026.

2609 - D2 PATIENT ENGAGEMENT & EXPERIENCE EVENT 2026 & PROPOSED ENGAGEMENT PROGRAMME 2026/27

Decision Item | Karen Jessop, Chief Nurse | 10:35

10 minutes

REFERENCES

Only PDFs are attached

D2 - Patient Engagement & Experience Event 2026 & Proposed Programme 2026-27.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Patient Engagement and Experience Event 2026 and Proposed Engagement Programme 2026/27**			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Kirsty Clarke, Associate Chief Nurse			
Appendices:				
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			
For decision papers only: 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

The inaugural DBTH Patient Engagement and Experience Event, held in June 2026, successfully brought together patients, carers, community partners and staff to inform future service improvement priorities. Feedback was highly positive, with an overall satisfaction score of 4.1/5, two-thirds of respondents awarding the highest rating, and 90% expressing an interest in ongoing involvement with the Trust. Attendees particularly valued direct conversations with staff and opportunities to influence change.

Strong support exists for continued patient and community engagement, demonstrating a clear appetite for co-production and involvement in service improvement.

Accessibility and inclusive communication emerged as a major theme, including the need for information in accessible formats, improved support for people with sensory impairments, and better identification of communication needs.

Communication remains a key driver of patient experience, particularly regarding treatment plans, discharge processes, involvement in decisions and consistency of information provided by staff.

Patients and carers want greater confidence and clarity in how concerns can be raised, including awareness of escalation routes and support when worried about deterioration in a patient's condition.

Support for carers was identified as a priority, particularly recognising carers as partners in care and improving their involvement in decision-making and care planning.

Emergency Department experience remains a significant area of interest, with participants highlighting communication during waits, understanding next steps, support for vulnerable patients and carers, and the opportunity to use findings from the National Urgent and Emergency Care Survey to inform improvement actions.

Recommendations	
The Board is asked to support the development of a structured annual programme of patient and community engagement events and to consider whether future reporting arrangements should be via the Quality Committee	
Healthier together – delivering exceptional care for all	
Patients	*Safe and effective care*
People	*Keeping our people safe*
Partnerships	*We work together to enhance our services with clear goals for our communities.*
Pounds	n/a
Health Inequalities	n/a
Legal/ Regulation:	n/a
Partner ICB strategies	n/a
Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

Purpose
To provide the Board with a summary of the Trust's inaugural Patient Engagement and Experience Event and outline proposals for a structured engagement programme that enables patient, carer and community voices continue to influence quality improvement, accessibility, patient safety and experience priorities.

Background
On 20 June 2026, DBTH hosted its first Patient Engagement and Experience Event at the Doncaster Royal Infirmary site. The event brought together patients, carers, community representatives, voluntary sector partners and Trust colleagues to strengthen patient involvement and better understand what matters most to local communities. The event focused on accessibility, communication, patient experience, raising concerns, emergency care and support for unpaid carers.

Activities included:

- Presentations from colleagues, relatives and companies working in partnership with DBTH in relation to accessibility on patient feedback, inclusive communication, accessibility and working with carers
- Facilitated Conversation Café discussions.
- Community and partner organisation exhibition stands.
- Opportunities for patients and carers to provide structured feedback and share lived experiences.

Event Outcomes
Participation and Satisfaction
Initial evaluation data demonstrates positive engagement and strong support for continuing the programme:

- Overall satisfaction score: **4.1/5**
- **Two-thirds of respondents** awarded the highest satisfaction rating.
- 90% of respondents indicated an interest in continuing involvement with the Trust, with almost half expressing this for the first time following the event.

Most Valued Activities
Participants particularly valued opportunities for direct dialogue:

- Conversation Café discussions: 29%
- Presentations: 21%
- Networking opportunities: 18%
- Exhibition stands: 18%
- Patient stories: 14%

These findings suggest that people most value meaningful conversations with Trust staff and opportunities to influence service improvement.

Key Themes Emerging
Based on discussion topics, presentations, accessibility work and feedback received, several recurring themes have emerged.

Accessibility and Inclusive Communication
Patients highlighted the importance of:

- Accessible information in a range of formats.
- Improved support for people who are deaf, hearing impaired or visually impaired.
- Better identification and recording of communication needs.
- Consistent use of interpretation and translation services.
- Reduction of barriers affecting people with SEND and other additional needs.

Communication on Wards
Feedback indicated that clear, timely and compassionate communication remains a key determinant of patient experience, particularly regarding:

- Understanding treatment plans.
- Discharge communication.
- Involvement in decisions.
- Consistency of information from staff.

Raising Concerns and Speaking Up
Patients and carers requested:

- Greater awareness of how to raise concerns in relation to planned or outpatient based care where there are delays in appointments or admission dates.
- Easier access to support when worried about a deterioration in condition.
- Confidence that concerns are listened to and acted upon.

Support for Carers
Key issues included:

- Recognition of carers as partners in care.
- Flexible visiting arrangements.
- Better information and signposting.
- Involvement in care planning and decision-making.

Emergency Care Experience
Participants highlighted the importance of:

- Feeling included and informed during emergency attendances.
- Understanding waiting times and next steps and effective communication from department staff.
- How the department staff support vulnerable patients and carers.

Recommendation: Development of an Annual Patient and Community Engagement Programme
To maintain momentum and strengthen co-production arrangements, it is proposed that DBTH establish an Annual Patient Experience and Engagement Forum, rotating across Trust sites and community settings.

Objectives

- Strengthen patient and public involvement.
- Support delivery of the Trust's Quality Strategy.
- Improve accessibility and health equity.
- Gather real-time patient insight.
- Demonstrate "You Said, We Did" improvements.
- Support learning linked to patient safety initiatives, including Martha's Rule.

Proposed Programme 2026/27

1: Accessibility and Inclusive Communication - completed 20th June 2026
Follow up session - Feedback from the Trust and Accessable of the findings of the surveyor visits and next steps.

Focus Areas

- Outcome of the Accessable site visits and assessment against accessible access and information requirements.
- Trust response to the findings and commitment.

Outcomes

- Accessibility improvement priorities established and shared.

2: Martha's Rule and Raising Concerns - Worksop location

Focus Areas

- Awareness of Martha's Rule.
- Escalating concerns when a patient's condition deteriorates.
- Family and carer confidence in speaking up.
- Experience of first line resolution at department level, PALS and complaints pathways.

Outcomes

- Increased public understanding of escalation routes for clinical and non-clinical concerns.
- Feedback to inform implementation and communication plans.

3: Emergency Department Experience and National Survey Results - Doncaster and Worksop locations

Focus Areas

- Findings from the National Urgent and Emergency Care Survey
- Emergency Department waiting experience
- Communication whilst waiting
- Information, comfort and reassurance
- Experiences of vulnerable patients, carers and families
- Patient flow and discharge from the Emergency Department

Format

- Presentation of DBTH survey findings and benchmarking
- Patient stories and lived experiences
- Facilitated discussion groups
- "You Said, We Did" review of previous actions

Expected Outcomes

- Better understanding of patient priorities within urgent and emergency care
- Co-produced improvement actions
- Increased visibility of progress against survey findings
- Direct patient input into Emergency Care improvement plans

Board Considerations

Building on the success of the inaugural Patient Engagement and Experience Event, the Trust proposes an annual programme of themed engagement events. Each event will focus on priorities identified through patient feedback, national survey findings and strategic quality objectives. Planned themes across 2026 / 2027 include feedback from Accessable site survey's and site reports, Martha's Rule and Raising Concerns, Emergency Department Experience and National Urgent and Emergency Care Survey Findings. The programme will provide a structured mechanism for listening to patients, carers and communities, demonstrating improvements made in response to feedback, and supporting delivery of safer, more personalised and accessible care.

Conclusion

The first event of 2026 demonstrated strong public appetite for meaningful engagement with DBTH, with high satisfaction scores and significant interest in ongoing involvement. Establishing an annual programme will create a sustainable mechanism for listening to patients and carers, supporting delivery of safer, more accessible and person-centred care while strengthening public confidence in the Trust.

2609 - D3 ANNUAL PATIENT EXPERIENCE REPORT 2025/26

Information Item | Karen Jessop, Chief Nurse | 10:45

5 minutes

REFERENCES

Only PDFs are attached

D3 - Annual Patient Experience Report 2025-26.pdf

D3i - Annual Patient Experience Report 2025-26.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Annual Patient Experience Report 2025/2026**			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Kirsty Clarke, Associate Chief Nurse Caroline Marsden, Feedback and Complaints Manager			
Appendices:	N/A			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1			

Executive Summary – Key messages and Issues

The report demonstrates a broad and maturing patient experience programme, with multiple mechanisms in place to capture feedback, including the Friends and Family Test, Care Opinion, PALS, complaints, national surveys, engagement events, volunteers and targeted accessibility work. There is evidence that patient feedback is being reviewed, shared with services and used to inform learning and improvement, particularly in relation to upheld PHSO complaints, accessibility for people with hearing or visual impairments, interpreting and translation services, unpaid carers and progression in piloting localised team-based feedback through Care Opinion.

Key areas of assurance: Established feedback routes remain in place, national survey action planning is overseen through patient experience governance structures, engagement with communities and people with lived experience is informing accessibility and inclusion work and volunteer-supported feedback collection is being strengthened to improve patient voice. Learning from complaints and PHSO outcomes is being identified and progressed through appropriate governance routes.

Gaps and areas for continued oversight: Further improvement is required in complaints response times, sustained levels of Friends and Family Test response rates in line with Trust KPI, and the triangulation of patient experience intelligence with wider quality, safety, workforce, incident and operational data. Developing further the programme of patient digital stories on the Quality Committee workplan and consideration of options for developing more real time patient feedback. Continued divisional ownership and evidence of measurable impact will be important during 2026/27.

Recommendations

The Board is asked to receive the Patient Experience Annual Report 2025/26 acknowledge the areas requiring continued oversight and support the planned priorities for 2026/27 to strengthen patient voice, learning and measurable improvement.

Healthier together – delivering exceptional care for all	
Patients	Safe and Effective Care
People	n/a
Partnerships	n/a
Pounds	n/a
Health Inequalities	n/a
Legal/ Regulation:	CQC Safe Care and Treatment, Health and Social Care Act

Partner ICB strategies	n/a
Assurance Route	
Previously considered by - including date:	Caring Assurance Group
Any outcomes/next steps / time scales	July 2026 – approved for QC

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patient Experience Annual Report 2025/2026

Kirsty Clarke / Caroline Marsden

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Executive summary

This annual report provides information on the breadth and maturity of the Trust's patient experience programme during 2025/26. It demonstrates that the Trust has continued to use a range of mechanisms to hear and respond to the voices of patients, families, carers and community partners, including the Friends and Family Test, Care Opinion, PALS, complaints, national surveys, engagement events, volunteers and targeted accessibility work.

The report provides evidence of learning and improvement activity, particularly in relation to upheld Parliamentary and Health Service Ombudsman complaints, accessibility for people with hearing or visual impairments, interpretation and translation services, unpaid carers, volunteer-supported feedback collection and the development of more localised team-based feedback through Care Opinion.

Significant assurance can be taken that the Trust has established multiple routes for receiving feedback and that learning is being identified and progressed through appropriate governance routes. However, further assurance is required in relation to complaints response timeliness, variable Friends and Family Test response rates, and the need to strengthen the triangulation of patient experience data with quality, safety, workforce, incident and operational intelligence.

The key priorities for 2026/27 are to improve complaints handling performance, increase the representativeness of feedback, strengthen divisional ownership of learning, demonstrate measurable impact from engagement activity, and ensure that patient voice continues to inform quality improvement, accessibility and service development.

1 INTRODUCTION

The 2025/26 Patient Experience Annual Report provides an overview of the Trust's patient feedback, engagement and learning activity. It draws on intelligence from the Friends and Family Test, national surveys, Care Opinion, PALS contacts, complaints, website communications, volunteer activity and patient engagement events. Taken together, these sources provide a broad view of patient, family and carer experience across Trust services and support the identification of themes requiring action, oversight and assurance.

The report should be considered alongside wider quality, safety and operational intelligence. This includes incident reporting, patient safety investigations, clinical audit, workforce information, performance data and divisional governance reports, enabling patient experience themes to be triangulated and translated into targeted improvement activity.

2 ACTIVITY



3 PATIENT EXPERIENCE

During 2025/26 we continued to provide a variety of ways for our patients to provide feedback on our services. This included friends and family test, PALS contacts, engagement events, Care Opinion, national and local surveys.

Care Opinion

We continued to actively seek the view of our patients throughout 2025/26. There were 69 patient feedback submissions to Care Opinion in 2025/2026. Care Opinion feedback received during 2025/26 was predominantly positive, with patients and families consistently praising staff for their kindness, compassion, professionalism and supportive approach to care. Maternity services attracted particularly positive feedback, with women reporting feeling safe, reassured and well supported throughout pregnancy and childbirth. Feedback also highlighted patients' confidence in clinical teams and appreciation for the dignity and respect shown to both patients and relatives. While a small number of concerns were raised regarding staff compassion and communication, these were small in number within an otherwise highly positive dataset. Organisational responsiveness remained strong at 96%, with over 3,000 public views of Care Opinion stories each month, demonstrating effective engagement with patient feedback.

The below word cloud pulls through themes from care Opinion across the 2025/2026 period:



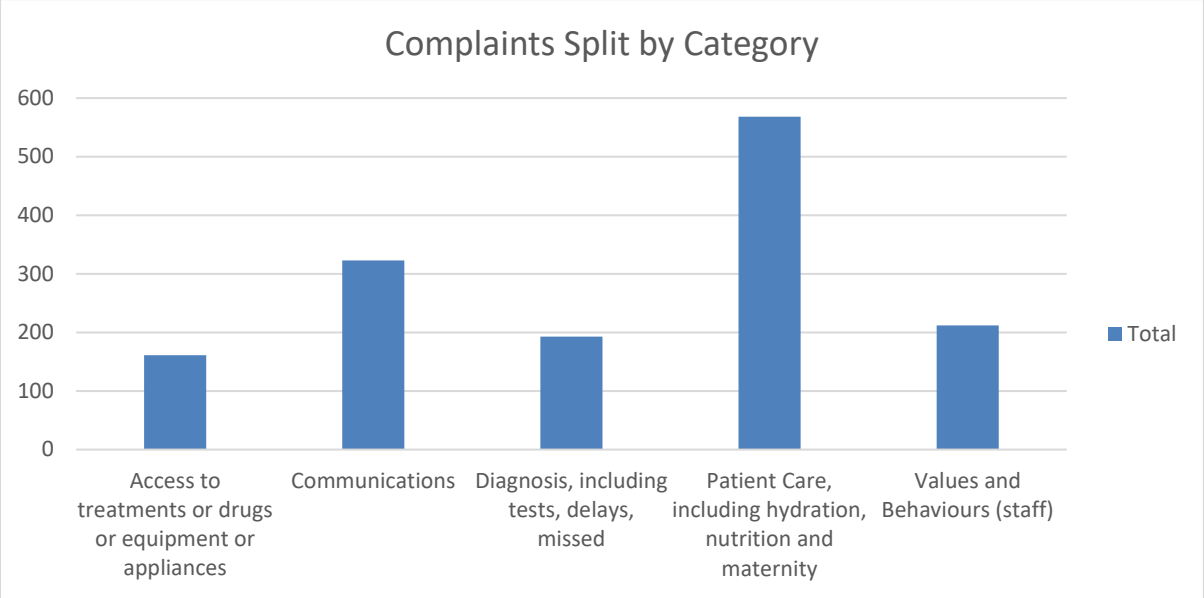
A free trial of team-based Care Opinion has been secured to commence during July 2026. This approach will enable feedback to be directed to and managed by specific clinical teams, wards, departments or services, rather than only at organisational level. This will support greater local ownership, more timely responses and clearer evidence of learning from patient stories. This includes:

- **Feedback alerts for teams** - teams receive notifications when stories are posted about their service.
- **Team responses** - authorised team members can publicly respond to patient stories.
- **Learning and improvement tracking** - teams can demonstrate actions taken as a result of patient feedback.
- **Service-level reporting** - organisations can analyse feedback by speciality, ward, site, or service area.
- **Recognition and staff morale** - positive feedback can be shared directly with staff and teams to celebrate success and improve engagement

Complaints

During 2025/26, 790 complaints were reported to the Trust, representing a 16% increase compared with 682 complaints reported during 2024/25. It should be noted that in comparison to last year the Trust did experience an increase of 13% in Outpatient attendances, 8% increase of inpatient admissions, 10% increase in Emergency Department attendances and a 6% increase in maternity episodes of care, which may have contributed to some of this increase. Oversight of complaints trends including volume and themes is undertaken at Speciality and Divisional level, with reporting through to the Patient Experience and Involvement Group and Caring Group.

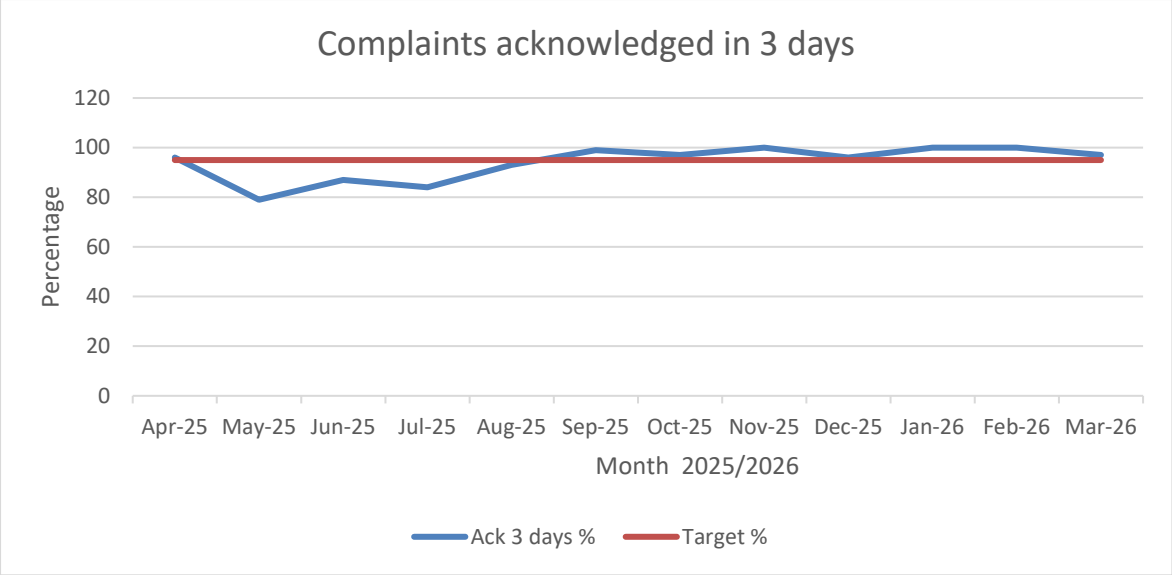
The below graph illustrates the five main themes by category during the 2025 / 2026 reporting period



DBTH use the following key performance indicators to monitor the effectiveness of our complaints handling process:

- Acknowledgement within 3 days (Target 95%)
- Complaints closed within 6 months, in line with the PHSO consideration of the maximum reasonable timeframe.

Trust performance against the KPI for acknowledging cases within three days fell below the 95% target between April and August, however this was primarily due to significant staffing challenges within PALS. This impacted the team's capacity and response times with a return to achieving or exceeding the 3-day KPI acknowledgement from August across the remainder of the year.



During 2025/26, a total of 704 complaints were closed across the Trust (Quarter 1: 117, Quarter 2: 191, Quarter 3: 228 and Quarter 4: 168). Complaint closures increased significantly following Quarter 1, with the Surgical Division closing the highest number of complaints in Quarters 2 and 3, and Urgent Emergency Care recording the highest number in Quarter 4. Three complaints logged during 2025/2026 remained open beyond the 6-month PHSO recommended maximum reasonable time frame. Where complaints are open beyond 6 months, the PHSO recommends that the reasons should be clearly evidenced along with clear communication with complainants and new timeframes identified. All three complaints were concluded and recorded as closed.

Complaints performance continues to be monitored through established patient experience and divisional governance routes. Actions are in place to improve performance against internal closure timescales, with a focus on recovery planning, divisional accountability, investigation capacity, process controls and the expected improvement trajectory during 2026/27. Continued oversight will be maintained to ensure these actions deliver sustained improvement and provide evidence of strengthened complaints handling performance.

To enable Trust wide learning from complaints, as part of the Matron development programme, a structured process for capturing patient experience, associated learning and actions taken in a digital format was developed towards the end of 2025/2026. Capturing patient experience and associated learning using digital stories supports demonstration of improvements in care, transparency and accountability, cultural change, knowledge translation and alignment with NHS Complaint standards.

An annual programme of patient stories capturing experience that demonstrates where learning is required or where good care needs to be celebrated and shared, has been developed, with the initial maternity and early pregnancy stories developed and shared Trust wide during February 2026. Initial feedback from both patients, relatives and staff, identified that digital patient stories enable capture of key themes, sharing of personal and pertinent experiences and also demonstrated what actions have been put in place to improve outcomes and experience.

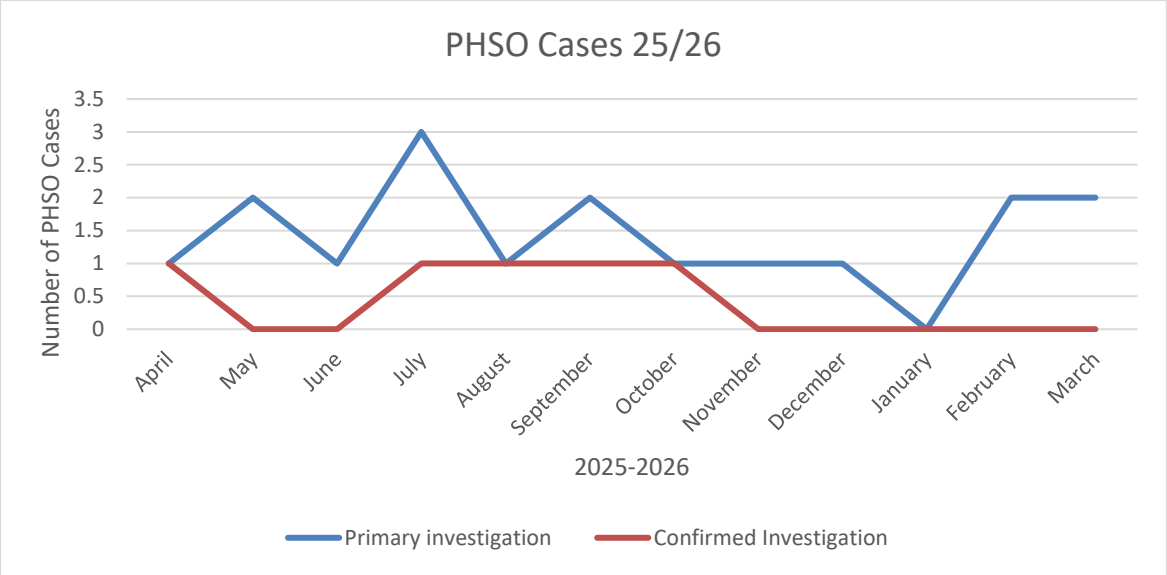
Learning from complaints is collated by Divisional Lead Nurses and disseminated via Divisional Governance processes and shared Trust wide via Caring Group on a quarterly basis and disseminated through Patient Experience and Involvement Group. The below table provides a summary of some areas of learning during this reporting period.

Division	LEARNING FROM COMPLAINT
Medicine	Improvements in recording of patient's preferences around hygiene needs on and during admission to inform effective care planning and care delivery. Improving timely response to calls for assistance via nurse call system, positively improving patient confidence in team caring for them. Improve levels of assistance with activities of daily living, including timely hygiene, mouth care and nutritional support, through improvements in documentation and handover communication. Improvements to the safe administration of oral thrush medication and the importance of ensuring the syringe is cleaned after each use, improving treatment outcomes and patient comfort. Embedding principles of Visitors Charter and improving accessibility to ward leaders through promotion with patients, visitors and staff including use of information posters.
Surgery	Improving staff knowledge of the "was not brought Policy" to improve continuity / oversight of patient care including prisoners. Improving process for patients and visitors to raise concerns, share positive feedback at a ward / department level through promotional posters and discussions.
Clinical Speciality Services	Raising the importance of safe handling and storage of hearing aids during inpatient admissions and use of the DBTH funded patient property boxes, improving patient experience through effective communication for those with a hearing impairment. Improving imaging safety in the MRI suite, providing hooks for patient's locker keys and adding related question to pre-MRI checklist. Improving use of isolation posters on patient side rooms through improved communication between MDT, Patients and Visitors and use of Trust approved posters.
Unplanned & Emergency Care	Improving recognition of early signs of stroke through additional training to improve skills, knowledge and confidence of triage nursing team. Improving nurse handover process including discussions in the line of sight of each patient. Training on Functional Neurological Disorder across the Emergency Department to improve recognition of associated symptoms.
Women's & Families	Improving the completion of BSOTS (Birmingham symptom specific obstetric triage system) through focused training for staff prior to undertaking triage role.

	Improving patient experience by promoting pre-booked and on demand interpreter and translation services, including tools available to translate information whilst patients are in the department including information boards. Focus on assessment and documentation of functionality of intra venous access cannula and frequency of skin assessment in children integrated into fluid balance chart checks. Reducing cannula associated skin damage and fluid infusion delays.

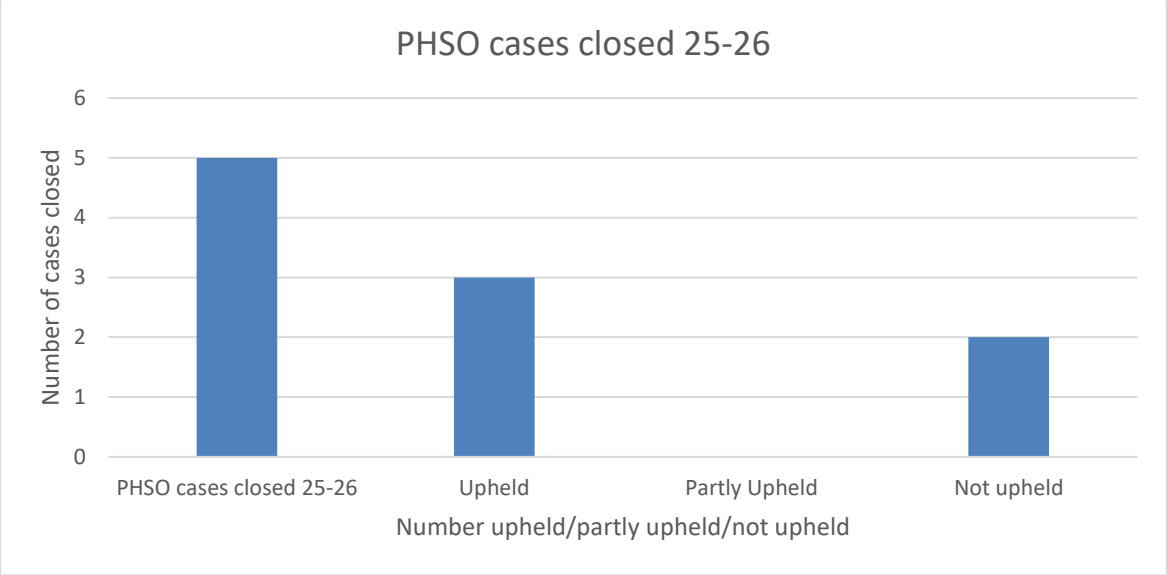
Parliamentary and Health Service Ombudsman (PHSO)

The number of PHSO contacts increased by 61% however, as detailed in the table below, the number of cases for primary investigation was 16, while the number of cases accepted for confirmed investigation was 5, which remained in line with the previous year.



The table below details the number of PHSO cases closed during the reporting period, totalling five cases. Of these, three cases were upheld and two were not upheld.

PHSO outcomes are reviewed to identify learning and actions. The number of confirmed investigations remained in line with the previous year; however, PHSO contacts continue to be monitored alongside complaints themes and response timeliness to ensure any emerging risks are identified early.



Learning from PHSO Complaints

During 2025/26 three complaints were upheld by the PHSO, with none being partially upheld and 2 not upheld.

The learning identified from the upheld and partially upheld was as follows:

PHSO	SUMMARY	LEARNING FROM COMPLAINT	IMPACT ON CARE
Upheld	Delay in administering antibiotics	Reinforced escalation processes for medication stock shortages, ensuring prompt medical review, microbiology advice where required, and timely administration of antibiotics to deteriorating patients.	Improves timely access to treatment and reduces risks associated with delayed antibiotic administration.
Upheld	Standard of care	Strengthened family and carer involvement, IPC compliance, and fundamental care through enhanced digital records, auditing, ward oversight, nutritional monitoring, and quality improvement initiatives.	Strengthens patient safety, experience, infection control, and delivery of fundamental care.
Upheld	Medication Administration “rapid tranquilisation”	Reviewed care through governance processes and introduced education and ongoing governance oversight to strengthen the safe prescribing and use of sedative medications.	Improves safe prescribing practices and reduces the risk of medication-related harm.

National Surveys

The Trust completed participation in all nationally required CQC surveys during 2025, including the Annual Adult Inpatient Survey, Maternity Survey and National Cancer Patient Survey. Following each survey, dedicated action planning sessions are undertaken with key stakeholders. Action plans are in place at Trust and divisional level and are monitored through the Patient Experience and Involvement Group, with oversight maintained by the Caring Group.

National survey findings are translated into action plans with identified oversight through patient experience governance structures. Further assurance will be strengthened where action plans include clear owners, milestones, measurable outcomes and evidence of impact.

Inpatient Survey 2025

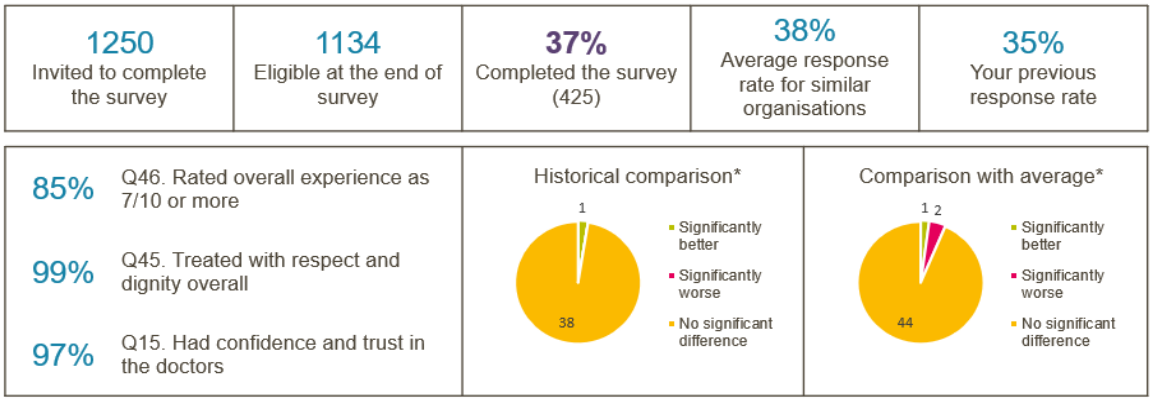


*Chart shows the number of questions that are better, worse, or show no significant difference

Maternity 2025 Survey Results

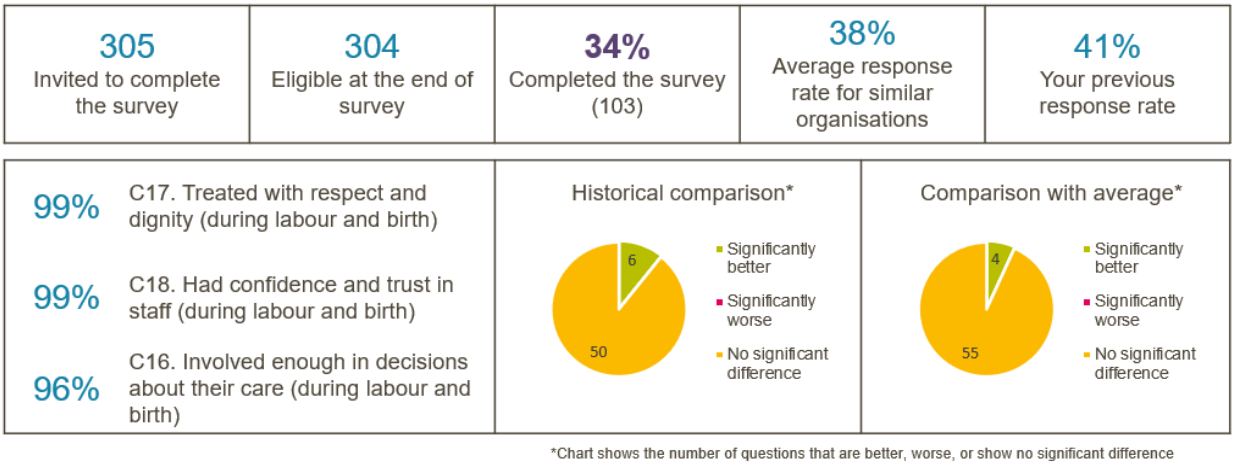


*Chart shows the number of questions that are better, worse, or show no significant difference

Friends and Family Test

The Friends and Family Test (FFT) remains a key component of the Trust's approach to listening to and learning from patient experience. As a national feedback tool, FFT provides patients, families and carers with a simple and accessible way to share their views on the care and services they have received. The feedback obtained supports the Trust in understanding what is working well, identifying opportunities for improvement, and informing service development.

The FFT consists of a standard national question alongside free-text comments, enabling patients to describe their experiences in their own words. These qualitative insights provide valuable information that helps teams recognise good practice, address concerns, and enhance the quality of care delivered.

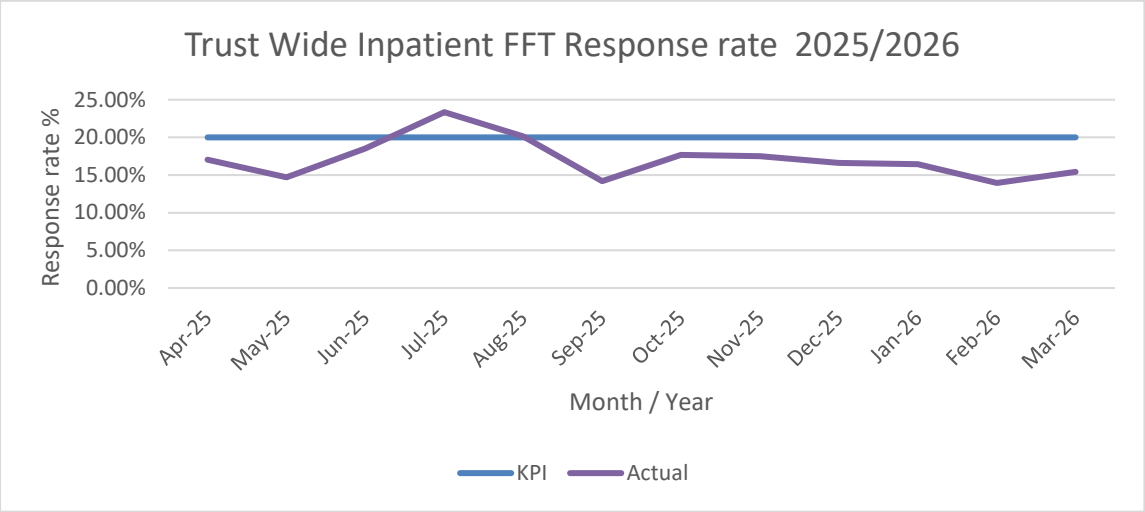
While NHS England does not publish response rates for FFT due to the ability of individuals to provide feedback multiple times, the volume of responses received can be used as an indicator of patient engagement and the effectiveness of local FFT processes. Benchmarking against national FFT activity also provides assurance that the Trust remains aligned with comparable healthcare providers.

The Trust continues to offer a range of accessible methods for patients to provide feedback, including text messaging, paper forms, QR codes and the IWantGreatCare platform. The availability of multilingual options through digital platforms further supports inclusivity, ensuring that patients from diverse communities can share their experiences and contribute to service improvement.

The Trust has maintained multiple accessible routes for FFT feedback and is using both response volume and qualitative comments to understand patient experience. Areas with low or variable response rates continue to be targeted to improve representativeness and reduce the risk of drawing conclusions from limited feedback volumes.

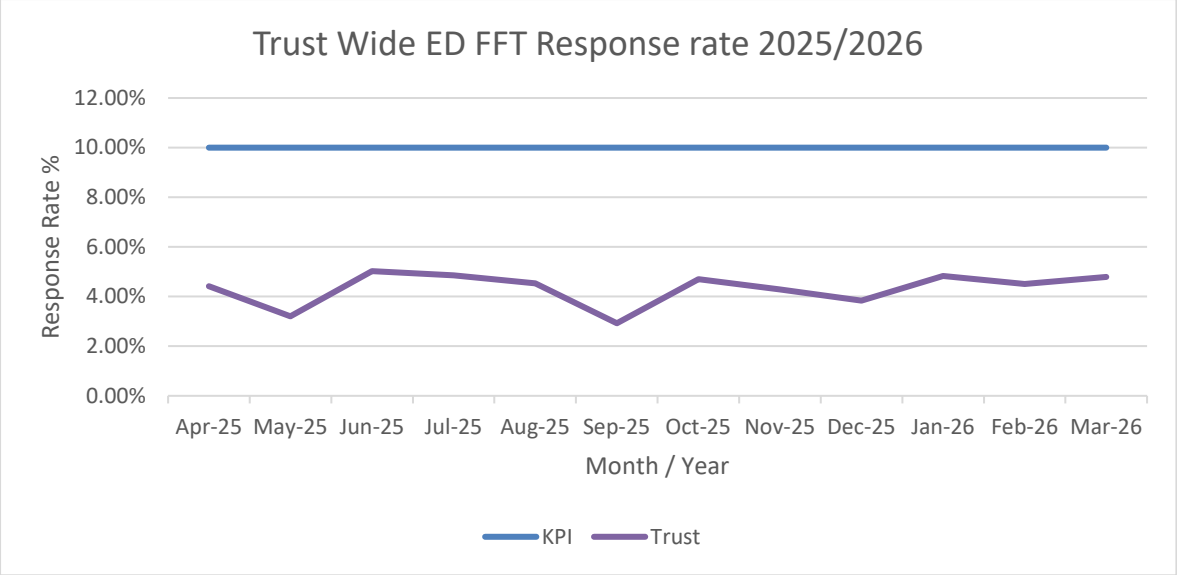
Inpatients

In 2025/26, the internal key performance indicator for inpatient FFT response rates increased from 15% to 20%. This KPI was only achieved in July and August 2025, with overall Trust average across 2025/2026 being 17.2%. Focused improvement work has supported sustained improvement in a number of ward areas, with 24 out of 37 wards achieving a response rate of 20% or above in month 12. This provides evidence of progress, while also indicating the need for continued targeted support in areas not yet achieving or sustaining month on month the expected response rate.



Emergency Department

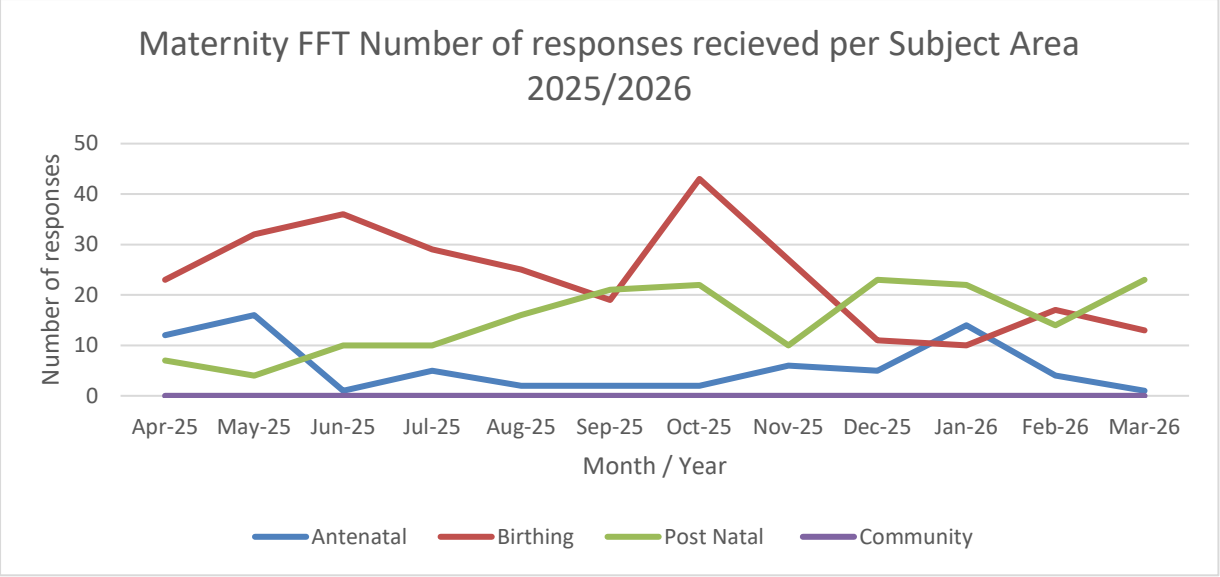
The average monthly Emergency Department FFT response rate has remained below the nationally recommended 10% benchmark. Caution should therefore be exercised when interpreting positivity ratings, as low response volumes may affect reliability and representativeness. Focused improvement work is underway across Emergency Department services, including the provision of digital devices to support FFT data collection, display of QR codes, recruitment of Patient Experience volunteers and incorporation of feedback completion into discharge processes.



Maternity

Unlike the Inpatient and Emergency Department Friends and Family Test (FFT), the Maternity FFT data collection records only the number of responses received and does not capture the total number of eligible women surveyed. As a result, a response rate cannot be calculated, and interpretation of the data relies on the volume of responses received when assessing the reliability and representativeness of positivity scores.

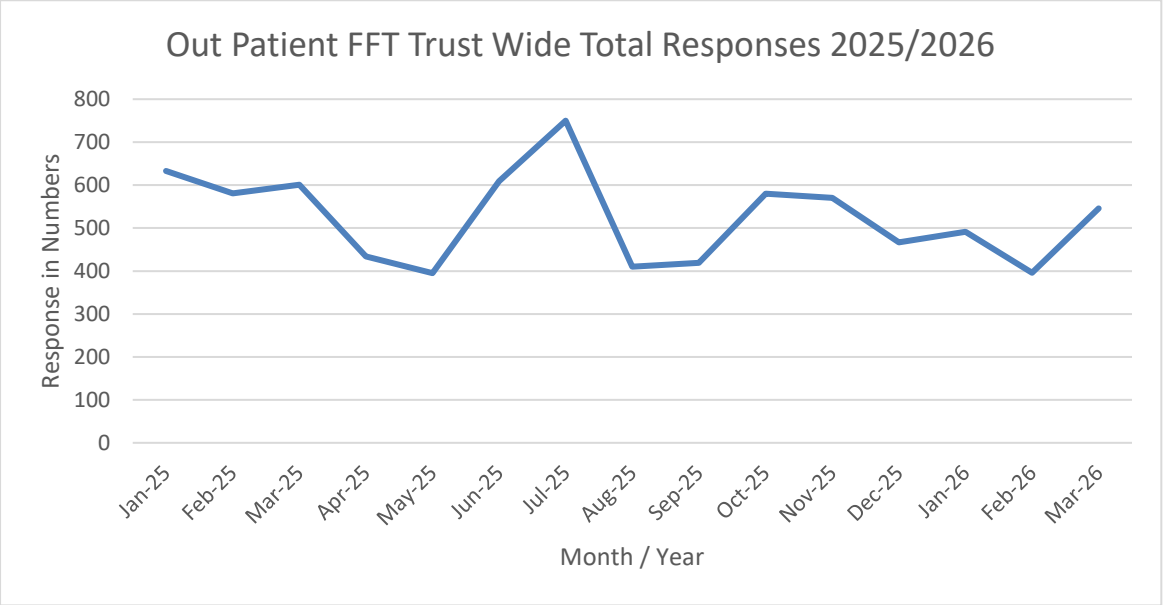
National benchmarking can be undertaken using positivity scores alongside the number of responses received, with professional judgement applied in the context of average monthly births and service activity. While DBTH positivity scores may appear comparable to local and national performance, the low response volumes can limit confidence in the findings and may not provide a fully representative picture of patient experience. Although use of text messages and paper surveys are utilised across DBTH maternity services, response rates remain consistently low, with a particular low response related to community services. The maternity team remain focused on working with patients on differing approaches to increasing response rates including promotion of survey QR codes at every contact and through the Maternity and Neonatal Voices Partnership.



Outpatients

Response rates across Outpatient services remain variable as seen in the previous reporting period and Divisional Matrons / Department Managers are focused on increasing proactive promotion of the survey within the waiting areas, including feedback on changes made as a result of feedback. Patient Experience volunteers will also be focused on outpatient surveys, with the aim of promoting the survey and also supporting patients to complete the survey prior to leaving either on paper or via digital devices.

Targeted actions are in place across inpatient, Emergency Department, maternity and outpatient services to increase response volumes and improve the reliability of patient feedback. Continued monitoring is required to demonstrate that these actions result in sustained improvement and more representative feedback across all service areas.



4 PATIENT ENGAGEMENT

Patient engagement activity during 2025/26 demonstrates a broad commitment to involving patients, carers, community groups and people with lived experience in service improvement. The table below provides examples of engagement activity, insights identified and actions taken during 2025/2026;

PUBLIC/ COMMUNITY ENGAGEMENT PIECE OF WORK	GROUPS ENGAGED WITH FOR THEIR VIEWS	INSIGHTS GAINED	ACTIONS TAKEN
Care Accreditation Patient Involvement	Patient Safety Partners	The Patient Safety Partners have participated in the Trusts Care Accreditation visits across the Trust during 2025 / 2026.	Feedback to ward areas on caring aspect of accreditation.
Accessibility Visual Impairment	The partially Sighted Society	Initial discussions undertaken to commence collaborative work with the Partially Sighted Society community, with further stakeholder discussions planned to identify areas of focus for collaborative work including improvements in care and staff awareness training.	Future meeting with the community scheduled with key Trust partners attending. Training opportunities scoped and will feed into development of collaborative opportunities with Partially Sighted Society.
Accessibility Hearing Impairment	Doncaster Deaf Trust, Deaf Society and Healthwatch partners.	Collaborative working with the Action for Audiology Group, Deaf Community in relation to information, interpreter access and methods, Deaf Awareness week an exploring Sign4Health accreditation process. Letter to all Audiology Patients developed in partnership with the Action for Audiology Group, this included inclusion of an easy read summary and QR code linked to BSL version of the letter.	Ongoing collaboration with key community partners. Work undertaken includes changes to letter to Audiology patients to include easy read summary and QR code link to BSL version. Supported meetings between deaf / hearing impaired community to

			understand the use of on demand video BSL interpreter service “Convo”. Community members invited to attend Trust sites to use convo and provide feedback in general of experience in reception areas. Convo signage rolled out Trust wide and further work to be undertaken at Audiology services at Sandringham in relation to digital connectivity.
Trust sites accessibility	AccessAble	DBTH charity have funded a project for the Trust to work with AccessAble to enable production of resources for current and future service users to access information about Trust services with an accessibility lens prior to visiting the Trust. The resources will provide patients with a range of information aimed at enabling pre planning for hospital visits where accessibility may be a concern for the patient, family or carer.	Promotion of the AccessAble resources to be planned in line with survey and resource development completion dates. Recommendations guide that will also be provided for consideration by Estates and Planning colleagues to be shared via Caring Group
PLACE Visits	People Focused Group, CHAD members, Partially Sighted Society, Retford Oaks Academy, Hall Cross Academy, Healthwatch, Citizens Panel, Volunteers.	Patient led visits on Trust estates and facilities.	Action plan to be developed based on the report. Initial priority areas selected for work to improve disability and dementia domains.

Patient Experience and Engagement Events	Open to all members of the community and Trust staff to attend.	The event included a series of presentations highlighting key themes for consideration and discussion, including how patient feedback is being used to improve experience, wider work around accessibility and support for carers, and a powerful session on inclusive communication led by a family member sharing their mother's experience as a patient. The event also gave attendees the opportunity to understand more about work being undertaken across local hospitals to improve access to a range of interpreter and translation services. This included video relay, telephone and face-to-face support, helping to improve access to British Sign Language and spoken interpretation services available 24 hours a day. Attendees also had the opportunity to take part in facilitated conversations exploring topics such as emergency care experiences, unpaid carer experience and accessibility. South Yorkshire Interpreter providers were also in attendance demonstrating the services available and raising the profile of the role of an interpreter and career opportunities.	Attendees who expressed an interest being signed up to be members of the Trusts Community Collective Group as Community Connectors. PALS colleagues to follow up on specific concerns raised during the event, requiring feedback. Review of general feedback to be fed into established workstreams and will be used to identify topics and themes of future events. Consideration of staff awareness training opportunities working with key partners and members of the community with lived experience.
Think Carer	Unpaid carers	The Trust has continued to build upon working relationships with Carers Groups and other key partners across Health and Social Care to strengthen the awareness of the role or unpaid carers in patient care and the challenges and barriers they face. Work is ongoing working with partners to strengthen the understanding of the importance of including unpaid carers in patient care and the resources available to both unpaid carers and Trust staff.	Continue to be key members of the Doncaster Carers Oversight Strategic Board and strengthen relationships with health and social care partners. Promotion of the council health and wellbeing assessments team and the concessions offered at DBTH for unpaid carers including - car parking and meal concessions.

Transitional Services	Young People transitioning to Adult Care	Transitional team including Youth Worker launched the Youth Forum, having a youth focused approach aims to re-build the relationship with the young people.	Continued progression of the Youth forum engaging with young people from a range of communities including the hearing impaired, who will be reviewing the Trusts new on demand BSL video interpreting services.

5 VOLUNTEERS

Volunteers continue to make a significant contribution to patient experience across the Trust, with an average of 165 active volunteers supporting services throughout 2025/26. Working across a range of roles, including patient escort duties, ward and clinic support, library services and the Emergency Department, volunteers provide valuable assistance to both patients and staff, enhancing patient care and experience.

During the year, the Trust recognised and celebrated volunteers through events including the annual Volunteers' Christmas Brunch and National Volunteers' Week. To further strengthen patient engagement, 18 new volunteers are being recruited to support the collection of Friends and Family Test feedback using Trust-issued tablets. The Trust also redeveloped the Chaplaincy Volunteer role, with strong interest resulting in 15 applicants progressing through onboarding.

Looking ahead, the Trust is exploring the implementation of a digital volunteer management system to streamline recruitment, communication and volunteer support, reflecting its ongoing commitment to developing and expanding volunteer services.

Volunteer activity continues to support patient experience, operational flow and feedback collection. The planned recruitment of volunteers to support FFT collection provides a direct mechanism to improve response volumes and strengthen patient voice within service improvement.

6 INTERPRETERS

In June 2025, the Trust transitioned to Language Empire as its interpretation and translation service provider through the South Yorkshire ICS joint contract. While some challenges remain in achieving desired fulfilment rates, support from the previous provider, DITU, has helped maintain service continuity.

To improve access to interpreting services, the Trust via DBTH Charity has invested in mobile tablet technology to be used across clinical areas. When fully rolled out this will enable faster access to video interpretation and on demand telephone interpretation via tablet technology. The introduction of CardMedic has further enhanced communication by supporting multilingual interactions and providing direct access to on-demand telephone interpreters via digital devices. Further work will see Language Empire's video on demand service also being accessible via the CardMedic solution. In addition, QR code-enabled British Sign Language (BSL) interpretation services have been made available throughout the hospital, improving accessibility for patients and staff to video interpreters 24/7, 7 days a week.

Although challenges with digital device deployment are being worked through, these developments represent a significant step forward in improving communication, accessibility and patient experience across Trust services.

Investment in interpretation, translation, BSL and digital accessibility solutions demonstrates clear progress in improving communication access. Ongoing monitoring should focus on fulfilment rates, deployment of digital devices, user experience and evidence that patients and staff can access appropriate interpreting support when required.

The next 12 months and beyond

During 2026/27, patient experience work will focus on strengthening the representativeness, impact and visibility of patient voice. Engagement will continue with unpaid carers and people with visual

and hearing impairments, ensuring that feedback from those with lived experience informs service development, accessibility improvements and staff awareness.

Focused work with divisions will include improving mechanisms for collecting and acting on feedback through the Friends and Family Test, Care Opinion and wider engagement routes. This will support a broader and more representative understanding of patient experience and strengthen the use of patient stories and feedback within governance, learning and quality improvement.

Priority area	Planned action	Measure of assurance
Complaints timeliness	Strengthen recovery plans, divisional accountability and oversight of response times.	Improved performance against internal closure timescales and routine reporting through governance routes.
FFT response rates	Target areas with low or variable response rates using volunteers, digital devices, QR codes and discharge processes.	Increased response volumes and improved representativeness across inpatient, Emergency Department, maternity and outpatient services.
Triangulation of intelligence	Strengthen links between patient experience data, complaints, incidents, surveys, workforce and quality intelligence.	Clearer evidence that themes are identified, escalated and translated into improvement activity.
Accessibility and inclusion	Continue engagement with communities and expand access to interpreting, translation, BSL and accessibility resources.	Evidence of improved access, user feedback and monitored fulfilment of interpreting and accessibility support.
Learning and impact	Strengthen documentation of actions taken in response to feedback and complaints.	Demonstrable examples of changes made, outcomes achieved and sustained improvement.

Conclusion

During 2025/26, the Trust continued to strengthen its approach to listening to and learning from patients, families and carers. Across the year, 790 complaints were received, Care Opinion stories were submitted with a 96% response rate, and an average of 165 volunteers supported patient care and experience across Trust services. Patient feedback remained positive, particularly in relation to staff kindness, compassion, professionalism and the support provided to patients and their families.

The Trust has also made significant progress in improving accessibility and inclusion through enhanced interpretation and translation services, partnership working with hearing and visually impaired communities, engagement with other local providers to support unpaid carers, and greater involvement of patients and community partners in service development and quality improvement activities. Learning from complaints, PHSO investigations, national surveys and engagement activity has informed targeted improvement initiatives across a number of services.

While these achievements provide assurance regarding the breadth and maturity of the Trust's patient experience programme, there are clear opportunities for further improvement. Challenges remain in improving complaint response timeliness, increasing Friends and Family Test participation and representativeness, and strengthening the triangulation of patient experience intelligence with quality, safety, workforce and operational data to demonstrate measurable impact and outcomes.

During 2026/27, further movement beyond simply collecting feedback will continue and a continued focus to demonstrate how patient voice directly influences change. A key priority will be ensuring that every division can evidence how patient feedback, complaints, survey findings and engagement activity have informed tangible improvements in care, accessibility, communication and patient outcomes. The implementation of team-based Care Opinion, expansion of volunteer-supported feedback collection, continued focus on accessibility and inclusion, and strengthened oversight of complaints performance will support this ambition.

The Quality Committee is asked to acknowledge the progress made during 2025/26, acknowledge the areas requiring further improvement, and support the delivery of the 2026/27 priorities to ensure the patient voice remains central to quality governance, service improvement and the delivery of safe, effective and compassionate care across DBTH.

2609 - D4 WINTER PLAN 2026/27

Decision Item | Denise Smith, Chief Operating Officer | 10:50

5 minutes

REFERENCES

Only PDFs are attached

- D4 - Winter Plan 2026-27.pdf
- D4 - Appendix A - NHSE letter 17 July 2026.pdf
- D4 - Appendix B - DBTH BAS Self Assessment Winter 2026-27.pdf

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	1 September 2026
Report Title / Ref:	**Winter Plan 2026/27**		
Sponsor:	Denise Smith, Chief Operating Officer		
Authors:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:	**Appendix A:** NHS England Winter planning 2026/27 – expectations and assurance letter **Appendix B:** Winter Planning 26/27 Board Assurance Statement Template		
Purpose of the report	~~Assurance~~	**Approval / decision**	~~Information~~ ~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 3		
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		

Avoid	Minimal	Cautious	Open	Seek	Mature
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

This paper sets out the final proposed winter plan schemes for 2026/27; these are designed to:

- Increase inpatient capacity
- Maintain patient flow
- Increase senior decision-making capacity

The winter plan provides an additional 37 beds at Bassetlaw and 29 beds at Doncaster, plus extended opening hours for the Trauma Ambulatory Care Unit (TACU) at Doncaster.

Most of the winter plan schemes are to be in place January – March 2027, however a small number of schemes are to remain in place until the end of April 2027 to ensure sufficient capacity is in place until after the Easter period. Therefore, the cost of the winter plan is split across 2026/27 and 2027/28:

2026/27	£2,370,303
2027/28	£186,335
	£2,556,638

The cost of 2025/26 winter pressures was £1,376,974. This year's request is £2,556,638. The key differences for 2026/27 are the opening of ward 22 at DRI and an expanded bed base on B5 at Bassetlaw which total £1,096,992 together.

The 2026/27 Trust financial plan allocated £1.388m towards winter pressures but £120,084 of this has already been drawn down to support peaks in demand in 2025/26 year to date. Therefore, the total

reserve remaining is £1.268m. Approving this winter plan will therefore give the Trust a cost pressure of £1,102,303 in 2026/27 financial year which will be either funded by any other unused reserves and/or a worsening the year end forecast outturn.	
Recommendations	
The Board of Directors is asked to APPROVE the winter plan for 2026/27.	
Healthier together – delivering exceptional care for all	
Patients	Winter plan schemes support the delivery of safe and timely access to care during peaks in winter demand
People	Winter plan schemes support colleagues to effectively manage peaks in winter demand, provide timely access to emergency care and maintain patient safety through the winter period
Partnerships	
Pounds	Winter plan schemes require investment in additional capacity
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	Executive Team 24 June, 22 July, 12 August 2026 Hospital Leadership Team 1 July 2026 Finance and Performance Committee 28 July 2026 Board Development Session 14 August 2026
Any outcomes/next steps / time scales	

1. Introduction

This paper sets out the:

- National winter planning and preparedness requirements for winter 2026/27
- Trust winter plan schemes for 2026/27

2. Background

NHS England wrote to NHS Trusts, Integrated Care Board, Primary Care Networks (PCNs) and Local Government on 17 July 2026 to set out expectations and assurance requirements for winter 2026/27.

In addition, the 2026/27 planning framework, urgent and emergency care (UEC) priorities, and medium-term planning guidance detail the expectations for Acute providers over the winter period.

3. National winter planning and preparedness requirements

3.1 The NHS England letter of 17 July 2026 set out the core expectations for all local areas as follows:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named executive winter lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the board assurance statements (BAS) and submitted by 30 September 2026

Specific expectations for NHS Trusts and foundation trusts, as providers accountable for operational delivery through winter, are as follows:

1. complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
2. implement the Model emergency department (ED), Model acute pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care treated as a patient safety priority, while maintaining elective capacity throughout the winter period
3. assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

The board assurance statement provides a checklist of the key considerations for winter planning.

- Section A is for Trusts to describe the approach to creating the winter plan and demonstrate how links with other aspects of planning have been considered
- Section B provides a checklist of what Boards should ensure is covered in the 2026/27 winter plan

The board assurance statement has been completed in draft, based on the current state of readiness and a copy of this is provided at Appendix B. It is noted that this should not be submitted until after a regionally led winter exercise programme, this is planned to take place on 17 September 2026.

The draft completed self-assessment dashboard is summarised as follows and shows the Trust as having full assurance in three domains and moderate assurance in three domains.

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 4 - Substantial assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	3 - Moderate assurance
	Capacity and community	5 - Full assurance
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	3 - Moderate assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	Awaiting assessment

The current gaps in the domains shown as 'moderate assurance' are:

Flow, occupancy and discharge

- The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services.

  The model discharge pathway was published in July 2026. An initial gap analysis has been completed, and all actions are incorporated into the UEC improvement programme with Trust led actions to be implemented prior to the winter period.

- The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission

  The Trust has a frailty assessment unit and provides frailty in reach to ED. Subject to approval, a dedicated frailty SDEC service will be trialled prior to winter.

UEC flow

- The Board is assured that emergency department mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm

  Implementation of the GIRFT corridor care improvement guide recommendations are incorporated into the UEC improvement programme with Trust led actions to be implemented prior to the winter period.

Infection Prevention and Control (IPC)

- The Board is assured that plans, infrastructure, estate arrangements, IPC governance and operational credibility are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of cohorting arrangements during period of increased demand or infection disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections

The Trust currently has arrangements in place for the rapid reconfiguration of physical space within ED.

- The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.

The Trust has recruited to a dedicated team, and this will be trained and in place prior to the winter period.

3.2 The 2026/27 planning framework, urgent and emergency care (UEC) priorities, and medium-term planning guidance outline the following expectations for Acute providers over the winter period:

Improve emergency department flow and 4-hour performance

- Implement new emergency care standards and guidance aimed at improving 4-hour performance.
- Ensure patients unlikely to require admission are directed to Urgent Treatment Centres (UTCs) where appropriate.
- Establish robust processes so non-admitted patients can be assessed, treated and discharged within 4 hours.

Reduce discharge delays

- Improved in-hospital discharge processes.
- Better use of community beds.
- Expansion of home-based intermediate care and community capacity.
- Stronger system working with community, social care and integrated care board (ICB) partners.

Maintain elective recovery while managing winter pressures

- Protecting elective activity and waiting list improvements.
- Balancing urgent care pressures with planned care delivery.
- Using productivity improvements and capacity management to avoid winter-related reductions in elective work where possible

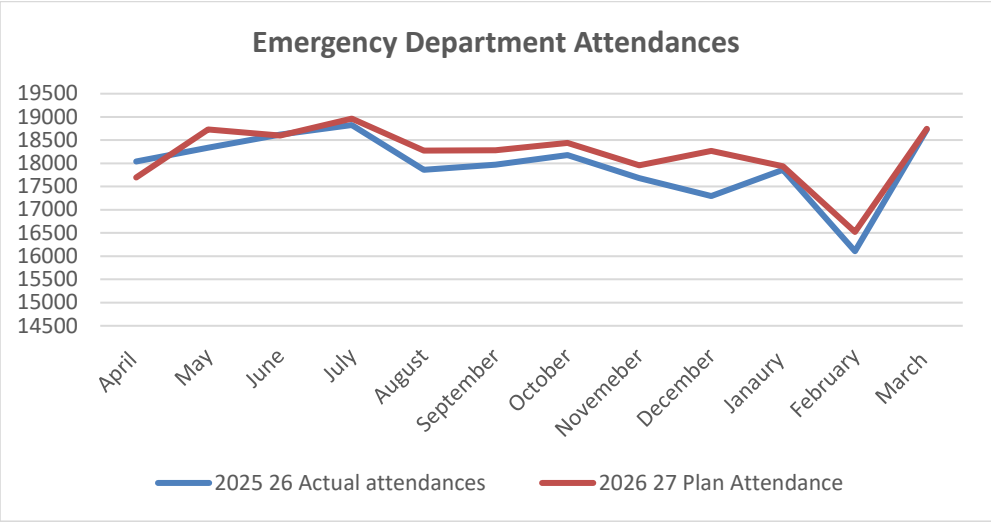
4. Winter planning timeline

The winter planning timetable for 2026/27 is summarised below:

- April – June 2026 Divisional and corporate teams winter planning workshops
- 24 June 2026 'Perfect Week' (to test learning from winter 2025/26)
- 24 June 2026 Executive Team review of the winter plan
- 1 July 2026 Hospital Leadership Team review of the winter plan
- 28 July 2026 Finance & Performance Committee receive the winter plan for approval
- 12 August 2026 Executive Team review of the final winter plan
- 14 August 2026 Trust Board of Directors review of the final winter plan
- 1 September 2026 Trust Board of Directors receive the final winter plan for approval
- 30 September 2026 Board Assurance Statement to submitted to NHS England

5. Forecast demand

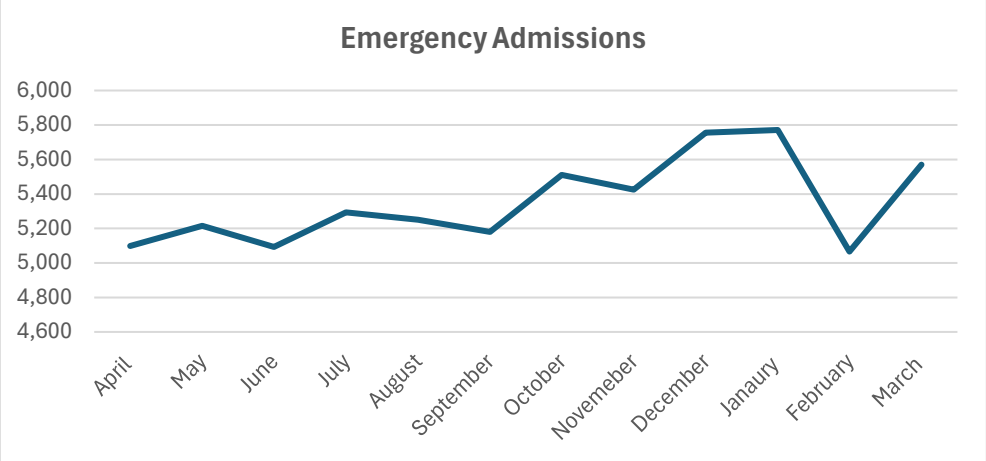
The winter plan assumes activity will broadly follow the same seasonal pattern as the previous year, with modest increases in attendances during most months to reflect anticipated demand.



Whilst Emergency Department attendances remain relatively consistent throughout the year and do not demonstrate a significant winter spike, emergency admissions show a clear seasonal increase. Admissions fluctuate between approximately 5,100 and 5,800 per month**,** with activity remaining relatively stable between April and September, averaging around 5,200 admissions per month and only minor month-to-month variation.

From October onwards, demand begins to increase, with admissions rising to around 5,500 before reaching their highest levels in December and January, at approximately 5,750–5,780 admissions. This represents an increase of around 10–11% compared with average activity during the spring and summer months.

This seasonal rise in emergency admissions places significant additional pressure on inpatient capacity. As more patients require admission from the Emergency Department, bed occupancy increases, reducing the availability of inpatient beds and impacting patient flow throughout the hospital. Increasing inpatient capacity over the winter period is therefore essential to accommodate the predictable rise in demand, maintain timely admissions from the Emergency Department, reduce delays in care, and support delivery of the four-hour standard while ensuring safe, high-quality patient care.



6. Winter planning

The proposed approach is recommended to ensure that the Trust has sufficient capacity and resilience in place to manage the anticipated increase in demand during winter 2026/27. The approach enables the

required additional capacity and workforce to be planned, recruited and mobilised in advance, providing greater operational stability and allowing services to prepare for increased demand in a controlled manner.

A reactive approach would increase the likelihood of the Trust needing to respond to periods of increased demand through short-notice measures, including the use of bank and agency staffing, temporary capacity and changes to planned activity. This would be less cost-effective and may present additional operational and patient safety risks, particularly if demand increases rapidly and appropriately skilled staff or capacity cannot be secured at short notice.

Learning from last winter, the proposed plan includes provision for some of the additional capacity to remain operational into 2027/28. This will provide additional resilience to manage the anticipated increase in demand associated with the Easter period and reduce the need for a further short-term capacity response

On this basis, the proposed approach is considered to provide the best balance of patient safety, operational resilience, workforce sustainability and financial value**,** while ensuring the Trust is better prepared to respond to winter pressures.

7. Winter plan schemes 2026/27

The majority of the winter plan schemes are to be in place January – March 2027, however one of the inpatient schemes at Bassetlaw is to remain in place until the end of April 2027 to ensure sufficient capacity is available until after the Easter period. Therefore, the cost of the winter plan is split across 2026/27 and 2027/28:

2026/27	£2,370,303
2027/28	£186,335
	£2,556,638

The cost of 2025/26 winter pressures was £1,376,974. This year's winter plan is requesting £2,556,638. The key differences for 2026/27 are the opening of ward 22 at Doncaster and an expanded bed base on B5 at Bassetlaw which total £1,096,992.

The 2026/27 Trust financial plan allocated £1.388m towards winter pressures but £120,084 of this has already been drawn down to support peaks in demand in 2025/26 year to date. Therefore, the total reserve remaining is £1.268m. Approving this winter plan will therefore give the Trust a cost pressure of £1,102,303 in 2026/27 financial year which will be either funded by any other unused reserves and/or a worsening the year end forecast outturn.

7.1 Increasing inpatient capacity

The inpatient capacity plan for winter maximises all available inpatient capacity at Doncaster and Bassetlaw and assumes all available beds will be open from January – March 2027 to manage demand and support patient flow.

The Executive Team considered initial plans to phase in the inpatient capacity from November 2026, however this was discounted due to the further increase in funding required. So, although the rise in emergency admissions is forecast from November, the Trust is planning to mitigate this through the urgent and emergency care improvements such as increased same day emergency care and reducing length to stay.

The additional inpatient capacity provides 37 beds at Bassetlaw and 29 beds at Doncaster, alongside extended opening hours for the Trauma Ambulatory Care Unit (TACU) at Doncaster. These schemes are

planned to be available from January 2027 and will be opened only where inpatient demand requires it, using a phased and proportionate approach.

A planned approach to increasing inpatient capacity will ensure this is delivered safely and in a coordinated way, with nursing and medical workforce requirements managed in advance, using substantive staff wherever possible and reducing reliance on bank and agency staffing.

Without this planned approach, additional beds may need to be opened reactively and without the necessary clinical and operational safeguards, creating a potential patient safety risk.

Financial Year 2026/27

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Extend TACU opening hours	01-Jan-27	31-Mar-27	3	£144,252
Bassetlaw	Ward B5 expansion	01-Jan-27	31 Mar-27	3	£500,217
Doncaster	Winter ward (Ward 22)	01-Jan-27	31-Mar-27	3	£490,539
Bassetlaw	Winter ward (Ward A5)	01-Jan-27	31-Mar-27	3	£490,539
Doncaster	Winter Ward (Modular)	01-Jan-27	31-Mar-27	3	£430,036
					£2,055,583

Financial Year 2027/28

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Bassetlaw	Ward B5 expansion	01-April-27	30-April-27	1	166,739
					£166,739

7.2 Increasing senior decision maker capacity

Financial Year 2026/27

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	ED (T4) cover overnight	01-Jan-27	31-Mar-27	3	£86,100
Bassetlaw	Resident Doctor overnight and weekend	01- Jan-27	31- Mar-27	3	£58,290
Doncaster	Acute Medicine Consultant	01-Jan-27	31-Mar-27	3	£43,680
					£188,070

Financial Year 2027/28

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Bassetlaw	Resident Doctor overnight and weekend	01- Apr-27	31- Apr-27	1	£19,596
					£19,596

7.3 Maintaining patient flow

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost

Doncaster	Additional discharge transport	01-Jan-27	31-Mar-27	3	£56,650
Doncaster & Bassetlaw	Additional portering	01-Jan-27	31-Mar-27	3	£70,000
					£126,650

8. Risks

There is a risk that failure to approve the proposed additional winter capacity will leave the Trust insufficiently resilient to manage anticipated winter demand and surge. This could result in increased ED crowding, ambulance handover delays, delayed admissions and discharges, increased length of stay and pressure on patient safety, alongside deterioration in UEC and elective performance. It may also require reactive and potentially higher-cost measures during periods of peak demand, including temporary capacity and cancellation of planned activity.

9. Recommendations

The Board of Directors is asked to APPROVE the winter plan for 2026/27.

To:
- All NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- Primary care networks
- Local government chief executives
- Directors of Adult Social Services
- Directors of Public Health

cc.
- Regional:
  - directors
  - chief operating officers
  - medical directors
  - chief nurses
  - directors of commissioning
  - chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

17 July 2026

Dear colleagues

Winter planning 2026/27 – expectations and assurance

Last winter was the best in 3 years for 4-hour performance and ambulance response times, despite an early flu season, a January norovirus peak and industrial action. That was the result of early planning and strong collaboration across health and care, for which we thank you. This letter sets out the national approach to winter 2026/27 and the actions we need every part of the NHS and local government to take, starting now.

Every local area must have a robust, clinically led and deliverable winter plan. The core expectations are:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named Executive Winter Lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the attached Board Assurance Statements (BAS), submitted to england.eecpmo@nhs.net by 30 September 2026

Responsibilities for winter reflect the new operating model set out in the Model ICB and Model Region Blueprints: ICBs commission, providers deliver, and regions oversee. The BAS templates set out in full what boards will be asked to assure; use them now to shape your plans rather than as a retrospective checklist. In summary:

ICBs

ICBs are responsible for the winter plan for their area, agreed with all partners and signed off by their board. Plans must be built on a whole-area demand and capacity analysis with robust planning assumptions, tested against surge and extreme surge scenarios. As strategic commissioners, ICBs must lead prevention now – vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather – and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector

ICBs must also co-ordinate the winter response day-to-day through their co-ordination centre, operating 7 days a week and using the OPEL framework, with tested escalation, surge and mutual aid arrangements agreed by all partners.

NHS trusts and foundation trusts

Providers are accountable for operational delivery through winter. Trusts must:

- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the Model Emergency Department, Model Acute Pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care

treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Ambulance services

- Plan to deliver the 2026/27 Category 2 response time trajectory, maximising hear and treat, see and treat and referral into alternatives to ED, to reduce conveyance rates.
- Work with acute partners to deliver 15-minute handovers, with none exceeding the 45-minute maximum.

Regional teams

In line with the Model Region Blueprint, regional teams will oversee winter preparedness and performance across providers and ICBs, arrange the September stress test exercises, assure plans across their geographies and co-ordinate mutual aid across ICB boundaries where needed, including specialised services and pathways commissioned outside of ICB arrangements.

Support available

We will share performance data to support planning by the end of July via NHS Futures, run online sessions in July on improving vaccination uptake, and publish further guidance on Urgent Community Response and community beds shortly. We will continue to work with ICBs and providers to support communication on 111, Pharmacy First, vaccination, and alternatives to ED.

Thank you for everything you and your teams are doing to prepare. Early, collaborative planning delivered a better winter for patients last year; together we can do so again.

Yours sincerely



Sarah-Jane Marsh CBE

NHS England Chief Operating Officer

Winter Planning 26/27
Board Assurance Statement (BAS)

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

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

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**



Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	Doncaster And Bassetlaw Teaching Hospitals Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	Denise Smith, Chief Operating Officer
Date:	01/09/2026

Please complete these sections

		Assurance statement	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The Trust Board received the final winter plan for approval on 1 September 20226	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	EHIIA and QIA have been completed for the overall winter plan	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	The Trust particapted in the South Yorshire winter plan workshop which included all system partners	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	No	The NEY event is scheduled to take place on 17 September and the Trust will be participating	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	The Chief Operating Officer is the named Executive Winter Sponsor The Chief People Officer is the named Exececutive for vaccinations	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

		Section B: 26/27 Winter Plan checklist	Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	The Trust Board received the vaccination programme in July 2026	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	As above	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	As above	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Winter demand is profiled as part of the operational develoment of the winter plan and winter plan schemes are designed to manage bed demand and occupancy	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	No	The model discharge pathway was published in July 2026. An initial gap analysis has been completed and all actions are incorporated into the UEC improvement	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes		
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	EEMAC was implemented at Doncaster in July 2026 and is due for implementation at Bassetlaw w/c 31 August. A standardised approach to SDEC implementatio	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	No	The Trust has a frailty assessment unit and provides frailty inreach to ED. Subject to approval, a dedicated frailty SDEC service will be trialled prior to winter.	
Capacity					
	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes		
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Targeted increase in senior clinical decision making capcity is included in the winter plan.	

3	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes		
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Community partners participated in the South Yorkshire winter planning workshop.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	No	Implementation of the GIRFT corridor care improvement guide receommendations are incorporated into the UEC improvement programme with Trust led actions t	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes		
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes		
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The Trust has agreed the model of care to implement the Model ED requirements by XXX. A gap analysis against the Model Discharge requirements has been co	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	No	The Trust currently has arrangements in place for the rapid reconfiguration of physical space within ED.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	The IPC Nurse Consultant was involved in the development of the winter plan	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	No	The Trust has recruited to a dedicated team and this will be trained and in post prior to the winter period.	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	The Trust has a standard operating procedure in place, developed by the IPC team	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Strategic and Tactical on call arrangements are in place. Access to nursing advice in the out of hours period would be via the Site Team and access to medical ac	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					

7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

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

Trust / Provider Name:	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Provider CEO name:	Dr Richard Jenkins
Date reviewed:	
Provider Chair name:	Mark Bailey
Date reviewed:	

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Denise Smith, Chief Operating Officer (denise.smith43@nhs.net)

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

The SRO has reviewed and approved the responses within the document

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 4 - Substantial assurance



		Rating
Section B	Prevention	**5 - Full assurance**
	Flow, occupancy and discharge	3 - Moderate assurance
	Capacity and community	**5 - Full assurance**
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	3 - Moderate assurance
	Leadership and operational grip	**5 - Full assurance**
	Specific actions for Mental Health Trusts	Awaiting assessment

2609 - D5 TRAUMA & ORTHOPAEDIC RECOVERY PLAN

Decision Item | Denise Smith, Chief Operating Officer | 10:55

10 minutes

REFERENCES

Only PDFs are attached

D5 - Trauma & Orthopedics Recovery Plan.pdf

D5 - Appendix A - Trauma & Orthopaedics Recovery Plan.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		Meeting Date:	1 September 2026
Report Title/ Ref:	**Trauma & Orthopaedic Recovery Plan**			
Sponsor:	Denise Smith, Chief Operating Officer			
Authors:	Suzanne Stubbs, Deputy Chief Operating Officer Sabrina Jones, General Manager, Division of Surgery James Tabour, Associate Director of Planning, Performance and Improvement			
Appendices:	Appendix A - T&O Recovery Plan			
Purpose of the report	~~Assurance~~	**Approval/decision**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 3			
For decision papers only: **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 paper seeks approval the for the Trauma and Orthopaedic (T&O) recovery plan which is designed to:

- Eliminate 65 week waits by the end of February 2027
- Clear the remaining backlog and deliver the Medium-Term Plan referral to treatment trajectory from 2027/28
- Deliver a sustainable T&O service which meets the referral to treatment access standard of 92% recurrently from April 2029

The recovery plan

- Is based on demand and capacity modelling, which has been developed in conjunction with the GIRFT Elective Team
- incorporates productivity improvements to partially close the gap between demand and capacity
- details the 3-year capital and revenue investment required to close the remaining gap between demand and capacity

The financial elements of the recovery plan are summarised in the table below:

	2026/2027			2027/28			2028/29		
	Income	Revenue Cost	Capital Cost	Income	Revenue Cost	Capital Cost	Income	Revenue Cost	Capital Cost
65 Week Backlog Clearance	£6,365,570	£3,000,100	£0	£0	£0	£0	£0	£0	£0
Sustainability	£0	£0	£0	£6,637,824	£6,205,104	£1,013,333	£9,956,736	£9,307,656	£1,520,000
Option 2: Internal Solution	£4,260,999	£2,949,712	£0	£17,078,568	£11,809,450	£0	£17,113,140	£11,820,051	£0
Total	**£10,626,569**	**£5,949,812**	**£0**	**£23,716,392**	**£18,014,553**	**£1,013,333**	**£27,069,876**	**£21,127,707**	**£1,520,000**

It is noted that the income assumptions associated with each element of the plan are based on T&O average tariff and are subject to commissioner agreement for activity delivered above contract.

Recommendations	
The Trust Board of Directors is asked to APPROVE the T&O recovery plan	
Healthier together – delivering exceptional care for all	
Patients	The recovery plan supports the delivery of timely access to care for patients
People	The recovery plan provides the additional workforce capacity to deliver timely access to elective orthopaedic services
Partnerships	
Pounds	The recovery plan requires additional investment and generates additional activity above the current medium-term plan
Health Inequalities	
Legal/ Regulation:	The NHS Standard Contract sets out the access standards for Acute Trusts to deliver
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	Executive Team 22 July 2026 Finance & Performance Committee 28 July 2026 Executive Team 12 August 2026 Trust Board of Directors 14 August 2026
Any outcomes/next steps / time scales	

1. Introduction

This paper seeks approval the for the Trauma and Orthopaedic (T&O) recovery plan which is designed to:

- Eliminate 65 week waits by the end of February 2027
- Clear the remaining backlog and deliver the Medium-Term Plan referral to treatment trajectory from 2027/28
- Deliver a sustainable T&O service which meets the referral to treatment access standard of 92% recurrently from April 2029

The recovery plan is

- based on demand and capacity modelling, which has been developed in conjunction with the GIRFT Elective Team
- incorporates productivity improvements to partially close the gap between demand and capacity
- details the 3-year capital and revenue investment required to close the remaining gap between demand and capacity

2. Background

T&O is the Trust's most challenged specialty with regard to elective care performance. As of July 2026:

- The T&O RTT waiting list is 12,275, 23% of the overall Trust RTT waiting list. Of these patients, 50% have been waiting > 18 weeks and 9% have been waiting > 52 weeks
- T&O accounts for 30% of all patients waiting over 18 weeks, 80% of all patients waiting over 52 weeks and 90% of all patients waiting over 65 weeks

3. Demand and Capacity Modelling

Demand and Capacity modelling, undertaken jointly with the GIRFT Elective team using the nationally recognised tool, has demonstrated that there is an overall gap between capacity and demand, with the main constraint in admitted elective capacity. Whilst there are productivity gains to be made, these alone will not close the gap between demand and capacity.

4. Recovery Plan

The recovery programme comprises three distinct elements:

1. **Long waits:** eliminating 65 week waits
2. **Backlog:** clearing the remaining backlog and deliver the Medium-Term Plan referral to treatment trajectory from 2027/28. Three options are presented for the backlog clearance.
3. **Sustainability:** delivering a sustainable T&O service which meets the referral to treatment access standard of 92% recurrently from April 2029

Built into all 3 elements is the assumption of increased productivity and efficiency which will maximise the use of existing capacity through:

- Improved Patient Tracking List (PTL) management and validation
- Adherence to booking rules for outpatient and theatres
- Improved utilisation of existing outpatient and theatre capacity
- Demand management with primary care and outpatient redesign to reduce avoidable outpatient appointments

4.1 Long waits: eliminating 65 week waits

The proposed productivity improvements are forecast to reduce the projected 65-week waiting list backlog by 108 patients. However, a residual backlog of 430 patients will remain, and will require additional theatre capacity.

The proposed recovery plan will utilise a combination of increased internal capacity through additional weekend operating, optimisation and reallocation of existing theatre capacity, and targeted outsourcing to the independent sector. This blended approach will accelerate the reduction in long waits whilst maintaining delivery of routine elective activity.

The estimated cost of the recovery programme is **£3.0 million in 2026/27**. Based on the average national tariff, the additional activity is expected to generate approximately **£6.3 million** of income. As this activity exceeds the contracted activity plan, agreement with commissioners will be required to secure the associated funding and ensure the financial sustainability of the programme.

The recovery plan forecasts the elimination of 65 week waits by **February 2027**.

4.2 Backlog: clear the remaining backlog

The backlog comprises c. 7,500 patients and requires a recovery programme for the remainder of 2026/27 and running through to March 2029.

The Trust has evaluated three delivery options to support backlog recovery:

Option 1: Insourcing of activity, utilising existing theatre capacity
Option 2: Recruitment of additional consultants supported by flexible programmed activities
Option 3: Outsourcing activity to independent sector providers

Each option is modelled to eliminate the backlog and achieve the national 92% Referral to Treatment (RTT) standard by March 2029, with T&O returning to the Trust medium term plan RTT trajectory during 2027/28. The options differ in terms of implementation timescales and cost.

The current elective Trauma and Orthopaedic (T&O) bed capacity is anticipated to be sufficient to accommodate the proposed increase in activity to clear the backlog. However, a detailed bed capacity modelling exercise will be undertaken to validate this assumption by profiling the backlog cohort, expected case mix, and anticipated length of stay (LoS).

4.2.1 Option 1 - Insourcing of activity, utilising existing theatre capacity

This option delivers additional elective orthopaedic activity through insourcing of T&O Consultants, operating in fallow Trust theatre sessions

Over a 3-year period (2026/27 – 2028/29) this could clear an estimated backlog of 7,467 patients > 18 weeks and enable T&O to be back on track with the Trust MTP RTT trajectory in 2027/28 and deliver the RTT access standard by March 2029.

This option requires investment **£8 million** revenue funding in **2026/27**, increasing to **£10.7 million per annum** in **2027/28** and **2028/29**. No **capital investment** is required.

The additional activity is forecast to generate **£8.8 million** of income in **2026/27**, and **£11.8 million per annum** in 2027/28 and 2028/29.

4.2.2 Option 2 - Internal recruitment to utilise fallow lists

This option would require 10.00 wte increase in the T&O Consultant workforce, which would be delivered through a combination of substantive and locum appointments. This proposal would also require investment in other clinical, operational and administrative capacity.

Over a 3-year period (2026/27 – 2028/29) this could clear an estimated backlog of 7,467 patients > 18 weeks and enable T&O to be back on track with the Trust MTP RTT trajectory in 2027/28 and deliver the RTT access standard by March 2029.

This option requires investment of **£2.9 million** of revenue funding in **2026/27**, increasing to c. **£11.8 million per annum** in 2027/28 and 2028/29.

The additional activity is expected to generate **£4.2 million** of additional income in **2026/27**, increasing to approximately **£17.1 million per annum** from **2027/28**. No **capital investment** is required.

4.2.3 Option 3 - Outsourcing activity to independent sector providers

Whilst outsourcing to the independent sector would provide additional capacity, a significant proportion of the Trust's Trauma and Orthopaedic backlog comprises complex cases. These patients are often unsuitable for treatment within the independent sector due to case mix restrictions and clinical complexity. Consequently, outsourcing is likely to be limited to lower-complexity procedures, leaving the most challenging long-wait patients within the Trust.

Outsourcing delivers backlog recovery through the procurement of additional capacity from independent sector providers.

This option requires investment of **£8.8 million** of revenue funding in **2026/27**, and **£11.8 million per annum** in **2027/28** and **2028/29**.

The additional activity is expected to generate equivalent income in each financial year, resulting in a cost-neutral position.

4.3 Sustainability: delivering a sustainable T&O service which meets the referral to treatment access standard of 92% recurrently from April 2029

To establish a sustainable service model, recurrent investment is required in the Trust's workforce and infrastructure. The proposed investment includes:

- Recruitment of **4.00 wte additional consultant orthopaedic surgeons**, targeted at the sub-specialisms with the greatest capacity constraints
- Expansion of the theatre, recovery and inpatient ward workforce to support increased elective operating capacity
- Expansion of elective theatre capacity to increase the number of available operating sessions and improve resilience. It is anticipated that two additional theatres will be required.
- Expansion of the elective orthopaedic bed base. It is anticipated that c. 11 additional beds will be required
- Growth in outpatient capacity to ensure timely access for new referrals and support sustained RTT performance.

This option requires investment of £**6.2 million** of revenue funding in **2027/28** and **£9.3 million of recurrent funding per annum** from 2028/29. These costs include all pay and non- pay costs associated with the delivery of an expanded orthopaedic service and include clinical, operational and administrative costs to support the

additional theatres and increased bed base. The costs assume the bed base is staffed 24/7 as an inpatient ward, depending on case mix. However, it may be possible to deliver the activity through a combination of day case and inpatient capacity, a detailed bed modelling exercise will need to be undertaken to assess this.

The additional activity is expected to generate **£6.6 million** of additional income in **2027/28**, and c. **£10 million per annum** recurrently from **2028/29**.

This option also requires two additional theatres and the anticipated cost of these is £1.01m in 2027/28 and £1.52m from 2028/29.

This investment will provide the recurrent capacity required to meet future demand, maintain delivery of the **92% RTT standard**, and ensure the long-term sustainability of the Trauma and Orthopaedic service.

4. Financial Summary

The financial elements of the recovery plan are summarised in the table below:

	2026/2027			2027/28			2028/29		
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It is noted that the income assumptions associated with each element of the plan are based on T&O average tariff and are subject to commissioner agreement for activity delivered above contract.

5. Expected Outcomes

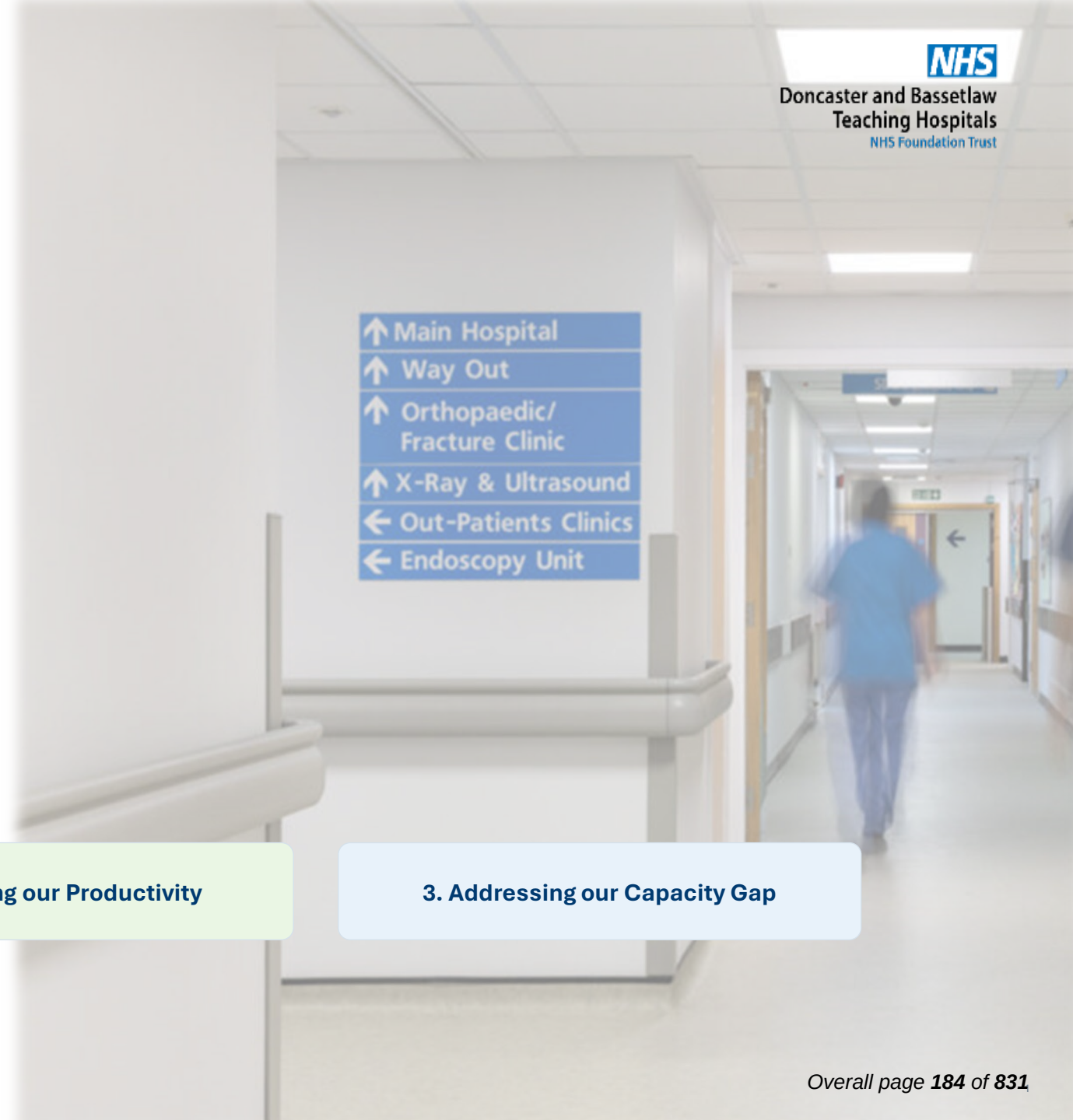
Approval of the proposed recovery plan will:

- Eliminate 65-week waits by February 2027
- Deliver sufficient recurrent workforce and theatre capacity to meet forecast demand and prevent the re-emergence of long waiting times.
- Improve Referral to Treatment (RTT) performance from the current 48.4% to the national standard of 92% by March 2029, with a sustainable model in place to maintain compliance thereafter.
- Establish a resilient and sustainable Trauma and Orthopaedic service, reducing reliance on non-recurrent recovery initiatives and independent sector providers.
- Reducing waiting times, improving timely access to care and treatment, and ensuring patients receive care in the most appropriate setting.
- Strengthen the Trust's long-term elective performance, supporting delivery of national recovery objectives and improving operational and financial sustainability

6. Recommendations

The Trust Board of Directors is asked to

- Note the capacity gap identified through the demand and capacity modelling exercise
- Approve the plan to eliminate 65 week waits
- Approve the plan to deliver a sustainable T&O elective service
- Approve option 2 of the backlog plan as the primary solution to deliver the Medium Term Plan referral to treatment trajectory from 2027/28



NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Trauma and Orthopaedics Recovery Plan

Aug 2026

1. Understanding our Demand and Capacity

2. Maximising our Productivity

3. Addressing our Capacity Gap

Background and context: why T&O needs a recovery plan

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

National context

c.860k

people waiting for T&O treatment nationally in late 2025.

DBTH position

7th

most challenged trust nationally in T&O RTT backlog in Jan-26.

Waiting list scale

11,745

T&O RTT backlog patients reported for DRI in Jan-26.

Current RTT 18 Week Performance

51.6%

Performance has fluctuated around 50% since the covid pandemic despite continuous improvement work

Service profile

- 19.29 budgeted consultant posts, with 18.78 posts filled by 22 consultants.
- Subspecialties: hips, knees, spine, hand and wrist, upper limb, foot and ankle, acute knee and paediatrics.
- 54 outpatient clinics per week; capacity reduced following job-plan changes in June 2025.

Theatre estate

- DRI: 4 trauma theatres / 34 sessions per week, with 2.3 sessions converted to elective complex cases.
- Bassetlaw: 3 elective theatres / 24 sessions per week; arthroplasty and radiographer constraints.
- MEOC and Mexborough provide elective/day-case capacity with exclusion or procedure limitations.

Summary

T&O is the most challenged surgical specialty at DBTH for RTT performance and total waiting list size, with a considerable backlog and a large gap between weekly incoming demand and capacity. The plan therefore needs to combine booking grip, outpatient pathway change, and explicit admitted capacity decisions.



1

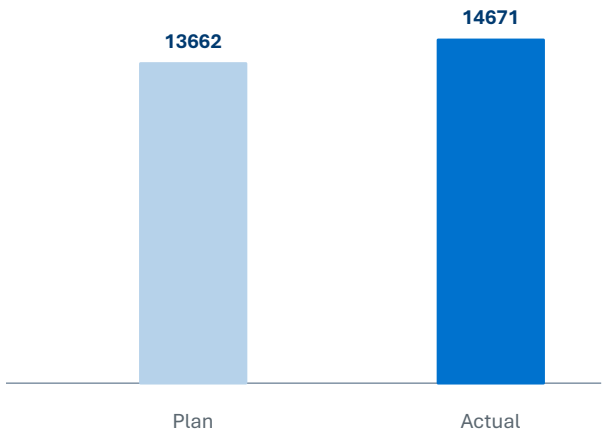
Understanding our Demand and Capacity

In partnership with the GIRFT team, DBTH has undertaken extensive modelling to understand demand for orthopaedic services across Doncaster and Bassetlaw, and the capacity constraints.

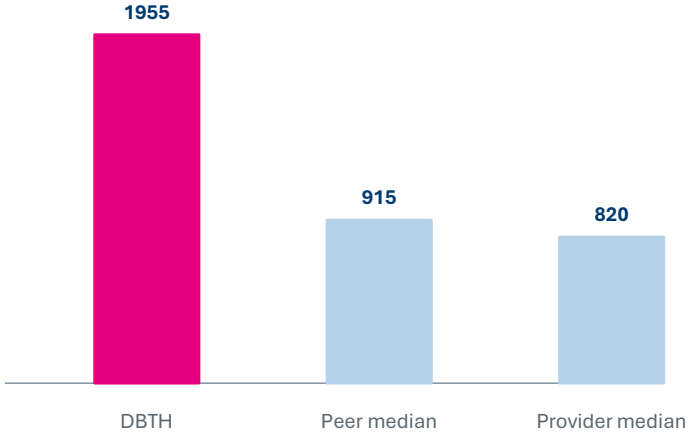
Source: T&O recovery action plan and demand & capacity modelling.

Capacity and demand: activity is ahead of plan, but incoming demand is an outlier

YTD activity vs plan



Clock starts vs peers



What this tells us

- Total YTD activity is 14,671 against plan of 13,662 (+1,009 / +7.4%).
- Day case, NEL, OPFA and OPFU activity are strong, while OP procedures are below plan.
- DBTH is an outlier in terms of incoming orthopaedic demand

Service scale

More than 27,000

elective new patients in 2025/26

Demand pressure

113%

above peer median clock starts

Demand Pressure

+138%

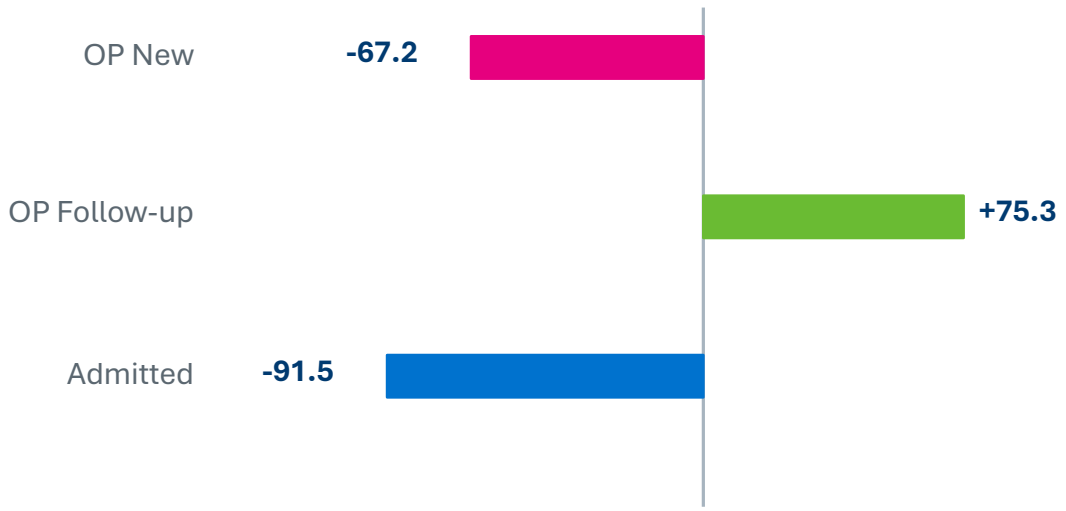
above all provider median clock starts

Implication for recovery

The specialty must reduce avoidable demand and maximise booking discipline, but the plan also needs an solution to the remaining capacity gap once realistic productivity improvement is applied.

Capacity and demand: summary of demand and modelling

Weekly gap / surplus in volume of patients by pathway



New outpatient gap

67.2 patients/week short against demand and backlog clearance. This equates to c.11 clinics, but not all capacity is interchangeable across subspecialties.

Follow-up capacity

+75.3 patients/week aggregate surplus. The opportunity is controlled conversion of some follow-up capacity into first activity where clinically safe.

Admitted bottleneck

91.5 patients/week below the requirement before actions. This is the principal constraint on 65-week recovery and RTT improvement.

What the modelling has told us

To date we have been unable to model trauma demand and quantify

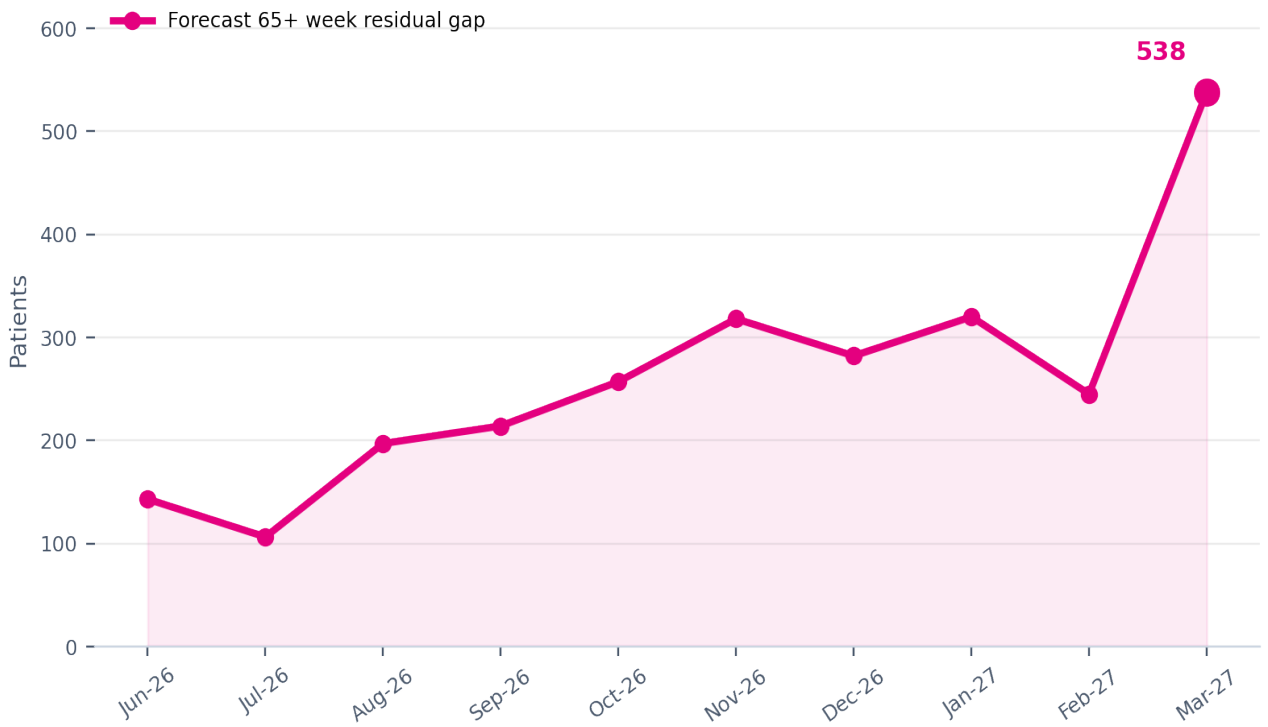
The outpatient model needs targeted improvement, but the admitted pathway is the rate-limiting factor. A sustained recovery plan therefore needs to:

- protect long-wait booking priority
- match patients to the right sites
- use all available theatre time
- manage pre-op and cancellation risk
- increase capacity where productivity cannot bridge the gap.

Long waits - forecasted baseline position

Without further intervention, the modelled 65-week wait position grows materially by the end of 2026/27.

Forecast residual 65-week waits with 45% booking and no additional capacity



Year-end risk

538 patients

forecast residual 65+ week gap by Mar-27 if booking and capacity remain unchanged.

Growth from June

+395

patients from Jun-26 to Mar-27; c.3.8x the starting gap.

Summary

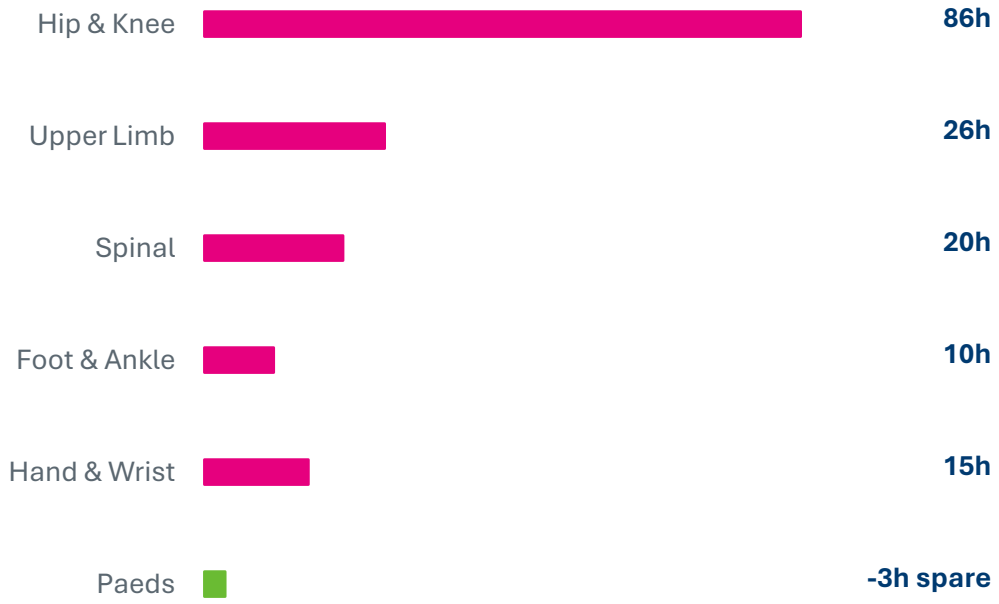
Long-wait risk grows

This is the baseline risk case for 65-week recovery. It assumes no efficiency gain and no additional capacity, so the residual gap rises through winter and peaks at year-end.

Admitted pressure is concentrated in Hip & Knee and complex work

Not all theatre capacity can be used for the patients who drive the long-wait risk

Admitted capacity gap by subspecialty — hours per week



Total admitted gap

c.156 hours per week

equivalent to c.39 four-hour sessions

Hip & Knee

86 hours per week

c.21 four-hour sessions: the main driver

Case-mix constraint

The admitted gap is not interchangeable. E.g. Paediatric, foot and ankle or low-complexity capacity cannot absorb arthroplasty and complex patient cohorts where site, implant, equipment, anaesthetic and consultant skill mix constrain delivery.

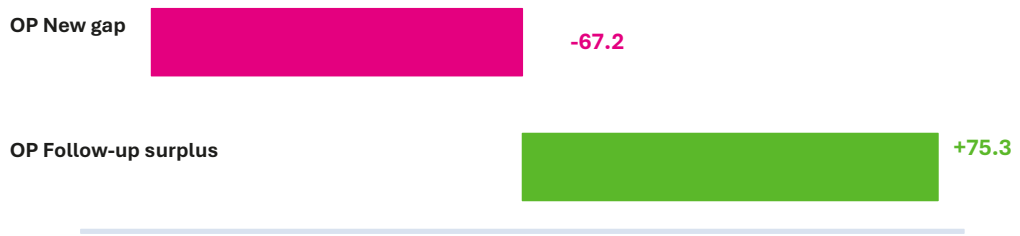
Why this matters for booking

The recovery plan has to improve the proportion of long-wait patients booked in order, but also has to preserve clinical appropriateness and operational deliverability.

Outpatients: re-aligning follow-up surplus to create new capacity

A controlled conversion of a proportion of follow-up slots will reduce the new outpatient gap, but it will not close it completely.

Weekly outpatient gap / surplus after demand and backlog modelling



New patient gap

67.2 patients per week

c.11 clinics; although capacity is not fully interchangeable by subspecialty.

Follow-up surplus

75.3 patients per week

aggregate surplus; requires careful clinical validation before conversion.

Repurpose a controlled proportion

33.5 patients per week

Modelled opportunity from reducing follow-up activity and converting two follow-ups into one new appointment slot where clinically safe.

Residual new OP gap

33.7 patients per week

The remaining gap is still c.5–6 clinics per week, after the realistic follow-up conversion opportunity.

Delivery approach

Clinic template rules, PIFU confidence, consultant triage and CATS/MSK pathway support. Follow-up activity will not be reduced where it would create clinical risk.

2

Productivity and booking: what can be improved

Recovery requires better in-order booking, patient-level grip and practical theatre utilisation improvements

Booking productivity actions: summary of our action plan for RTT improvement

Our action plan focuses on PTL accuracy, booking discipline, demand management and list utilisation so that existing capacity treats the right patients in the right order.

1. Understanding our Demand | **Maximising our Productivity** | 3. Addressing our Capacity Gap

1. PTL Validation Improvement

Twice-weekly PTL meetings, DrDoctor validation, duplicate referral review and service-level data cleanse to identify the true long-wait cohort.

2. Booking Efficiency

Weekly patient-level sign-off of booked utilisation, pooled long waits and central team resilience to protect oldest-first booking where clinically appropriate.

3. Use the right capacity

Clinic templates, DCC repurposing and site/list stratification to match patients to DRI, BDGH, MEOC and minor ops capacity.

4. Reduce avoidable demand

Consultant triage, treatment-of-referral-joint rules, PIFU, one-stop pathways and CATS/MSK hub development to reduce inappropriate referrals and follow-up demand.

5. Protect theatre time

Improve booked utilisation, pre-op readiness, radiology support and fallow-list backfill so booked capacity translates into actual treatment.

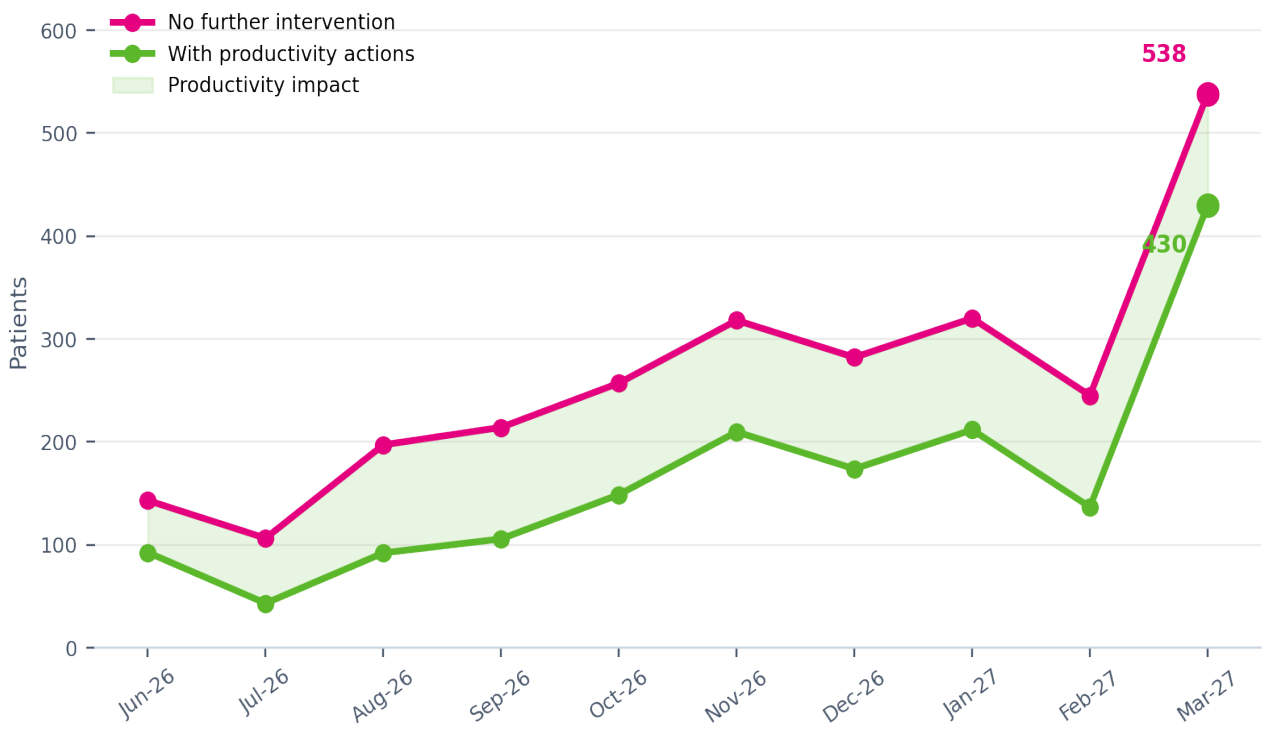
6. Add recovery support

Weekend lists, mutual aid, outsourcing/insourcing and robotic/minor-ops release to supplement productivity while recurrent solutions are developed.

Long waits - impact of productivity actions

Productivity actions improve the modelled 65-week position, but a residual gap remains without additional capacity.

65-week residual gap: baseline versus productivity actions



Baseline position

538

patients by Mar-27 in the no-efficiency / no-additional-capacity forecast.

After productivity

430

patients by Mar-27 after efficiency assumptions but before additional capacity.

Productivity impact

-108

fewer residual 65-week waits by Mar-27 from booking and efficiency actions.

Residual gap

430

patients still need to be mitigated or funded without further capacity intervention.

Summary

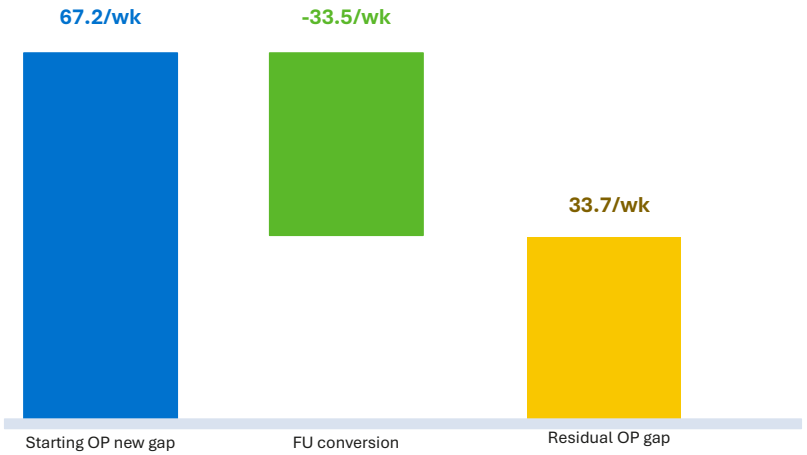
Capacity gap remains

The green line shows the improved position from productivity and booking actions. The remaining gap stays material and requires the capacity choices described in the following section.

Outpatients: convert safe follow-up surplus, then tackle the residual gap

The outpatient opportunity reduces the first appointment pressure but still leaves c.34 new patients per week to address.

Weekly new outpatient gap after follow-up conversion



Starting OP new gap

67.2/wk

new appointments short of demand and backlog clearance.

Follow-up surplus

+75.3/wk

aggregate surplus available for targeted review.

Safe conversion

33.5/wk

small proportion switched to new capacity using 2 FU to 1 New conversion.

Residual OP gap

33.7/wk

c.5–6 clinics per week still to fund or mitigate.

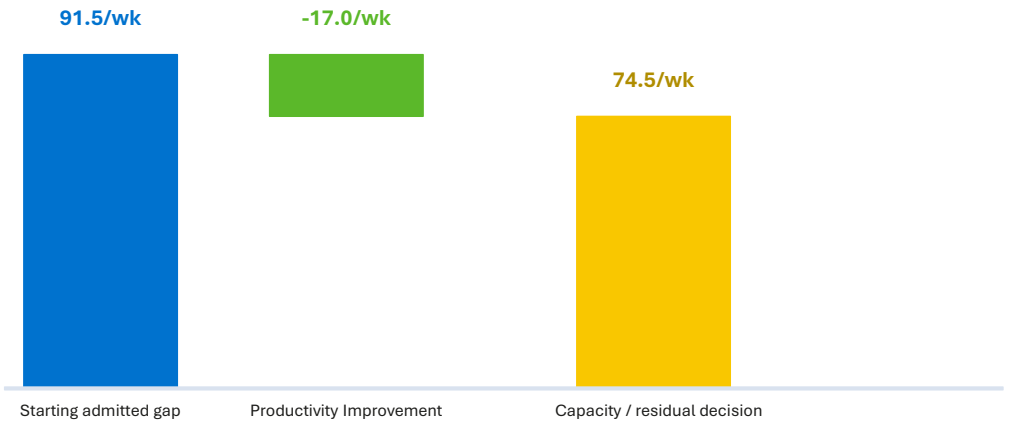
Summary

This will be managed through clinic template conversion, PIFU, CATS/MSK triage and demand management.

Admitted pathway: combine additional capacity and the residual gap

Productivity improves the position, but additional funded capacity is needed and there remains a residual admitted gap to own explicitly.

Weekly admitted patient gap after productivity improvement



Starting admitted gap

91.5 patients per week

patients below demand and backlog clearance requirement.

Productivity actions

17 patients per week

patient-level booking grip and utilisation actions.

Residual gap

74.5 patients per week

Summary

After booking productivity, 74.5 patients per week remain as one capacity decision: deliver 42.5/wk through named short-term actions and agree how to close or fund the remaining 32/wk residual gap.

3

The remaining demand gap and funding choices

After the controllable productivity and booking improvements, the residual gap becomes a capacity and affordability decision.

Three-part plan with three backlog clearance options

	2026/27		2027/28		2028/29		Implementation	
	Revenue Required	Income Generated	Revenue Required	Income Generated	Revenue Required	Income Generated	Start	End
Eliminate 65 weeks	£3.0m	£6.3m	£0m	£0m	£0m	£0m	July 2026	Feb 2027
Backlog Recovery: Option 1 Insourcing	£8.0m	£8.8m	£10.7m	£11.8m	£10.7m	£11.8m	Aug 2026	March 2029
Backlog Recovery: Option2 Internal recruitment	£2.9m	£4.2m	£11.8m	£17m	£11.8	£17m	Jan 2027	March 2029
Backlog Recovery: Option 3 Outsourcing to ISP	£8.8m	£8.8m	£11.7m	£11.7m	£11.7m	£11.7m	Aug 2026	March 2029
Sustainability	£0m	£0m	£6.2m	£6.6m	£9.3m	£10m	Aug 2027	Recurrent

- **The sustainability element of the plan requires capital investment in two additional theatres of £1.01m in 2027/28 and £1.52m recurrent from 2028/29. Revenue costs include the staffing of the additional theatres**
- **The sustainability element of the plan requires an increase in the bed base of c. 11 beds and costs include the staffing of these beds**

Element A: Stabilise long waits

A nine-month, front-loaded package to reduce immediate long-wait risk. The refreshed cash position uses the appendix supplier and internal delivery rates.

Total package capacity

37.8/wk

All capacity elements at 85% utilisation.

Potential Jul–Mar delivery

1,475

Treatments if all elements deliver for 39 weeks.

Known cash cost 26/27

£3.01m

Weekend lists, outsourcing, A/L backfill and minor-ops staffing.

Income assumptions

£6.4m

Note: Based on average cost per case of Daycase and Elective

Part costed capacity

10.6/wk

Note Minor –ops staffing included at c £0.31m

Package delivery and cost working

Action	Patients / wk	Jul–Mar cost	Start	Cost status
Additional weekend lists	9.35	£1.26m	Jun-26	Known
Long-wait outsourcing	6.80	£0.87m	Aug-26	Known
A/L backfill with insourcing	4.25	£0.57m	Aug-26	Known
Robotic + minor-ops capacity	10.63	£0.31m	Aug/Oct-26	Minor-ops staff costed; robotic TBC
Total	**37.83**	**£3.01m**	**Jul–Mar**	**1,475 treatments; income excluded**

Element B: Grow inpatient capacity through recruitment and new theatre capacity

A sustainable inpatient response: recruit the workforce early, mobilise the estate route, and make the additional capacity available from August 2027. This deals with the incoming demand gap

Demand-only shortfall

49h/wk

The admitted demand gap before a recurrent response.

Capacity required

28.8/wk

Patients treated; c.6.1 all-day elective lists per week.

Consultant growth model

4 WTE

2 hip/knee, 1 upper limb and 1 spine

When capacity is live

Aug-27

Funding and recruitment assumed from April 2027.

Annual recurrent revenue assumptions

Component	Annual cost 2027/28	Annual Cost 2028/29	Basis
Consultants	£0.5m	£0.80m	4 WTE at c.£200k
Theatre/recovery workforce	£1.1m	£1.68m	ODP, scrub, recovery and theatre support
Consumables	£3.2m	£4.82m	Beds, pre-op, anaesthetic and support
Ward Costs	£1.4m	£2.0m	Ward, staffing, consumables (based on modular ward 2025/26
Total recurrent revenue	**£6.2**	**£9.3m**	**Full-year run-rate from 2028/29**

Annual recurrent capital assumptions

Component	Annual cost 2027/28	Annual cost 2028/209 recurring	Basis
Five year theatre hire	£1.01m	£1.52m	Commence August 2027 (described in accompanying estates paper)
Total recurrent Capital	**£1.01m**	**£1.52m**	**Full-year run-rate from 2028/29**

Element C: Grow outpatient capacity

This element replaces the assumption of follow-up-to-new conversion with explicit new-patient capacity

Total OP new gap

67.2/wk

Demand and backlog clearance requirement.

Incoming demand gap

44.3/wk

Recurring new-patient capacity to recruit or commission.

Clinic requirement

7.3 PAs

Weekly new-patient clinic PAs to cover the incoming gap.

Workforce equivalent

0.73 WTE

Capacity, timing and cost

- Capacity live: April 2027 after recruitment, job planning and clinic mobilisation.
- Recurrent annual revenue: £0.087m; £0.174m through the three-year plan.
- Cost basis: £1,964 per weekly new slot, allocated from the original full-gap model.

Relationship to the outpatient backlog

- The remaining 22.9 new-patient slots/week are a backlog recovery requirement.
- Partner activity in element D covers this backlog and the mobilisation period before C is live.
- No follow-up-to-new conversion is assumed in the current plan

No additional funding required to deliver this element

4

3 options to clear the backlog

1. Insourcing
2. Further recruitment
3. Outsourcing

1: Insourcing using fallow theatre capacity

Total backlog activity

7,502

Workbook activity envelope; financial values begin one quarter later.

Quarterly activity

682/qtr

Eleven quarters from Q2 FY2026/27; financial profile starts Q3.

Workbook gross income*

£32.43m

Ten financially valued quarters at £4,321.50/case.

Three-year insourcing cost

£29.45m

50% of gross income = £2,160.75 per financially valued case.

Income and cost analysis

Financial year	Activity	Cost	Gross income*
FY2026/27	2,046	£8.03m	£8.85m
FY2027/28	2,728	£10.71m	£11.79m
FY2028/29	2,728	£10.71m	£11.79m
Total to Mar-29	**7,502**	**£29.45m**	**£32.43m**

2: Recruit consultants with flexible PA arrangements

Consultants required

10 WTE

Full ten-post backlog model assumed live from Q2 FY2027/28.

Total backlog activity

6,920

986 in the first delivery quarter; c.989 per quarter thereafter.

Workbook gross income*

£34.2m

£4.261m first quarter, then £4.278m per quarter.

Three-year workforce cost

£23.63m

Seven quarters at £1.21m; £4.83m annual bundle.

Income and cost analysis

Financial year	Activity	Cost	Gross income*
FY2026/27	986	£2.9m	£4.2m
FY2027/28	3,950	£11.8m	£17m
FY2028/29	3,956	£11.8m	£17m
Total to Mar-29	**8,892**	**£26.5m**	**£38.2m**

2: Consultant posts follow the largest gaps

The 10-post mix still follows the Feb-26 demand/capacity model; Element D v3 assumes the full backlog model is live from Q2 2027/28.

Specialty group	New OP gap / wk	Admitted gap / wk	Proposed posts	Start phasing
Hip & knee / young adult hip	29.3 incl. acute knee	88.3 hours	**5**	Q2 FY27/28
Upper limb + hand & wrist	31.8	41.4 hours	**3 (2 + 1)**	Q2 FY27/28
Spine	1.0	20.1 hours	**1**	Q2 FY27/28
Foot & ankle	6.0	9.8 hours	**1**	Q2 FY27/28

Delivery variables **Q2 27/28 live** **£11.8m pa** **3,950 activity pa**

3: Outsource the backlog recovery

Total external activity

7,502

682 cases per quarter across 11 quarters.

FY2026/27 activity

2,046

Three quarters at 682 cases from Q2 FY2026/27.

Workbook gross income*

£32.42m

7,502 procedures at £4,321.50 each.

Three-year outsourcing cost

£32.42m

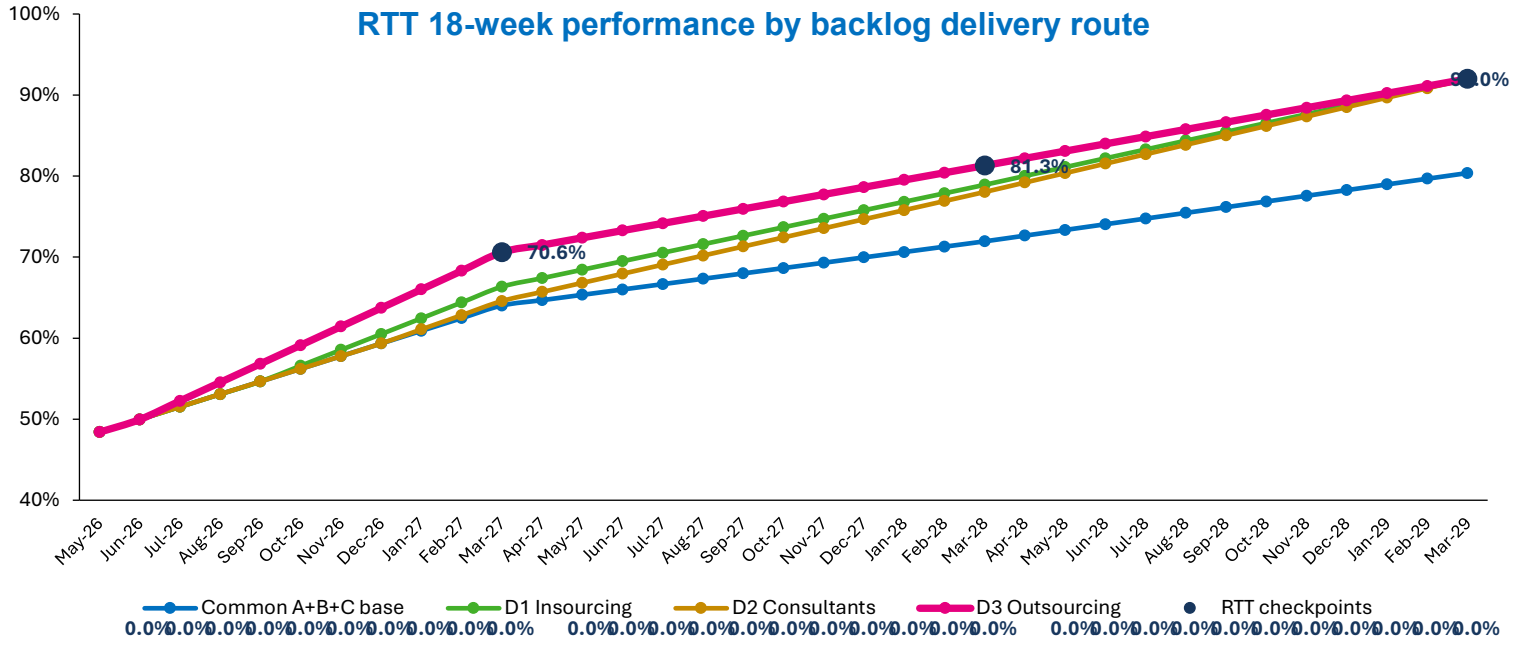
Common £4,321.50 unit rate across all activity.

Income and cost analysis

Financial year	Activity	Cost	Gross income*
FY2026/27	2,046	£8.84m	£8.84m
FY2027/28	2,728	£11.79m	£11.79m
FY2028/29	2,728	£11.79m	£11.79m
Total to Mar-29	**7,502**	**£32.42m**	**£32.42m**

RTT recovery by route: all reach 92% by Mar-29

RTT 18-week performance by backlog delivery route



RTT outcome by delivery route

A-C	Common A+B+C	80.4% Mar-29 without D
D1	Insourcing	78.9% Mar-28; 92% Mar-29
D2	Consultant model	78.0% Mar-28; 92% Mar-29
D3	Outsourcing	81.3% Mar-28; 92% Mar-29

Opening position

48.4%

May-26 actual RTT

Mar-27 checkpoint

70.6%

D3 meets; D1 66.4%, D2 64.6%

Mar-28 checkpoint

81.3%

D3 meets; D1 78.9%, D2 78.0%

Mar-29 target

92.0%

All routes require the full D envelope

2609 - E PEOPLE

11:05

2609 - E1 DBTH WAY IN ACTION & WELL-LED REVIEW PROGRESS UPDATE

Discussion Item | Zara Jones, Deputy Chief Executive & Zoe Lintin, Chief People Officer | 1

10 minutes

REFERENCES

Only PDFs are attached

E1 - DBTH Way in Action & Well-led Review Progress Report.pdf

E1 - Appendix 1 -DBTH Way in Action and Well Led.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**DBTH Way in Action and Well-led review progress update**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive Zoe Lintin, Chief People Officer			
Authors:	Executive Team			
Appendices:	Appendix 1 – table of recommendations with progress update			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	All strategic risks are impacted			

Executive Summary – Key messages and Issues

This report provides the Board of Directors with an update on progress in responding to the recommendations arising from the independent Well-Led Review and DBTH Way in Action review. The previous update to Board focused primarily on whether the Trust had established the actions, governance arrangements and interventions required in response to the reviews. This report moves the emphasis from action completion towards implementation, impact and sustainability.

The nature of the culture aspects of this work and some of the well-led areas, means that embedding and sustaining change and impact will require continued review over time. Ultimately providing assurance on:

- Whether agreed actions have been delivered or remain on track
- Evidence that changes are being implemented consistently
- Evidence that changes are having the intended impact
- Indications that improvements are becoming embedded within normal Trust business

The detailed recommendation-by-recommendation position is provided at Appendix 1.

Since the previous update to Board in May 2026, further progress has been made in implementing the recommendations arising from the Well-Led and DBTH Way in Action reviews. This is in alignment with the Culture and Leadership Programme established under Reset.

The Trust has increasingly moved from establishing the foundations of its response, linked to existing workstreams where applicable, to embedding changes within its leadership, governance, workforce and improvement arrangements and testing whether these are having the intended effect.

As at the end of August, at the time of writing this report:
<u>For the Well-Led Review</u>

- 17 recommendations are complete (vs 14 completed in May)
- 5 partially complete and 4 on track (vs 13 on track in May)
- 1 off track (vs 0 in May)

For the DBTH Way in Action Review

- 8 recommendations are complete (vs 5 complete in May)
- 5 on track (vs 8 on track in May)

There is increasing evidence that a number of these changes are becoming embedded within routine Trust arrangements, including leadership expectations, governance meetings, EDI oversight, divisional involvement in decision-making and Board assurance processes.

Assurance regarding sustained cultural and behavioural impact remains developing. This is consistent with the position reported previously: cultural change cannot be demonstrated solely through completion of individual actions and requires evidence over time from colleague experience, behaviours, FTSU and employee relations intelligence, leadership practice and other qualitative and quantitative sources including the staff survey results.

The principal focus over the next period will therefore be to:

- Complete the remaining actions
- Strengthen evidence of impact at divisional and frontline level
- Triangulate quantitative and qualitative evidence
- Address any areas where implementation is inconsistent
- Progressively transfer assurance from the standalone review action plans into business-as-usual governance arrangements.

Approach to assurance

As we continue to monitor improvement actions over time, we will assess against the assurance levels set out below.

Level	**Assurance question**
Action	Has the Trust completed the action it committed to undertake?
Implementation	Is the change being applied consistently in practice?
Impact	Is there evidence that it is producing the intended outcome?
Embedding	Is the change becoming part of normal organisational practice and likely to be sustained?

This is important because completion of an intervention does not necessarily demonstrate that its intended outcome has yet been achieved.

For example, a number of recommendations identified improvement in the annual staff survey, reductions in repeated FTSU/HR casework themes or sustained changes in leadership behaviour as their ultimate measures of success. These measures necessarily require evidence over a longer period.

The assessment within this report therefore distinguishes between completion of actions and demonstration of sustained impact.

Culture, values and behaviours

Following Trust-wide engagement, three focus behaviours have been agreed:

- Speaking Up for Patient Safety
- Personal Accountability
- Collaborative Relationships

The behaviours are being reinforced through a range of mechanisms including meeting reflection, leadership communication and development of the Line in the Sand work. A data triangulation approach has been embedded to bring together intelligence on people and patient metrics and support Executive oversight. Speaking Up for Patient Safety will be an integral theme throughout the FTSU activities in October.

The “I will…” behavioural commitment has been incorporated into the 2026 appraisal season and medical appraisal, and the Trust Leadership Team (TLT) and Clinical Leaders' Forum have provided an additional route for discussing behavioural and professional expectations.

The updated action plan also records that two Clinical Leaders' Forums have been held with the Executive team, Trust Leadership Team development sessions have focused on culture and leadership, the bullying and harassment deep dive has commenced and targeted Civility Saves Lives and A Kind Life interventions have continued in identified teams.

Current evidence provides assurance that behavioural expectations are increasingly being incorporated into organisational systems and leadership activity.

Further evidence is required to demonstrate whether colleagues are consistently experiencing these expectations in day-to-day practice on a sustained basis. Early indications are that colleagues are referring to the Line in the Sand ethos when talking about their concerns or expectations regarding behaviours.

Examples of progress includes:

- Our appraisal season completion rate this year has been 91.6% against the 90% standard (subject to data validation at the time of writing). Evaluation of appraisal season will follow later in the year and surveys have already been sent out seeking feedback.
- The Line in the Sand communication and cascade continues including with facilitated sessions with clinical leaders and senior leaders, and development of supporting videos. Following several requests from external trusts, a meeting has been arranged for September to share our approach on developing the Line in the Sand.
- Facilitated development sessions with Civility Saves Lives and A Kind Life have concluded and evaluation is underway.
- FTSU activity and themes – as set out in July 2026 Board report
- Bullying and harassment deep dive – due for conclusion in Q3

Early indications of embedding include incorporation of these activities within appraisal, leadership development, governance meeting reflection and established leadership forums.

The key test over the remainder of 2026/27 (and beyond) will be whether multiple sources of intelligence demonstrate a consistent improvement in colleague experience and a reduction in repeated behavioural concerns over time, with concerns being addressed when they are raised.

Leadership, communication and colleague engagement
Revised organisational leadership arrangements are now embedded, including the Hospital Leadership Team as a decision-making forum involving Executive and Divisional Directors and the revised Trust Leadership Team as a wider leadership development and engagement forum. These arrangements were introduced in response to recommendations seeking stronger divisional involvement in Trust-wide decision-making and greater engagement of frontline leaders.

The original success measures included increased frontline leadership participation in service improvement and improvements in colleague perceptions that leaders listen, act and work as one team.

A proposal for a new Colleague Assembly has subsequently been agreed by the Executive Team, providing an additional mechanism through which colleagues can contribute to significant organisational developments and transformation. The new DBTH Assembly has been launched with representatives from across the three sites currently being sought and the first meeting planned by October.

Evidence of impact:

- Wider discussions contributing to decision-making through engagement of divisional leaders in HLT, for example on mandatory training processes.
- Items being scoped based on feedback for consideration by the first DBTH Colleague Assembly

The formal inclusion of Divisional Directors within the HLT decision-making structure provides evidence that changes in leadership involvement have been incorporated into core governance arrangements and are embedding, rather than remaining as a standalone response to the review. Richer debate to support decision making is evident.

Further assurance is required on the consistency of communication and engagement below divisional leadership level. We will assess through future staff survey results and pulse surveys (once these have been introduced).

Freedom to Speak Up

Since the previous update, further action has been taken in response to the independent FTSU peer review. Themes from the review have been communicated through the Speaking Up Forum, People Committee, Board and Trust-wide engagement arrangements across all three sites. The Trust has strengthened ongoing feedback mechanisms and embedded FTSU into colleague touchpoints including corporate welcome and learner induction.

Further reports were considered by People Committee and Board during June and July 206 and the training offer and uptake have improved. The FTSU report included details of year-on-year activity/cases, themes, local engagement and impact, progress on actions, together with an update on national developments in relation to FTSU. Significant Assurance was reported by People Committee and Board following the presentations of the reports.

A rise in concerns should not automatically be interpreted negatively. The action plan previously recognised that clearer behavioural expectations and Line in the Sand may initially increase reporting as colleagues become more confident in raising inappropriate behaviour.

Equality, Diversity and Inclusion (EDI)

The updated EDI improvement plan and annual report were considered by People Committee in June 2026, with Significant Assurance reported. Detailed analysis has been undertaken across staff survey, Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and pay-gap information and progress is routinely reviewed through the EDI Forum and People Committee. This data analysis is embedded practice and occurs annually.

The Trust has also achieved Bronze anti-racism accreditation from the North-West BAME Assembly and an Internal Audit of EDI policies gave Significant Assurance. The People Committee has oversight of the EDI Improvement Plan which aligns with the national NHSE high impact actions, and this has recently been refreshed.

Our internal auditors assessed Significant Assurance for their review of the People Strategy 2023-2027 – Equality, Diversity and Inclusion.

Governance, accountability and Board assurance

A substantial proportion of the governance recommendations have been completed, including:

- Strengthening of the BAF
- Clearer definitions of assurance
- Revised Board and committee assurance arrangements
- Revised HLT/TLT governance
- Explicit consideration of values and behaviours within meetings
- Strengthening of risk and assurance processes
- Increased use of external and internal assurance

The next stage is to demonstrate that these arrangements are being applied consistently throughout the organisation and have improved the quality and timeliness of escalation and decision-making.

Further developments include Board approval of volume 1 (Board and Committees) of the Governance Manual and accountability arrangements. Volume 2 (Executive Led governance) and Volume 3 (Divisional led) of the Governance Manuals are being finalised and will be taken through approval forums by the end of September.

Our Performance Assessment Framework (PAF) has been fully operational over the course of the 2025/26 financial year and through 2026/27 to date. Aligned to the National Oversight Framework (NOF), we have applied NOF metric performance to our clinical divisions to determine the level of escalation through our Performance Review Meetings (PRMs). As a result of these calculations, two of our five divisions (Urgent and Emergency Care and Surgery) have been at the higher tier of escalation which in practical terms means attendance at CEO chaired accountability meetings to review recovery actions.

Integrated Performance Report (IPR)
Recommendations 12 and 13 of the well led review required greater use of benchmarking, external information, trajectories and health inequalities information within the IPR.

A revised IPR has been developed to incorporate medium term plan framework requirements, NHS Standard Contract and Quality schedules and the NOF metrics. This alignment is important to ensure we have a single report tracking the metrics we are externally held to account for.

In addition, we have utilised the external benchmarking tool Public View to provide wider analysis of our trended performance against peers.

The financial metrics are now fully incorporated into the IPR.

For Health Inequalities, an annual report has been produced which provides data across the majority of NHS England's Core20PLUS5 measurement framework, including Equity Index scores across elective, UEC, maternity, CYP and clinical areas; ethnicity data quality across all four Commissioning Data Sets; gestational age at booking disaggregated by deprivation and ethnicity; and emergency admission data for stroke and myocardial infarction. Several data gaps remain, principally relating to respiratory disease, cancer outcomes, and some CYP measures, and these are identified transparently within the report. More work is required to incorporate relevant metrics in the IPR. A revised date for this work is proposed as Q4 2026/27 to provide time for wider work on our information and data reporting as a Trust, to determine further actions to provide a more robust approach which feeds our performance reporting. We will prioritise focus on health inequality in relation to timely access to care.

Board Assurance Framework (BAF)
Our latest internal audit assessment for the BAF is Significant Assurance.
The BAF is reviewed routinely through committees of the Board and there is a clear line of sight of this through to the Board of Directors who also receive routine reporting. Evidence (via minutes and assurance

reports) of challenge within meetings to drive deeper understanding of our risks, controls and mitigations. The Board of Directors has held a deep dive into its highest rated BAF risk associated with the Estate.

Patient and lived experience
The reviews identified the need to strengthen the role of patient and lived experience in organisational assurance and improvement.

Actions have included revised Caring Group arrangements, Patient Safety Partner involvement, the experience of care framework, digital patient stories and strengthened routes through Quality Committee and Board.

The current tracker identifies completion of the core action but also sets further success measures around demonstrating how lived experience has directly influenced service design, improvement priorities and Board decisions.

Process and Governance for Digital patient stories agreed and subsequently Quality Committee have received 4 patient stories and further plans are outlined in the patient engagement event report.

Feedback from patients and carers with lived experience has directly influenced several service improvements across DBTH. This included the introduction of 24/7 access to British Sign Language (BSL) interpretation via video technology, complementing the existing business-as-usual face-to-face service available during weekday daytime hours. Patient experience and feedback also supported improvement actions relating to fluid balance monitoring to inform both training and importance of accurate recording amongst MDT's and has also supported the ongoing implementation of Martha's Rule, in relation to the purpose of the process. In addition, lived experience informed the redesign and procurement of interpretation and translation services across DBTH and South Yorkshire and Bassetlaw, resulting in enhanced accessibility through a wider range of support options, including the CardMedic translation app, 24/7 video interpretation services, telephone interpretation and face-to-face translation services

In April 2026, the Citizens Panel and Patient Involvement in Research Group merged to create a single forum for patient and public involvement. The group currently has 28 active members and meets on a quarterly basis. Members have been involved in a range of activities, including contributing to the pre-launch planning for Martha's Rule, providing feedback on a study relating to the issuing of fit notes, and reviewing information relating to the Armed Forces Veteran Covenant and Infection Prevention and Control information leaflets. The panel continues to provide valuable insight to ensure that patient perspectives inform Trust policies, communications and service developments.

Patient Safety Partners continue to play an integral role in supporting quality and safety improvement across the Trust. They are actively involved in a range of improvement workstreams, including Sepsis, Skin Integrity and Falls prevention programmes, as well as the Emergency Department CQC action plan. Patient Safety Partners also participate in safety walkarounds, contribute to the Enhanced Therapeutic Observations of Care patient and visitor feedback process, and provide independent challenge and assurance through membership of key governance groups, including the Caring Group, Patient Experience and Involvement Group, and Patient Safety Assurance Group (PSAG).

Improving the experience of patients with hearing and visual impairments has been identified as a key area of focus for 2026/27. Engagement with the local Deaf community continues through established relationships and the Audiology Action Group, helping to shape ongoing improvements in accessibility, communication and involvement in Trust workstreams. The Trust has also attended its first partnership meeting with the Partially Sighted Society and is currently developing a collaborative approach to ensure the voices of people with lived experience of visual impairment are heard, considered and acted upon. This work will support improvements in access to services, patient information and care delivery, helping to reduce barriers and improve the experience of care for patients with sensory impairments.

Quality improvement, innovation and organisational effectiveness
The reviews recommended clearer reporting and governance for implementation of the Quality Improvement and Innovation Strategy and alignment of improvement activity across the organisation. DBTHi is now established and the intention has been to align its work more explicitly with Trust priorities and the Reset Programme.

The established Reset approach brings reporting via a newly established Board and via the Executive Team and Hospital Leadership Team in-between the Reset Board meetings.

Linked to references earlier in this report regarding improvements to information and reporting will support further work to assess any changes to quality improvement specific metrics and reporting against the QII strategy.

Remaining risks and areas requiring further assurance

<u>Sustained cultural and behavioural change</u>
Several of the intended outcomes require evidence over a longer period. We will avoid equating completion of interventions with evidence that behaviours have changed consistently across all services and that these changes are sustained.

<u>Variation between teams and divisions</u>
There will be variability in the extent to which some standards and expectations are embedded, and the ambition is to achieve the highest standards on a consistent basis across all areas. Intelligence and data are used to identify teams with strong performance and teams requiring further focus, including through the data triangulation process, with appropriate support or intervention being considered. For example, the externally facilitated team development workshops in focus areas to support an improvement in cohesive multi-professional working relationships.

<u>Outcome evidence</u>
Some recommendations remain reliant upon future staff survey, pulse survey, audit or outcome data before sustained impact can be demonstrated.

<u>Actions beyond original completion dates</u>
Well-Led:

- Action 12 – it is proposed health inequality data is completed within the IPR by Q4 2026/27.
- Action 13 and 18 – Linked to the above it is proposed for benchmarking data to be incorporated in the IPR and alignment between corporate governance work with performance assurance framework by Q3 2026/27.
- Action 23 – largely completed, with extra time proposed for fresh eyes review of operational assurance wiring diagram by Q3 2026/27.
- Action 26 and 27 - It is proposed a stocktake on DBTHi and how QI work is delivered within the organisation is undertaken once Reset programme is embedded and Interim CEO has had time to review current arrangements with the Executive Team. Amend completion date from May and July 2026 to Q4 2026/27.

Next phase of work and transition to business as usual
The Trust's response to the reviews has, to date, required a dedicated action plan and regular Board oversight.

As implementation matures, the intention should be to progressively move from separate oversight of individual review recommendations to assurance through the Trust's established governance arrangements.

It is therefore proposed that:

- Remaining incomplete actions continue to be tracked to completion
- Impact of delivery of actions is monitored through the relevant Board committees and Executive governance routes
- Culture and colleague experience outcomes continue to be triangulated through People Committee and the Culture and Leadership work
- Quality, patient experience and improvement outcomes are monitored through Quality Committee and relevant operational governance
- Governance and risk recommendations are incorporated into routine BAF, IQPR and Internal Audit assurance
- A further formal Board review is undertaken in January 2027 to determine whether the standalone action plan can be closed and residual assurance incorporated fully into business-as-usual governance
- The closure test should not simply be that all actions are marked complete. Closure should require assurance that the required changes have either been embedded or have a clear ongoing governance route through which impact will continue to be assessed.

Recommendations

The Board of Directors is asked to:

1. Take moderate assurance for both well-led and culture related actions linked to progress made in implementing the recommendations arising from the independent reviews.
2. Note the increasing evidence that changes are becoming embedded within Trust leadership, governance, workforce and improvement arrangements.
3. Note that assurance regarding sustained cultural and behavioural impact remains developing and will continue to require triangulation of quantitative and qualitative evidence over time.
4. Note the areas where further evidence or action is required, as set out within this report and Appendix 1 and suggestions to extend some completion dates.
5. Support the proposed approach to progressively transition oversight of completed recommendations into business-as-usual governance arrangements, with a further Board assessment in January 2027.

Healthier together – delivering exceptional care for all

Patients	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports the delivery of safe and effective services.
People	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships.
Pounds	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports delivery of the strategic priority to be sustainable and spend money wisely.
Health Inequalities	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports a positive approach to tackling health inequalities.
Legal/ Regulation	It is a regulatory requirement for the Trust to assess itself against the Well-led domains and to address any cultural aspects a review may highlight
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies

<table>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Executive Team oversight
Review through the Reset Board (Culture and Leadership pillar)
Board of Directors update March 2026 and May 2026</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Continued review at relevant Board committees and Board of Directors meetings</td></tr>
<tr><td>In line with Current risk appetite

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

Appendix 1 – Table of Actions and progress

Well-Led Review

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Shared direction and culture	01	We recommend that the Trust incorporates quantitative measures within the planned six-monthly evaluation reports, as well as narrative updates. The evaluation should draw on both internal and external data and reporting to assess progress against the Trust's strategic priorities and ambitions.	Quantitative measures included in reports to Board	Easily identifiable measures which provide assurance to the Board of delivery	Deputy Chief Executive Officer	May 2026	Completed
	02	We recommend that the enabling plans are reviewed and refreshed to ensure full alignment with the new Strategy. Revised versions should be assured through the relevant Board sub-committees.	Enabling plans will be reviewed and refreshed when they become due for formal review; the Executive Team will have oversight of due dates. Refreshed plans will be assured through the Hospital Leadership Team prior to submission to the relevant sub-Board Committee for approval. Engagement with Trust colleagues and strategic partners will take place to inform the development of refreshed plans.	All enabling plans have gone through full review and approval process in line with formal review dates	Deputy Chief Executive Officer	March 2027	On Track
	03	We recommend the Trust work with its strategic commissioners and wider partners to establish the strategic direction for Bassetlaw and Montagu Hospitals as part of its implementation of its new strategy.	Reset Programme established with Shape Pillar Clinical Site Strategy workshop with leadership Team December 2025. CEO discussions with ICBs held April 2026 re commissioner direction and support. Continued Exec engagement with ICBs. Alignment remains with commissioners for future site strategies.	Board approved strategic direction for BDGH and MH including strategic commissioners and system partners input and support	Chief Medical Officer and Chief Nurse	July 2026	Completed
	04	We recommend that the Trust considers how the DBTH Way and We Care values and example behaviours could be operationalised and monitored in line with the People Plan	Trust wide engagement sessions will be undertaken to co-produce the focussed behaviour and cultural priorities, from the DBTH Way, for 2026/27. All colleagues invited to be involved in selecting the three specific behavioural priorities to focus on and embed across the Trust in 2026/27.	Three Trust-wide behavioural priorities explicitly defined, published and linked to the DBTH way descriptors Leadership job description templates and leadership development content updated to explicitly reference DBTH way behaviours Formal observation and reflective assurance confirm that DBTH way behaviours are being role-modelled (i.e.	Chief People Officer	September 2026	Completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			Communication and engagement across the Trust will commence in April 2026. Three focus behaviours agreed following Trust-wide engagement – Speaking Up for Patient Safety, Personal Accountability, Collaborative Relationships. Meeting reflection in line with the DBTH Way added to agendas, to also support committee effectiveness reviews. TBO supporting roll-out. Launch and communication of Line in the Sand – including video, shorter video, ACEO & CPO video, leadership cascade discussions video. Ongoing plan being enacted to support practical application. Extensive contact from external organisations to share learning on this approach. Data triangulation group in place to review people and patient metrics, with escalation route to Executive team. Detailed staff survey analysis on themes, professional groups, EDI characteristics undertaken.	from walkaround feedback and other activities) Leadership time out/culture sessions show evidence of learning and action. Triangulation of behavioural outcomes across multiple sources, such as staff survey data, pulse checks, FTSU themes, HR casework analysis			
	05	We recommend that the Trust considers strengthening the People Plan by identifying the responsibility of team leaders to ensure regular communication and engagement with their staff.	The Trust will continue to develop and implement the culture and leadership programme, incorporating the recommendations from 'DBTH Way in Action' as well as triangulation from the staff survey and other sources of data. This will commence in Q1 of 2026/27 This will also be considered when the People Plan is due for review.	Team leader responsibilities for regular communication and engagement are explicitly defined in the People Plan, leadership role profiles and 2026/27 appraisal objectives, with evidence of assessment through appraisal outcomes. 80% of teams demonstrate regular engagement activity (e.g. meetings, huddles or equivalent), with divisional oversight identifying and addressing variation and areas of non-compliance. Measurable improvement in relevant NHS 2026 Staff Survey and pulse survey questions linked to communication, involvement and confidence in immediate managers, triangulated with reductions in engagement related FTSU and HR themes. Routine evidence of feedback loops ("you said, we did") at team and divisional level, with examples reported through governance	Chief People Officer	July - March 2026/27	On Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				routes showing how colleague engagement has informed local improvement actions.			
	06	We recommend that the Trust strengthens its approach to engaging frontline leaders in service improvement and efficiency initiatives and reviews its corporate communications to ensure the language reflects a shared purpose and a 'one team' ethos.	The Trust will implement a revised decision-making structure. This will include the development of the Hospital Leadership Team whose membership will consist of the Executive Team and Divisional Directors. The Trust Leadership Team will remain in place and provide a regular leadership forum for all divisional and corporate leaders.	Increase front line leader engagement in service improvement and decision making by >10% as evidenced through QI programme plans, Reset programme pillars and HLT minutes. Improved colleague experience of leadership engagement, by a 3-5% point increase in relevant staff survey and pulse survey scores, particularly, "involvement in service improvement/QI", "confidence that leaders listen and act", "perception of joined up one team working"	Chief People Officer	April 2026	Completed
	07	We recommend that the Trust reviews current expectations, processes, and cultural norms in relation to medical leadership and engagement with medical staff. The Trust should ensure consistency in how professional behaviours are modelled and addressed across all staff groups to support an inclusive and equitable working culture.	The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The first event will take place in March 2026 and quarterly thereafter. The Executive Team have held two clinical leaders sessions off-site with clinical directors. The focus has included the recently launched Line in the Sand and how this is positively utilised by medical colleagues to support a consistent approach to tackling poor behaviours and supporting colleagues to have difficult conversations. The "I will" statements are in medical appraisals. The Clinical Directors programme of workshops is embedded and includes a range of topics including sickness absence and holding difficult conversations for medical colleagues.	>10% increase in participation of medical leaders in leadership development, QI programmes and time out sessions Evidence of medical leadership in put into Trust and divisional priorities through HLT papers, improvement plans, governance minutes and the reset programme pillars. 3-5% percentage point improvement in relevant staff survey scores including: "senior leaders act consistently with the organisation's values" "I feel safe to raise concerns" "staff are treated fairly and with respect" FTSU and HR case themes involving medical staff, reduce over time (recognising an increase initially will be expected) Medical leadership expectations explicitly aligned to the DBTH way with consistent standards applied across all staff groups, evidence from clinical leader's time out feedback and discussion. Reduction in repeat behaviour related concerns linked to the same themes	Chief Medical Officer	September 2026	Completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Capable, compassionate, and inclusive leaders	08	We recommend that the Trust considers introducing a standing agenda item across its governance meetings to reflect on whether the content and conduct of the meeting were consistent with the Trust's values and agreed behaviours.	The Trust will include this as a standard agenda item for the Trust Board and Board sub-Committee meetings from May 2026	Routine completion of the values/behaviours reflection item across board and committee meetings and evidence in minutes. Committee/Board effectiveness surveys demonstrate improvement in metrics relating to meetings purpose, and conduct aligned to the DBTH way.	Deputy Chief Executive Officer	May 2026	Completed
	09	We recommend that the Trust reviews its approach to leadership visibility, including the frequency, format, and purpose of Executive and Non-Executive walkarounds. Consistent and visible engagement by senior leaders, particularly in clinical areas, would help build staff trust and reinforce the organisation's values.	The Trust will review its approach to leadership visibility and this will include the following: - An increase in Board member visits to all areas across the Trust - Opportunities for all colleagues to request Executive visits - Regular, informal executive walkabouts to all areas across the Trust These will form part of the refreshed approach to Trust wide communication and will be included within the new Culture and Leadership programme.	Paper to Trust Executives and Trust Board of Directors outlining proposal for increased engagement results in a more structured approach to engagement activities 3-5% point improvement in relevant staff survey results particularly "senior managers are visible and approachable" and "I feel listened to by senior leaders" Themes arising from walkarounds are captured systematically and escalated via the relevant forums where appropriate and translated into visible actions Triangulated visibility with FTSU intelligence, qualitative feedback from walkarounds and engagement sessions.	Deputy Chief Executive Officer	April 2026	Completed
	10	We recommend that discussions are held with leaders across the Trust, to develop a consensus on the balance between holding meetings face to face and via Teams.	The Trust will increase the proportion of Trust Board and Board Development meetings that are held face to face. Hospital Leadership Team and Trust Leadership Team meeting will be held face to face. It is for colleagues to determine how they conduct their own meetings beyond this throughout the Trust to take account of business need.	All Board meetings, HLT and TLT planned and held as face to face meetings.	Deputy Chief Executive Officer	April 2026	Completed
	11	We recommend that the Trust undertakes development work with divisional leadership teams on how they work and lead on an integrated basis. This should incorporate a review of how the leadership teams inform Trust-wide decision making and assurance assessments.	The Trust is creating a development programme for Divisional Leadership Teams and the Trust Leadership Team.	Sustained appraisal completion >90% with appraisal outcomes evidencing leadership behaviours, collective working and accountability Strengthening staff engagement scores from the current Trust baseline to narrow the gap to the national average in 2026.	Chief People Officer	December 2026	On Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			The Trust will continue to develop and deliver the Culture and Leadership programme, which is available to all colleagues across the Trust.	Quarterly pulse survey participation increases by 3% points to a meaningfully higher and sustainable level.			
Governance, management, and sustainability	12	We recommend the Trust reviews what information is included in the Integrated Quality Performance Report on health inequalities and finance.	The Trust has procured the 'Public View' tool to support an improvement in the standardised of reporting and benchmarking of quality and operational performance data. The Trust undertakes an annual review of the metrics included in the IQPR to ensure this is aligned to the NHS Oversight Framework, NHS Standard Contract and medium term plan. Future development of the IQPR will incorporate health inequalities information. There is a separate report to Board on Health Inequalities twice a year. Finance is included in the IQPR. For Health Inequalities, an annual report has been produced which provides data across the majority of NHS England's Core20PLUS5 measurement framework, including Equity Index scores. More work is required to incorporate relevant metrics in the IPR. A revised date for this work is proposed as Q4 2026/27 to provide time for wider work on our information and data reporting as a Trust, to determine further actions to provide a more robust approach which feeds our performance reporting. We will prioritise focus on health inequality in relation to timely access to care.	The IQPR will contain a clearly defined and refreshed set of metrics that are demonstrably aligned to the 2026/27 NHSE Oversight Framework, NHS standard contract and medium term planning priorities, with explicit mapping set out within the report. Health inequalities and finance metrics are routinely presented in a clear accessible and comparable format supporting meaningful discussion of variation, trend and impact rather than descriptive reporting alone The IQPR will consistently contain: Benchmarking against peers or national standards, Improvement trajectories and, where relevant, tolerance thresholds.	Chief Operating Officer	June 2026 – proposed Q4 date for health inequality data	Partially completed
	13	We recommend that the Trust strengthens the Integrated Quality Performance Report by using benchmarking, external data, improvement trajectories, and clear measures linked to the Trust's strategic ambitions. This will support moving to assurance rather than reassurance.	The IPR has been revised to include all of the metrics in the medium term plan (MTP), NHS standard contract (quality schedule) and national oversight framework (excluding those where technical guidance is awaited nationally). For MTP metrics, where monthly trajectories are available, these are shown in the IPR. Benchmarking has now been embedded in Finance and Performance Committee reporting where available and will be incorporated into the IPR.	See above	Chief Operating Officer	June 2026 – proposed Q3 date for benchmarking data in IPR	Partially completed
	14	We recommend the Trust includes the actions being undertaken in relation to the elevated SHMI rate within the Trust Risk Register and consideration is given to appropriate inclusion within the BAF.	The elevated SHMI is included on the Trust risk register and is aligned to Strategic Risk 1 on the BAF. This will be regularly reviewed through Risk Management Group, Trust Board and relevant sub-Board Committee	The Elevated SHMI risk is actively managed through the Trust risk register and BAF, with Clear articulation of cause, controls and mitigating actions.	Chief Medical Officer	April 2026	Completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				Routine board and committee review, demonstrating effective oversight, challenge and decision-making linked to SHMI performance Evidence that actions identified through SHMI analysis are implemented, tracked and reviewed with learning embedded into clinical governance and QI processes Demonstrable improvement in SHMI trajectory over time Mortality data quality assurance internal audit scheduled for Q1/2 (360 assurance)			
	15	We recommend the Board receives detailed information and assurance on actions being taken to mitigate the impact of the estate condition at the DRI, on Trust finances, quality, access, and staff experience.	Board Development Session in February 2026 included consideration of all actions and mitigations; and will aligned to the BAF and Trust Risk Register. Actions agreed from this session form part of the Trust capital plan	The Board receives regular, structured and triangulated assurance that the risks associated with the condition of the DRI estate are being actively mitigated, evidenced by: A clearly articulated estates-related risk recorded on the Trust Risk Register and, where material, the BAF, setting out causes, controls, mitigating actions and residual risk; Routine Board and Committee reporting demonstrating oversight of the impact of estate condition on: • quality and safety • operational access and flow • staff experience • financial sustainability. Evidence that agreed mitigating actions are prioritised, funded where possible, tracked and reviewed, with clear rationale documented where actions cannot proceed due to affordability or capital constraints. Clear line of sight between estates risks, mitigation plans and decision-making, including escalation to the Board where risks exceed appetite. Assurance that key estate risks at DRI are stable or reducing over time, or that the	Chief Finance Officer	April 2026	Completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				Board has explicitly accepted residual risk where improvement is not immediately feasible (as supported by evidence and national context).			
	16	We recommend that the Board and its committees undertake a review of their processes for generating assurance outcomes, including working to standard definitions for each level of assurance. This should be informed by a review of controls and assurance levels within the BAF, alignment with latest internal audit opinions, robust outcomes data, and enhanced levels of external validation.	The assurance process will be reviewed as part of the Board Development Session in April 2026, this will be led by an external facilitator and attended by internal auditors. Further information triangulated with the Internal Report of the BAF (Significant Assurance).	All Board and committee papers will explicitly state the level of assurance using the agreed definitions with consistent interpretation evidenced through paper quality and Chair challenge. BAF, internal Audit and outcomes data will demonstrably align. Ongoing external assurance (via Internal audit/external reviews) will confirm improving governance maturity and effective use of the BAF – resulting in a continued significant assurance opinion.	Deputy Chief Executive	April 2026	Completed
	17	We recommend that a review is undertaken of the purpose and role of TLT. This review should consider the balance between decisions made at the Executive Team meeting and the TLT, and the degree to which the divisions are involved in Trust-wide decision-making processes.	The role and purpose of TLT reviewed and revised. This will become a development and engagement forum for senior divisional and corporate colleagues, taking place bi-monthly. A Hospital Leadership Team established as a decision-making forum, the membership of this will be the Executive Team and Divisional Directors.	Minutes of meetings where changes discussed TOR and Agenda demonstrate changed purpose HLT established TOR and Minutes provide evidence	Deputy Chief Executive	Apri; 2026	Completed
	18	We recommend that an organisational accountability framework document is developed, aligned to the Performance Assessment Framework, the scope of which covers governance arrangements from service level to the Board.	The Trust is developing a Governance Manual which will comprise of: - Corporate Governance - Executive Led Operational Governance - Divisional Governance This will be aligned to the Performance Assessment Framework. We have completed the corporate governance element. Final work to be completed by Q3 2026/27.	Board and committee papers consistently identify, accountable lead, decision making level and escalation route (where controls are insufficient). Risks, performance issues and improvement actions show a clear line of sight from ward to Board.	Chief Operating Officer	June 2026 – proposed finalisation by Q3	Partially completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				Fewer instances of late or reactive escalation, evidenced through risk register review and reduction in new but long-standing risks reaching Board. Internal audit or external review confirms that governance and accountability arrangements are clearly articulated, consistently applied and aligned.			
	19	We recommend the Caring Group discusses how to ensure that lived experience is better harnessed and used within DBTH.	The terms of reference for the Caring Group will be reviewed and the programme of work for the Citizens Panel will be incorporated into this. Work will continue to implement the experience of care framework and specific task and finish groups will be established. A refined engagement strategy, with 'patients with lived experience' groups supporting more focussed actions. Patient Safety Partners attend the Caring Group A programme of digital stories will be established across all Divisions. A Patient Experience Plan and strengthened Terms of Reference will be developed. The Quality Committee will receive patient stories from Q1 of 2026/27.	Board and committee papers explicitly reference lived experience insights (via patient stories, citizens panel feedback, patient safety partners) and show how these have informed improvement priorities, risk mitigations, quality actions or service design. Caring group will identify a recurring patient experience theme for focused attention during 2026/27 and demonstrate a 10% reduction by year end. Feedback from patient safety partners/citizens panel included in the annual patient experience report confirming that their input leads to visible change	Chief Nurse	April 2026	Completed
	20	We recommend that the BAF is strengthened to ensure clear threat descriptions, outcome-based assurance sources, alignment with the new Trust Strategy, consistency in committee reporting, and sufficient time for Board review and challenge.	See responses to Q16 above. The BAF will be regularly reviewed and updates provided to the relevant sub-Board Committee and Trust Board.	See Q 16	Deputy Chief Executive Officer	April 2026	Completed

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Freedom to Speak Up	21	We recommend that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all.	The Trust will utilise the FTSU peer review to support any identified improvements in the FTSU process, reviewing effectiveness, feedback loops, and confidentiality understanding as part of wider cultural programme. An overview and key themes from the FTSU Peer review shared with the People Committee in February 2026 together with identified improvement plans and support to the wider culture and leadership programme, focusing on improvements to safe patient care. A FTSU report was presented to the Trust Board in March 2026. Themes and feedback from external FTSU peer review considered and communicated widely including at Speaking Up Forum, People Committee, Board and Trust-wide engagement sessions. Process in place to seek ongoing feedback on current issues and FTSU included in employee touchpoints, e.g. corporate welcome, learner inductions. Additional report presented at People Committee in June 2026 and Board in July 2026 to consider FTSU reporting. Approach agreed. Annual FTSU data presented at People Committee and Board. Training offer and uptake has improved.	>95% of individuals who use FTSU service reporting that they would feel confident to use the service again. All FTSU cases evidence timely feedback to individuals raising concerns with themes, learning and actions reporting. Board and committee papers demonstrate clear “you said, we did” learning. Reduction over time in repeat FTSU themes relating to the same issue. It is expected that the ‘line in the sand’ work will lead to an initial increase in FTSU cases regarding behaviours.	Chief People Officer	September 2026	Completed
	22	We recommend that FTSU reports to the Board includes learning and actions to strengthen the feedback and learning loop.	The FTSU reports to the Trust Board will be strengthened to highlight the assurance requirements, include learning and actions to strengthen the feedback and learning loop.	Evidence provided in reports and minutes to People Committee and Trust Board of Directors	Chief People Officer	April 2026	Completed
Workforce, equality, diversity, and inclusion	23	We recommend that the Trust reviews whether its operational assurance arrangements as set out in the Operational Assurance and Information Flows wiring diagram for staff engagement are sufficient.	The Trust is reviewing operational governance arrangements as part of the development of the Governance Manual (see 18). As part of this review, the Trust will consider opportunities to strengthen colleague engagement. Executive Team have reviewed and finalised the operational arm of the operational governance arrangements. Independent quality governance resource is undertaking a sense check of the position.	See 18	Chief Operating Officer / Deputy Chief Executive Officer	June 2026 – proposed completion by Q3	Partially completed
	24	We recommend that the Trust strengthens workforce engagement and communication, ensuring changes to policies, roles, and systems are clearly explained to staff.	Trust Communications will be strengthened to ensure engagement in new policies, service and system changes.	Improvement to national average from Trust baseline in NHS staff survey questions on ability to contribute to improvements at	Chief People Officer	September 2026	On Track – will be fully closed October

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			The Hospital Leadership Team or Reset Board will receive final recommendations and approve any changes, strengthening clinical engagement in relevant decision-making processes. Trust communications to launch approved polices, service and system changes will be strengthened to ensure broader dissemination through the organisation. Proposal for new Colleague Assembly developed and agreed at Executive team. This includes input into business cases and other significant transformation. Communications launched in August 2026 for the new DBTH Assembly with first meeting planned to be scheduled by October 2026.	work and communication with senior management. HLT TOR and minutes will reflect Divisional Director engagement in decision making Audit of document management processes to be completed in Q4 26/27			linked to Colleague Assembly action
Partnerships and communities – Lived Experience	25	We recommend that the Board considers the assurance it receives with regards to how patient and lived experience is central to monitoring and driving service improvement, and how it can elevate prominence at Board meetings.	The Trust will review the terms of reference and programme of work to include the Citizens Panel. Implementation of the experience of care framework will be supported through a task and finish group. A revised engagement strategy will be developed, with input from key 'patient with lived experience' groups. This will be reviewed annually. Patient Safety Partners attend Caring Group. A programme of digital patient stories will be implemented in all Divisions. The Quality Committee terms of reference will be updated to reflect the necessary changes.	3-5% improvement (from baseline) in NHS staff survey scores relating to, staff feeling informed about changes, understanding why changes are happening and having confidence that leaders communicate clearly. 5% increase in quarterly pulse survey participation. Reduction in FTSU themes, HR queries or escalation (recognising that there will be an initial increase as work commences). Board and committee papers demonstrate clear evidence that staff feedback influenced final decisions. Divisions supported to established shared decision-making councils.	Chief Nurse	May 2026	Completed
Learning, improvement, and innovation	26	We recommend that the reporting arrangements for implementation of the Quality Improvement and Innovation (QII) Strategy 2024-2028 are clarified.	QI sits within our new DBTHi function and the strategy implementation is being aligned to our Reset Programme now that our medium term plan is agreed.	Clear outcome metrics monitored against reset programme linked to quality improvement	Deputy Chief Executive Officer	July 2026 (proposed new date Q4)	Off Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			It is proposed a stocktake on DBTHi and how QI work is delivered within the organisation is undertaken once Reset programme is embedded and Interim CEO has had time to review current arrangements with the Executive Team.	QI strategy reporting into HLT Further review of DBTHi function and agreed actions			
	27	We recommend that the current approach to quality, improvement, and innovation team meetings and huddles across the Trust is reviewed and actions are agreed to support improvement in line with the QII Strategy objectives.	The Trust has developed the DBTHi team, who support the approach to quality, improvement and innovation. The approach to team meetings and huddles across the Trust has been reviewed linked to other recommendations. Ensuring actions are aligned to the QII strategic objectives is linked to 26 above now that Reset programme has been developed.	DBTHi activity aligned with the Trust reset programme pillars, evidence of impact will be demonstrated via delivery of the reset programme and monitored via the reset programme board.	Deputy Chief Executive Officer	May 2026 – lined to above Q4	Previously marked as completed – suggest re-open linked to Reset: Partially completed

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Patient Care	6.1	The review team recommends that the Trust ensure that the 4Ps are appropriately balanced in their application within the Trust operating model.	The Trust will ensure balanced focus across the 4 P's, particularly when considering quality, patient safety and colleague working environment. This balance will also be considered as part of the annual review of the Trust risk appetite statements. 'Patients' will feature more explicitly in Board and sub-Board Committee agendas. Consistent and balanced messaging will be considered as part of all internal and external communications.	Board and committee papers will explicitly identify impacts on the 4 Ps via the cover sheet process. Workplans for relevant sub committees strengthened. 360 Audit facilitated risk appetite discussion held as part of Board development session on 14th April, balance considered as described and appropriate amendments made as agreed.	Deputy Chief Executive Officer	April 2026	Completed
Belonging & Community	6.2	The review team recommends that the Trust ensures that it provides leaders with sufficient local human resources support, ensuring local leaders implement staff policies consistently across the Trust.	The People Business Partners team provide HR support to Divisions and Directorates. Training and support is offered as part of the support and development offer for managers and additional training is available when key HR policies are launched. HR toolkits and additional guidance are available on the Trust intranet (the Hive) also available on the Hive (intranet).	Named People Business Partner coverage in place for 100% of Divisions/Directorates. Internal audit assurance confirms consistent adherence to agreed HR processes where relevant (aligned with internal audit plan 26/27). >90% of Managers complete mandatory policy related training or toolkits following launch of new/revised policies FTSU and HR case work theme triangulation shows a reduction over time in concerns relating to inconsistency or unfair treatment. The 'line in the sand' work is expected to lead to an increase in such cases in the short term.	Chief People Officer	April 2026	Completed
	6.2	The review team recommends that the Trust takes the opportunity to further build on the DBTH Way to ensure that staff are fully engaged with the values and descriptors.	Trust wide engagement sessions are planned for 2026/27, to co-produce the cultural priorities and agree the focus behaviour areas from the DBTH Way. All colleagues will be encouraged to be involved with selecting the three specific behavioural priorities to embed across the Trust.	Three Trust-wide behavioural priorities explicitly defined, published and linked to the DBTH way descriptors developed following different clinical engagement sessions and a Trust wide survey.	Chief People Officer	December 2026	Completed

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			This will be launched in Trust communications in April 2026. "One DBTH" expectations will be incorporated into team development and supervision arrangements. Three focus behaviours as above. “I will” built into appraisal season 2026 and medical appraisal. Feedback and effectiveness being sought during appraisal feedback process, with formal review of appraisal season in Q2.	80% of sampled (anonymised) appraisals demonstrate explicit reference to DBTH way behaviours. Improvement to national average in relevant NHS staff survey questions related to team working.			
Value, Behaviour and Respect	6.3	The review team recommends that the Trust produces a clear action plan with SMART objectives to consistently tackle bullying and harassment within the Trust	The Trust will undertake a deep dive into bullying and harassment, with clear methodology and a multi professional review group. This is expected to conclude in Q2 of 2026/27. An action plan will then be developed to address the key findings. The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The Trust will implement an agreed "I will …” statement as part of 2026/27 appraisal programme. “I will” statements included in appraisal season 2026 and medical appraisal. Clinical leaders’ forum introduced and two sessions held with Executive team, including focus on the Line in the Sand in the June session. Bullying & Harassment deep dive commenced. Action plan to be developed in Q3 based on findings and themes.	Following completion of deep dive, action plan to be presented to Board complete with measurable objectives, success criteria, delivery milestones and named leads. Ongoing monitoring via People committee “I will ..” behavioural commitment embedded within 2026/27 appraisal objectives for all colleagues included within >80% of sampled appraisals. Clinical leaders forum established and sustained with attendance and outputs demonstrating active leadership with ownership of behaviour, culture and professional standards. Reduction over time in FTSU and HR casework themes relating to bullying, harassment or inappropriate behaviour. The ‘line in the sand’ work is expected to lead to an increase in such cases in the short term. Improvement to 2024 levels in staff survey questions “in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers” and “from colleagues” (currently above average).	Chief People Officer	December 2026	On Track
	6.3	The review team recommends that the Trust undertakes a review of the effectiveness of its implementation of EDI policies.	As part of the Culture and Leadership Programme and ‘line in the sand’ work, the EDI principles and policy will be strengthened and embedded.	An Internal Audit of the EDI policies from 2025/26 was undertaken, this gave an audit opinion of ‘significant assurance’.	Chief People Officer	December 2026	Completed

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			The EDI improvement plan will be refreshed in Q2 of 2026/27 and presented to People Committee. EDI embedded within Culture & Leadership programme. Strengthening networks and their activities, including new networks. EDI improvement plan refreshed and presented to People Committee in June 2026 together with the EDI annual report 2025/26. Significant assurance received. Process in place to review completion and effectiveness of actions. Progress of EDI actions regularly reviewed at EDI Forum and People Committee. Detailed analysis of staff survey, WRES/WDES, gender pay, ethnicity pay and disability gap undertaken. Anti-racism Bronze accreditation achieved from North-West BAME Assembly.	EDI principles and "the line in the sand" expectations explicitly incorporated into leadership development. Reduction over time in unfavourable treatment in EDI related case work for HR and FTSU. WRES and WDES indicators demonstrate narrowing of inequalities over time, with any adverse trends escalated and mitigated via the EDI improvement plan and assurance to People Committee.			
	6.3	The review team recommends that the Trust further defines, embeds, and assures a zero-tolerance approach to the unacceptable behaviours identified by staff within this review, shaped by staff engagement.	The Trust has commissioned 'Civility Saves Lives' and 'A Kind Life' to deliver programmes to support and embed a zero tolerance approach to unacceptable behaviours. This will be prioritised for implementation in clinical Divisions initially, during Q2 – Q4. The Trust will launch the 'line in the sand' work in response to the culture review and staff survey feedback, this is a fundamental part of the Trust Reset Programme, as described in the Culture and Leadership programme. The Trust will undertake a deep dive into bullying and harassment, with clear methodology and a multi professional review group. This is expected to conclude in Q2 of 2026/27. An action plan will be developed to address the key findings. (See 6.3 above) I will" statements included in appraisal season 2026 and medical appraisal. Line in the Sand video launched supported by other videos and leadership cascade for discussion in teams.	Evaluation of the Civility Saves Lives and A Kind Life programmes will be undertaken upon completion, utilising relevant staff survey metrics, and patient safety culture survey results (for operating theatres) results will lead to improvement plan as required. Following completion of deep dive, action plan to be presented to Board complete with measurable objectives, success criteria, delivery milestones and named leads. Ongoing monitoring via People committee Outcomes for the culture and leadership pillar of the reset programme, will be reported via the reset programme board.	Chief People Officer	December 2026	On Track

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			Clinical leaders' forum introduced and two sessions held with Executive team, including focus on Line in the Sand in the June session. Bullying & Harassment deep dive commenced. Action plan to be developed in Q3 based on findings and themes. A Kind Life programme and Civility Saves Lives facilitated sessions held with target teams.				
Psychological & Physical Safety	6.4	The review team recommends the Trust conduct a review of the effectiveness of its site parking arrangements, particularly at the DRI.	The Trust has recently approved a capital scheme to increase the amount of car parking at DRI . This is part of the overall capital plan for the DRI site.	Car parking review completed, business case developed and approved.	Chief Finance Officer	April 2026	Completed
Communication, Coproduction and Raising Concerns	6.6	The review team recommends that the Trust ensures all teams establish regular meetings or huddles where they are not already in place	The Trust has developed the DBTHi team, who support the approach to quality, improvement and innovation. The approach to team meetings and huddles across the Trust will be reviewed to ensure actions are aligned to the QII strategic objectives. The People Plan will be strengthened to clarify the expectations of leaders and teams in relation to communication dn information sharing. Expectations regarding Team Brief attendance and cascade by leaders to be introduced. Intention to consider asking questions about this in future pulse checks. Trust-wide communications shared about expectations on holding team meetings and support for effective team meetings. Safety Huddle audit completed and associated work being taken forward with QI support. Linked to wider governance work, clarity has been sought regarding the meetings held at divisional level and will be documented in the finalised governance manuals.	Divisional leadership teams confirmed via Performance Review Meetings review that regular meetings are in place and established within the Divisions. Quality summit feedback includes establishing whether ward/team meetings exist and support to establish if required. Safety Huddle audit completed.	Chief People Officer	September 2026	Completed
	6.6	The review team recommends that the Trust continues and prioritises its development of a staff engagement strategy with clear timelines, deliverables and SMART objectives, approved by the board and developed in partnership with staff.	The Trust will implement an enhanced approach to colleague engagement. This will include - Informal walkarounds undertaken by Executive Team members. - face to face meetings with the Executive Team across all hospital sites.	Strengthening staff engagement scores from the current Trust baseline to narrow the gap to the national average.	Chief People Officer	December 2026	On Track

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			- 'Ask an Exec' open sessions. - Team Brief where open questions and dialogue are encouraged. - Acting CEO and Interim Chair vlog. Colleague engagement is a key element of the Culture and Leadership programme, which has been supported by People Committee and Board and communicated widely across the organisation The Culture and Leadership pillar has been developed based on colleague engagement, staff survey and other feedback/data themes, feedback from external reviews including colleague engagement. A new engagement plan and approach will be co-produced with colleagues to define how they wish to be engaged, how information is shared, triangulated with the staff survey findings. Initial scoping will commence in Q1. Colleague Assembly proposal developed and launched seeking representatives in August 2026. Scoping of an approach to new pulse checks is underway.	Themes arising from walkarounds are captured systematically and escalated via the relevant forums where appropriate and translated into visible actions Triangulated visibility with FTSU intelligence, qualitative feedback from walkarounds and engagement sessions. Co-produced plan as part of the Culture and Leadership programme with measurable deliverables and timelines presented at People Committee for assurance as agreed.			
Freedom to Speak Up	6.7	The review team recommends that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all.	The Trust will utilise the FTSU peer review to support any identified improvements in the FTSU process, reviewing effectiveness, feedback loops, and confidentiality understanding as part of wider cultural programme, focusing on improvements to safe patient care and triangulated with the staff survey An overview and key themes from the FTSU Peer review will be shared at with the People Committee in February 2026 together with identified improvement plans and support to the wider culture and leadership programme, focusing on improvements to safe patient care. A FTSU report presented to the Trust Board in March 2026.	Relevant committee and Board minutes reflect that the reviews have been presented and support ongoing monitoring and assurance of improvement plans.	Chief People Officer	April 2026	Completed
Leadership Impact	6.8	The review team recommends that the Trust continue to try to resolve the relationship issues between the Executive team and some senior medical staff.	The membership of the Hospital Leadership Team includes the Divisional Directors, thereby strengthening clinical leadership in decision making.	Evidence of medical leadership input into Trust and divisional priorities through HLT papers, improvement plans, governance minutes and the reset programme pillars.	Chief Medical Officer	December 2026	On Track

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			The Trust has commissioned 'Civility Saves Lives' and 'A Kind Life' to deliver programmes to support and embed a zero tolerance approach to unacceptable behaviours. This will be prioritised for implementation in clinical Divisions initially, during Q2 – Q4. The programme will be evaluated to assess effectiveness. The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The first event will take place in March 2026 and quarterly thereafter.	Clinical leader's forum established and sustained with attendance and outputs demonstrating active leadership with ownership of behaviour, culture and professional standards. Evidence provided in attendance and subsequent outputs once forum established. Evaluation of the Civility Saves Lives and A Kind Life programme will be undertaken upon completion, utilising relevant staff survey metrics, and patient safety culture survey results (for operating theatres) results will lead to improvement plan as required.			
Environment, Facilities and IT	6.9	The review team recommends that the Trust continues its review of its current utilisation of estates to ensure that staff have a safe working environment, and patients are cared for in appropriate conditions.	The Board Development Session in February 2026 will focus solely on the estate at DRI, this will include consideration of all actions and mitigations; and will be aligned to the BAF and Trust Risk Register. Actions agreed from this session will form part of the Trust capital plan. The first Hospital Leadership Meeting, in April 2026, will discuss clinical alignment and estate utilisation as part of the overall clinical strategy. Optimal service configuration and patient / colleague environment are key components of this work.	Board have a collective understanding of current estate condition and risks. Updated Estates master plans are developed for each of the Trust sites which integrate with wider plans within the SY ICS and Doncaster and Bassetlaw place more generally.	Chief Finance Officer	April 2026	Completed
	6.9	The review team recommends that the Trust consider how to disseminate information and engage staff with the development of the implementation of the EPR.	Dedicated communications and engagement resource is in place to support EPR awareness and engagement. The Chief Medical Officer is the Executive Lead for the EPR programme and clinical colleagues will be driving the development of the new EPR, with wrap around support from Digital colleagues. Regular communications are shred across the Trust through the Trust Leadership Team and all colleague bulletins.	Clinical colleagues engaged and contributing to EPR awareness – feedback via EPR Steering Group. EPR training figures 80% prior to go live ORBIT (EPR programme) has a dedicated space on the HIVE with a clear launch pad for colleague engagement.	Chief Medical Officer	December 2026	On Track

BREAK 11:15 - 11:30

2609 - F STATUTORY & REGULATORY

11:25

2609 - F1 PERINATAL SAFETY & QUALITY (INTERIM) REPORT

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

Lois Mellor, Director of Midwifery
Dr Joseph John, Medical Director for Operational Stability and Optimisation
Tomas Barani, Clinical Director Obstetrics & Gynaecology

10 minutes

REFERENCES

Only PDFs are attached

- F1 - Perinatal Safety & Quality Interim Report.pdf
- F1 - Appendix 1 - PMRT Q1 Report.pdf
- F1 - Appendix 2 - Maternity Metrics.pdf
- F1 - Appendix 3 - Perinatal Quality Oversight Measures.pdf
- F1 - Appendix 4 - Perinatal Culture Improvement Plan.pdf
- F1 - Appendix 3 - Perinatal Quality Oversight Measures.docx

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Perinatal Safety & Quality (interim) Report (previously the Maternity and Neonatal update)**		
Executive Sponsor:	Karen Jessop, Chief Nurse		
Authors:	Lois Mellor, Director of Midwifery Danielle Bhanvra,Deputy Director of Midwifery		
Appendices:	1. PMRT Q1 report (Appendix 1) 2. Maternity Metrics (Appendix 2) 3. PQOM Data Measures (Appendix 3) 4. Perinatal Culture Improvement Plan (Appendix 4)		
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: **Is this in line with Current risk appetite YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested		

Avoid	Minimal	Cautious	Open	Seek	Mature
		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 Q1, 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 6 August 2026.

Board Assurance Summary Quarter One

- Perinatal mortality performance remains within the expected range and did not trigger a Maternity Outcomes Signal System (MOSS) alert.
- Reportable outcomes were: 0 stillbirth and 1 late fetal loss (>22 weeks) reportable to MBRRACE; and 5 neonatal deaths reportable to MBRRACE.
- Learning from PMRT reviews - 3 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, this 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 Q1 PMRT report, Trust Quality Metrics, data measures and the MOSS update have been reviewed/noted as appropriate. - Approve the Perinatal Culture Improvement Plan

Healthier together – delivering exceptional care for all	
Patients	We deliver safe, exceptional, person-centred care
People	We are supportive, positive, and welcoming.
Partnerships	We work together to enhance our services with clear goals for our communities.
Pounds	We are efficient and spend public money wisely
Health Inequalities	
Legal/ Regulation:	CQC regulation 12 safe care and treatment
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 August 2026, as documented in the Quality Committee Chair's Assurance Log

It also presents the Trust Board with the Perinatal Mortality Review Tool (PMRT) update for Quarter 1, 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:

- Trust Quality metrics
- Perinatal Quality Oversight Data Measures
- MOSS update noted
- Perinatal Culture Improvement Plan

2. Perinatal Mortality Rate

A summary of July'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

Quarter 1 (1 April 2026 – 30 June 2026) we have had once late fetal loss reportable to MBRRACE.
During Quarter 1 of the 2026–2027 reporting year there were:

- No stillbirths at ≥24 weeks' gestation
- One late fetal loss between 22+0 and 23+6 weeks' gestation

2.2 Neonatal Deaths

During Quarter 1 of 2026–2027, there were five neonatal deaths reportable to MBRRACE.

- Three neonatal deaths in babies born ≥ 22+0 weeks' gestation
- Two neonatal deaths in babies born below 22+0 weeks' gestation

2.3 Learning from the PMRT reviews Q1 2026

Issues:

- A mother presented and booked late in her pregnancy
- A mother had poor/no English and an interpreter was not used on every occasion in the antenatal period
- A mother had poor/no English and language line was used in labour (not a face-to-face interpreter)

Q1 PMRT report attached at Appendix 1

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): reviewed August 2026:

- Level one signals last 3 months - 0
- Level two signals last 3 months - 0

This data is reviewed through divisional governance meetings, with oversight and challenge to ensure that 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 have 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 training 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 and Amos report

This report was published on the 24 June 2026 and the Amos report was published on 30 June 2026, the service is currently in the process of completing the baseline assessment outlined in the 10 point plan Immediate Actions as per the national letter dated the 30 June, together with the maternity triage specification. Benchmarking tools are expected soon from NHSE.

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 6 August 2026 in relation to perinatal safety performance and governance. The Board is also asked to formally record in the Trust Board minutes - as evidence for the Maternity (Perinatal) Incentive Scheme - that the following have been reviewed and approved/noted as appropriate:

- PMRT Q1 Report
- Maternity metrics
- Perinatal Quality Oversight Measures
- MOSS update noted
- Perinatal Culture Improvement Plan

PMRT - Perinatal Mortality Review Summary Report

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

Report of perinatal mortality reviews completed for deaths which occurred in the period:
Quarter 1 period: 1 April 2026 to 30 June 2026

1. Introduction

This quarterly report is produced by the Women & Children's 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 500g 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 2024) reports a national stillbirth rate of **3.18 per 1,000 births**, a slight reduction from **3.22 per 1,000** in the previous year. National figures are calculated from births at ≥24+0 weeks' gestation and exclude terminations of pregnancy.

The Trust's stabilised annual stillbirth rate for calendar year 2025, for pregnancies ≥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 1 (1 April 2026 – 30 June 2026)

During Quarter 1 of the 2026–2027 reporting year, there were:

- No stillbirths at ≥24 weeks' gestation
- During this period, there were 1,058 births across the Trust (720 at DRI and 338 at BDGH).

There were:

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

This results in a quarterly crude stillbirth rate of **0 per 1,000 births**. This is lower than Quarter 4 of 2025–2026 (2.79 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 2, 3 and 4 of the 2025–2026 reporting year and Quarter 1 of 2026-2027 reporting year, the Trust's rolling stabilised stillbirth rate is **1.85 per 1,000 births**, equating to **8** stillbirths from ≥24 weeks' gestation across 4,316 births at both sites. This remains below the national stillbirth rate, indicating sustained performance in this domain.

All stillbirths born at ≥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 2024) reports a national neonatal death rate of **1.6 per 1,000** live births**,** a reduction from **1.63 per 1,000** for births in the previous year. These figures apply to babies born at ≥24+0 weeks' gestation and include deaths occurring up to 28 days of life.

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 1 (1 April 2026 – 30 June 2026)

During Quarter 1 of 2026–2027**, there were:**

- Three neonatal deaths in babies born ≥22+0 weeks' gestation
- One neonatal death following medical termination of pregnancy at ≥22+0 weeks' gestation
- Two neonatal deaths in babies born below 22+0 weeks' gestation
- No neonatal death following termination of pregnancy below 22+0 weeks' gestation (excluded from Trust rates)

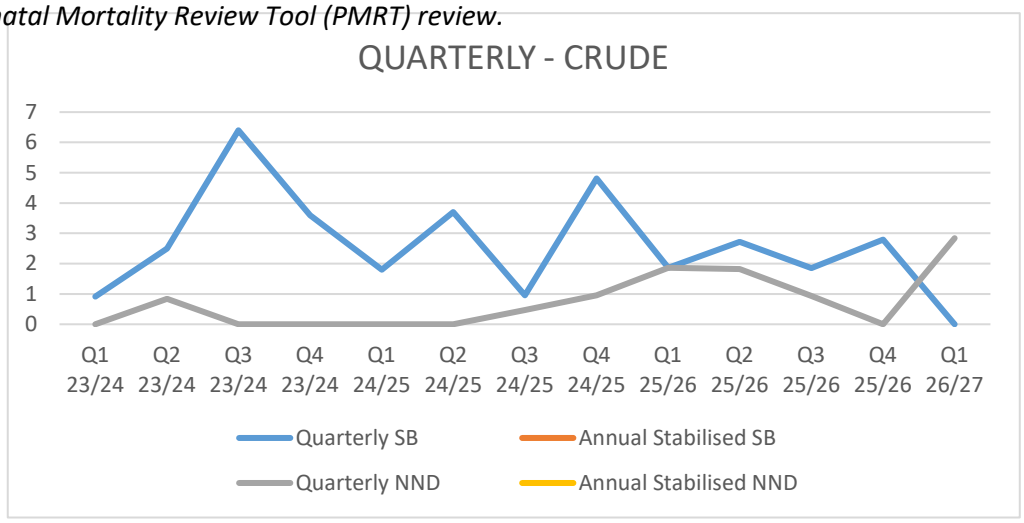
There were **1,058 births** across both sites during this period (720 at DRI and 338 at BDGH).

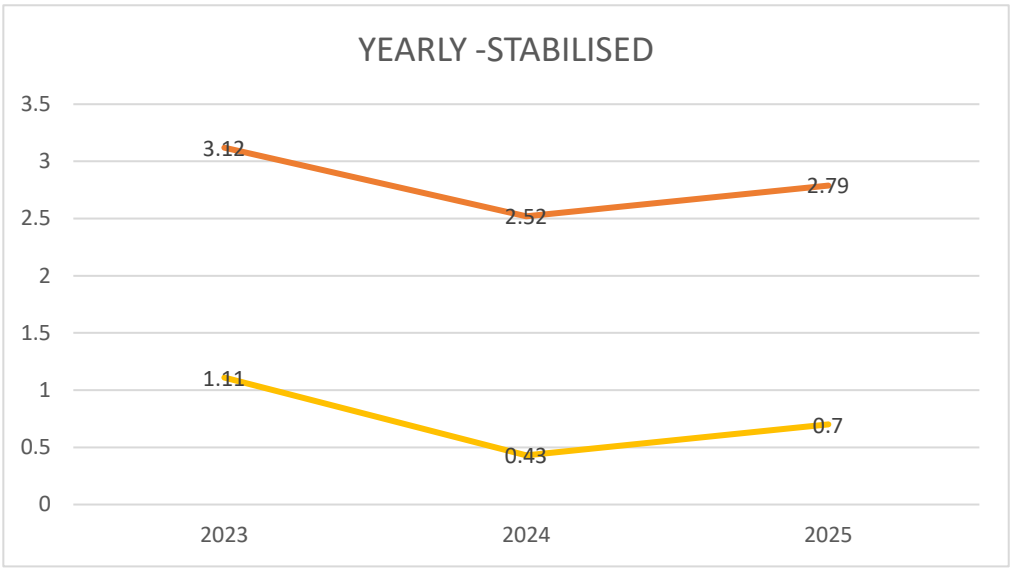
This resulted in a quarterly crude neonatal mortality rate of **2.84 per 1,000 live births**, compared with **0 per 1,000 live births** in Quarter 4 of 2025/26. As neonatal deaths are rare events, rates can fluctuate considerably between quarters due to small numbers. Continuous surveillance and governance oversight ensure that any concerns are identified, reviewed and escalated appropriately.

Rolling Annual Position

When combining data from Quarters 2, 3 and 4 of the 2025–2026 reporting year and Quarter 1 of 2026-2027 reporting year, excluding deaths below 22+0 weeks and those following termination of pregnancy, there were **six** neonatal deaths. This equates to a rolling stabilised neonatal death rate of **1.39 per 1,000 births** from 22+0 weeks' gestation across 4,316 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 ≥22+0 weeks' gestation and weighing ≥500 g meet the criteria for Perinatal Mortality Review Tool (PMRT) review.





Report Generated by: Rhian Morris
Date report generated: 03/07/2026 11:28

MIS Year 8 – Safety action C (Learning from reviews and investigations

Requirements	MIS requirement compliance	MIS Trust Compliance to date
Reporting & Review		
1. Notify all qualifying events: All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK and MNSI as soon as possible after the death/diagnosis.	Without delay	100%
2. Seek parents' views of care: For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	100%	100%
3. For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.	60%	**As of the time the report was compiled (July 26)** 1 December 25–30 November 26 = **71.42%** 7 cases: 3 prior to announcement date but had external reviewer 2 had external review 2 awaiting reviews as below 1 April 26 – 30 November 26 = **50%** 4 eligible deaths: 2 had external review = 50% with a trajectory of 100% 2 to be presented in September
Sharing information with families		
4. Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	100%	100%
5. Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	100%	1 December 25–30 November 26 = **28.57%,** trajectory of 100% 2/7 – Meeting offered as of compiling this report 5/7 – Not at stage in review to offer meeting at present 1 April 26 – 30 November 26 = **0%** 0/4 – Not at the stage in review to offer meeting at present

Thematic reports of learning and actions		
6. The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.	Quarterly report to Trust board	First quarterly report being drafted to be shared with Trust Board

This report provides assurance that stillbirths and neonatal deaths within scope are identified promptly, reviewed using the PMRT in line with MIS 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 process, and any learning highlighted for cases that have been presented through the MG-PSERP process for cases that are not subject to a PMRT review.

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
2	1	0	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
6	3	3	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 removed

Report Generated by: Rhian Morris
Date report generated: 03/07/2026 11:28

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

Social, economic and deprivation data (Neonatal Deaths) PMRT reviewable cases only		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25							
	26-35			2				2
	36-45						1	1
	46+							
Smoking status	Never smoked			1			1	2
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker			1				1
Ethnicity	White			1			1	2
	Black			1				1
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4			2			1	3
	5-8							
	8-10							
Employment	Employed			1			1	2
	Not employed			1				1
	Homemaker							
	Sick							
	Not stated							
Marital status	Married			1			1	2
	Single							
	Cohabiting			1				1
Learning or communication difficulties	Yes			1				1
	No			1			1	2

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 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	1	--	--	--	--	1
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*1*	*0*	*0*	*0*	*0*	*1*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	0	0	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	1	0	0	0	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	0	0	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	1	0	0	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	0	0	0	0
No	0	1	0	0	0	0	1
Hospital post-mortem offered	0	1	0	0	0	0	1
Hospital post-mortem declined	0	1	0	0	0	0	1
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 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	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

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

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	1	100% (1)
Admin/Clerical	2	100% (1)
Ambulance Team	0	0%
Bereavement Team	1	100% (1)
Community Midwife	0	0%
External	3	100% (1)
Management Team	6	100% (1)
Midwife	12	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	3	100% (1)
Neonatologist	5	100% (1)
Obstetrician	10	100% (1)
Other	2	100% (1)
Risk Manager or Governance Team	3	100% (1)
Safety Champion	1	100% (1)
Sonographer or Radiographer	0	0%

Table 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						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having 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	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
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 to 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 to 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	**1 causes of death out of 1 reviews**
	Arthrogryposis, gross nuchal oedema, fetal hydrops, severe fetal akinesia syndrome
Stillbirths	**0 causes of death out of 0 reviews**
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
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered
This mother booked late. Did this affect her care?	1	No action entered
This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care	1	No action entered
This mother had poor/no English and language line was used to interpret during her labour and birth	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 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

*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.

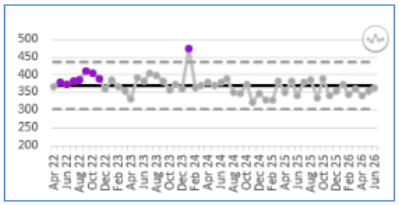
Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Patient Factors - Social Factors - Language	1	This mother booked late. Are there any organisations to consider in relation to her booking late?
		This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care
		This mother had poor/no English and language line was used to interpret during her labour and birth
Patient Factors - Social Factors	1	This mother booked late. Did this affect her care?

Appendix 2 Maternity Metrics

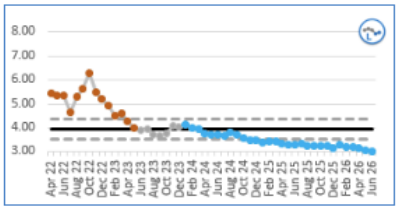
Latest month 01/06/26
Number of births 364

No significant change



Latest month 01/06/26
Still birth rate/1000 3.0

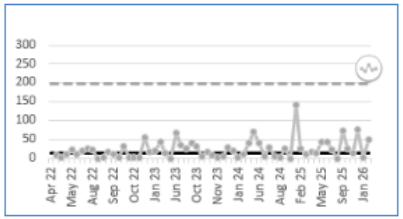
Significant Improvement



Date of last stillbirth 15/03/26

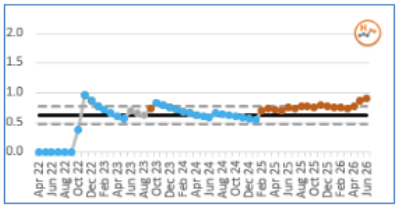
Average days between stillbirths 15.0

No significant change



Latest month 01/06/26
Neonatal Death rate/1000 0.9

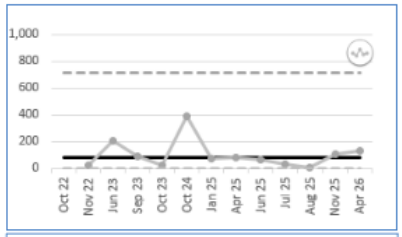
Significant deterioration



Date of last neonatal death 06/04/26

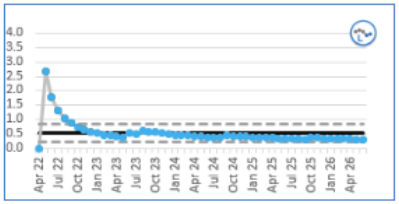
Average days between deaths 81.6

No significant change



Latest month 01/06/26
HIE rate/1000 0.3

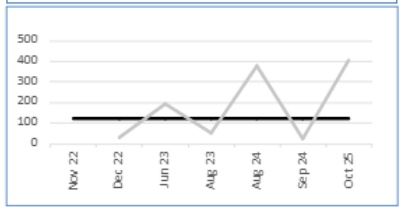
Significant Improvement



Date of last HIE 22/10/25

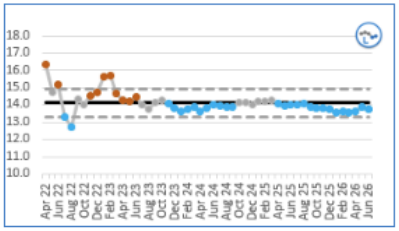
Average days between HIE 122.1

No significant change



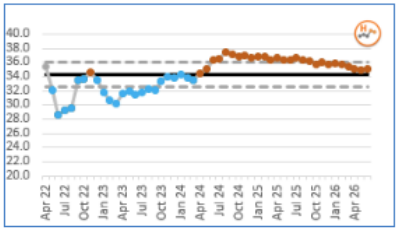
Latest month 01/06/26
3&4 degree tears (per 1000) 13.8

Significant Improvement



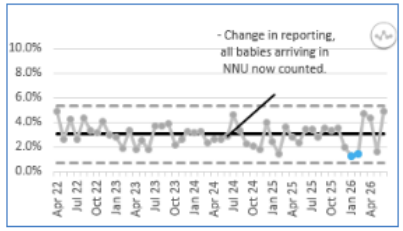
Latest month 01/06/26
PPH >1500 (per 1000) 35.1

Significant deterioration



Latest month 01/06/26
Unexpected admissions to NNU 0.0

No significant change



Appendix 3 Perinatal Quality Oversight Measures

2026	April	May	June	July	Aug
1. Number of reported perinatal deaths	3	2	1	1	
2. Number of MNSI cases	1	0	0	1	
3. Safety prompts from completed MNSI investigations		1 report received 0 SR or SP		1 report received 1 SR (the Trust to support staff to complete a full assessment of a mother and baby on admission) and 1 SP (ensure staff have access to equipment that is immediately available and easily accessible)	
Report on: 3a. The number of patient safety incidents logged and what actions are being taken /themes.	174 Incident reviewed through MGPSERP 1.2 due to PPH management 2.3 mortality cases 3.2 with concerns regarding an instrumental delivery 4.DCC admission 5.Congenital Syphilis case (Service to Service)	176 Incident reviewed through MGPSERP 1.Return to theatre and ITU admission, secondary PPH 2.C-Diff case attributed to M1 3.3 neonatal deaths	203 Incident reviewed through MGPSERP 1.Two 4th degree tears 2.Two neonatal deaths 3.Neonatal collapse at home 4.15/40 miscarriage 5.One low cord gases case	160 Incident reviewer through MGSERP 1.Facial trauma following instrumental delivery 2. Two intrauterine fetal deaths 3.One neonatal death 4.Two cases with CTG management concerns	

	6.Eclampsia **Learning:** 1.Hyperstimulation – timing of Terbutaline administration 2.Hypertension management 3.Guideline not followed when patient presented repeatedly with a worsening, unexplained rash	4.Incorrect VTE and administration of Dalteparin in the antenatal period **Learning:** Multiple courses of antibiotics and requirement for review 2.Incorrect classification of VTE/calculation of VTE without an accurate weight/BMI in this pregnancy 3.Clarity for process following a loss with religious beliefs	**Learning:** 1.Documentation of safety netting advice 2.Hypertension 3.Documentation of feeding support and feeds	5. One return to theatre 6. One ITU admission **Learning:** 1.CTG management of pathological traces 2. Assessment of language needs at booking 3. Recognition and escalation of the deteriorating patient	
	Ongoing Action Plan from Incidents reviewed through MGPSERP and thematic reviews:			2026 Action Plan.docx 2026 Action Plan.docx	
3b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (%) **Prompt**					
Consultants / SAS drs %	84.21	77.78	94.44	94.73	
Drs %	80	84.38	90.91	100.00	
Midwives %	94.72	94.65	96.75	95.14	
MSW's %	92.65	89.71	88.06	93.94	

Consultant anaesthetists % Anaesthetic drs %	100 96.30	94.12 100	88.24 100	94.12 100	
Fetal Monitoring and surveillance Consultants / SAS drs SD / CA % Drs SD/CA % Midwives SD/CA%	 84.9 90 87.80	 77.7 83.3 89.30	 94.4 80 94.72	 94.7 88.89 96.76	
Neonatal resus training Consultants % Drs % Nurses % ANNP % Midwives %	 95 100 91 100 93	 95 100 89 100 90.53	 95 100 85 100 92.28	 95 100 93 100 91.50	
3c. Minimum safe staffing in maternity services: midwife minimum safe staffing planned cover versus actual prospectively (%)	**DRI** MW – 100.25% MSW – 77.62 **BDGH** MW – 90.69 MSW - 76.33	**DRI** MW – 102.31% MSW – 71.8 **BDGH** MW – 80.83 MSW – 75.54	**DRI** MW – 101.75% MSW – 68.29 **BDGH** MW – 94.77 MSW – 76.09	DRI MW – 91.56% MSW – 67.10 **BDGH** MW – 92.91 MSW – 74.51	
3d. 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)	0	0	0	0	
4. Service User Voice Feedback – Themes	1Missed diagnosis	1.Delay in treatment/care/discharge/medical review	1.Use of SBAR communication.	1.Care of the woman on the postnatal ward	

	2.Cause of pain not considered 3.Discharged from ward too early	2.Comfort not maintained 3.Consent not obtained correctly	2.Infant feeding support. 3.Introduction of pump "quick start" guidance 4.Civility and communication training.	2.Cause of pain not considered 3.Lack of information to the patient	
5. Staff feedback from frontline champion and walk-abouts – themes	Skill mix related to flexible working contracts				
6. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	
7. Coroner Reg 28 made directly to Trust	-	-	-	-	
8. Progress in achievement of MIS Year 8 6 safety actions from April 26 (reset April annually)	0/6 (3/27 sub actions)	0/6 (2/27 sub actions)	0/6 2/27 sub actions)	0/6 9/27 sub actions	

9. 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%
10. 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%

Action No	Deliverable	Action	Outcome measure	30 days	60 days	90 days	Lead	Comments	RAG
Learning from Thematic reviews									
1	**Improve the Standard of Record Keeping**	Implementation of daily plans of care questions completed daily by the coordinator on the neonatal unit alongside the parents.	Completion of Record keeping audit standards	60%	75%	90%			
2		MDT approach to reviewing documentation. Audit of current examples of documentation of consent to allow specific areas of action to be created.							
3		Attendance at Seminar: The importance of documentation in clinical practice.							
4	**Language Assessment to be completed on all women reporting English as second language (including BSL)**	Embed the new language assessment proforma into routine practice at the booking appointment.	Audit of number of women with completed assessment	50%	75%	95%			
5		Language and interpreter action plan.							
6	**Patient-centred communication and informed choice**	To plan and complete a communication week throughout women's and neonates with tea-trolley teaching, safety messages of the day and staff engagement.	Reduction in safety incidents and complaints with communication as a contributory factor	10%	25%	50%			
7		Embed Martha's Rule across Maternity and Neonatal Services.							
Staff Experience									
8	**Improve colleague experience as reflected in staff survey outcomes**	Undertake colleague listening events.	Proportion of nurses/ midwives who agree/strongly agree they would recommend the Trust as a place to work or receive treatment						
9		Develop action plans from survey feedback.							
10		Recognise and celebrate colleague achievements							
11		Increase visibility of leadership through walk rounds.							
12	**Deliver consistent, high quality out of hours clinical supervision through clear standards, trained supervisors and regular monitoring of trainee feedback.**	Review consultant presence and accessibility.	Increase proportion of trainees rating out-of-hours clinical supervision as excellent/good						
13		Strengthen escalation pathways.							
14		Introduce trainee feedback forums.							
15		Monitor supervision concerns through educational governance							
Service user feedback									
16	**Translate high performing Picker domains into into service wide practice**	Share positive feedback across teams.	High performing Picker domains are maintained within subsequent surveys						
17		Identify best practice and standardise across services.							
18		Showcase examples during team meetings and governance forums.							
19	**Improve Picker Survey lowest-performing domains**	Complete deep-dive reviews.	Lowest-performing domains are translated into most improved domains in subsequent surveys						
20		Develop SMART action plans.							
21		Engage service users in improvement initiatives.							
22		Monitor progress through quality dashboards							
Workforce									
23	**Improve workforce sickness rates**	Review sickness trends.	Reduction in Monthly sickness absence rates						
24		Increase wellbeing support and occupational health referrals.							
25		Conduct return-to-work interviews consistently.							
26		Promote flexible working where appropriate							
27	**Stabilise workforce retention**	Conduct stay interviews and exit interviews.	Reduction Monthly turnover rates						
28		Review reasons for leaving.							
29		Develop retention initiatives.							
30		Support career development opportunities.							

Action No	Deliverable	Action	Outcome measure	30 days	60 days	90 days	Lead	Comments	RAG
31	**Translate Board Safety Champion Walk Round themes into targeted improvement actions with clear accountability and regular progress review.**	Record actions and assign leads.							
32		Provide feedback to teams on actions taken.							
33		Escalate unresolved risks through governance structures.							
34		Include learning in divisional meetings.							
Race Inequalities									
35	**Implement and embed the Perinatal Equity and Anti-Discrimination Programme**	Develop Anti discrimination governance processes.	Improvement in ethnicity stratified patient and workforce experience measures						
36		Engage community to ensure co production.							
37		Ensure there is regular recording and monitoring of WRES and WDES data.							
38		Increase proportion of staff trained in anti-discrimination.							
39		Monitoring the outcomes of ethnicity stratified outcomes and experience data.							
Date of meeting- **In Attendance-**									

2609 - F2 MATERNITY AND NEONATAL 10 POINT PLAN & TRIAGE SPECIFICATION BASELINE ASSESSMENT AND NHSE SUBMISSION

Decision Item | Karen Jessop, Chief Nurse | 11:40

Lois Mellor, Director of Midwifery
Dr Joseph John, Medical Director for Operational Stability and Optimisation
Tomas Barani, Clinical Director Obstetrics & Gynaecology

20 minutes

** Excel attachments are provided for ease of navigation only **

REFERENCES

Only PDFs are attached

- F2 - Maternity & Neonatal 10 Point Plan & Triage Specification Baseline Assessment.pdf
- F2- Appendix 1 NHSE letter 10 point plan assurance.pdf
- F2 - Appendix 2 - maternity-and-neonatal-services-reporting-template.pdf
- F2 - Appendix 3 -maternity-triage-specification-benchmarking-audit-tool DRI.pdf
- F2 - Appendix 4 - i-maternity-triage-specification-benchmarking-audit-tool - BDGH.pdf
- F2 - Appendix 2 - maternity-and-neonatal-services-reporting-template.xlsx
- F2 - Appendix 3 -maternity-triage-specification-benchmarking-audit-tool DRI.xlsx
- F2 - Appendix 4 - i-maternity-triage-specification-benchmarking-audit-tool - BDGH.xlsx

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	Maternity and Neonatal 10 Point Plan and Triage Specification Baseline Assessment and NHSE Submission			
Sponsor:	Karen Jessop, Chief Nurse Nick Mallaband, Chief Medical Officer			
Authors:	Lois Mellor, Director of Midwifery Danielle Bhanvra, Deputy Director of Midwifery			
Appendices:	Appendix 1 – NHSE letter outlining assurance process Appendix 2 – Maternity and neonatal services reporting template for the 10 point plan Appendix 3 - Benchmarking tool for Maternity triage specification for DRI Appendix 4 - Benchmarking tool for maternity triage specification tool BDGH			
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 against the baseline assessment for the 10 point maternity and neonatal plan. The Trust has established governance, workforce and safety controls identified by the 10 point plan and MIS Year 8. However, several important requirements remain only partially implemented or are not yet evidenced, particularly in relation to maternity inequalities, triage assurance, workforce deployment reviews and demonstrable improvements arising from learning from complaints and incidents. Improvement plans are in place with evidence of progress, but further work is required following this baseline assessment exercise as outlined in the supporting paper.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7			
For decision papers only: Is this in line with Current risk appetite YES/NO	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested			

Avoid	Minimal	Cautious	Open	Seek	Mature
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

This paper presents the Trust's baseline assessment against the national maternity and neonatal 10 point plan and the maternity triage specification, following the NHSE letter received on 30 June 2026 and publication of the benchmarking tools on 12 August 2026. The assessment has been completed by the Director of Midwifery and Deputy Director of Midwifery, with oversight from the Chief Nurse, and is submitted to Board for assurance and approval ahead of submission to NHSE by 25 September 2026.

The 10 point plan assessment is supported by an evidence log and corresponding evidence folders. The current baseline position identifies five non-compliant elements, nine partially compliant elements and eleven fully compliant elements. The most material gaps for Board relate to maternity inequalities data and outcome variation, formal review of maternity resource deployment, neonatal workforce compliance, Clinical Director attendance at Quality Committee and Board alongside the Director of Midwifery, and the need to demonstrate embedded learning and improvement from complaints and concerns.

Two maternity triage specification tools have also been completed, one for DRI and one for BDGH. The assessments identify areas requiring further support to meet the specification, including data analysis capacity, call recording for audit and quality assurance, maternity support worker capacity at BDGH, separation of antenatal and gynaecology pathways, suitable confidential space for triage calls, larger clinical spaces to support open access requirements, and support from primary care colleagues. Building and digital costs have not yet been fully quantified due to the timescale for completing the assessment and will need to be developed through the appropriate business planning route.

Overall, the assessment supports a Moderate Assurance rating. There is evidence of established governance, safety and workforce controls, and improvement plans are in place; however, the baseline assessment also identifies important areas where compliance is incomplete or not yet sufficiently evidenced. The Board is asked to approve the completed returns for submission to NHSE, note the gaps and further work required, and receive continued oversight via the Quality Committee ahead of the progress submission due by 31 December 2026.

n.b. Action 4 is the NHS wide staff engagement and culture programme that is being led nationally by NHSE and therefore has been excluded nationally from the return

Recommendations	
For approval by the board for submission to NHSE by 25 September 2026	
Healthier together – delivering exceptional care for all	
Patients	Supports safer maternity and neonatal care through baseline assessment against national requirements, evidenced gaps and agreed improvement actions.
People	Identifies workforce requirements and deployment gaps, including neonatal workforce compliance and maternity triage capacity.
Partnerships	Requires continued work with NHSE, the ICB, regional teams and primary care partners to meet the 10 point plan and triage specification.
Pounds	Highlights potential resource, digital and estates implications that require quantification through business planning.
Health Inequalities	Identifies the need for stronger maternity inequalities data to evidence variation in outcomes and target improvement.
Legal/ Regulation:	CQC regulation 12 providing safe care and treatment
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	N/A
Any outcomes/next steps / time scales	

1. Introduction

Following the publication of the Baroness Amos report and Donna Ockenden's independent review of maternity services at Nottingham the trust received a letter from Sir Jim Mackey on the 30 June 2026 with a 10 point plan of urgent actions for maternity and neonatal services. A maternity triage specification was published at the same time, and a benchmarking tool was published for both on the 12 August 2026.

NHSE have asked for these templates to be completed and returned for initial submission on the 25 September 2026. The templates need to be approved by the trust board prior to submission. This is to ensure that the actions are progressing at pace, risks are managed appropriately and significant concerns are escalated to the ICB and regional teams.

A progress update will need to be submitted by the 31 December 2026 having been reviewed by the board prior to submission

2. Benchmarking Process

Three benchmarking tools have been completed by the Director of midwifery, and the Deputy Director of Midwifery with oversight from the Chief Nurse. Evidence has been sourced from the leads for the relevant areas, together with the Quality Committee and Trust Board Minutes.

3. 10 Point Plan Baseline assessment

A baseline assessment has been undertaken by the Director of Midwifery and reviewed by the Chief Nurse. This has been done utilising the NHSE reporting template (appendix 2) and collating the relevant evidence available for each element required. Where there is no or limited evidence available this has been recorded on the tool. The evidence is arranged in folders for review when required and logged in the evidence log in the tool.

Outstanding Assurance requirements:

- There is limited data available to support review of maternity inequalities and identification of variation in outcomes (2.3, 5.2)
- Require Clinical Director attendance at the Quality Committee and Board of the Clinical director alongside the Director of Midwifery (3.2)
- Maternity services to undertake a formal review of internal maternity resource deployment (6.7)
- Board sign off re: Triage specification tool, contained within this report for approval (9.1)
- Learning from complaints and concerns is not yet demonstrably embedded by outcomes. (8.2)
- Neonatal workforce compliance in progress but not complete (6.3)

4. Maternity triage specification Benchmarking

There are two separate tools, one for the DRI site (Appendix 3) and one for the BDGH site (Appendix 4). This has been populated as per the requirements with the Board support required to meet the triage specifications.

The identified requirements are;

- A data analyst to support the requirements in the specification for data collection and analysis (this is wider than triage and would support the wider maternity analysis required)
- The ability to record triage telephone conversations for quality assurance and audit purposes
- A maternity support worker to support the triage service at BDGH
- Support to separate the ante natal and gynaecology clinics at BDGH which would assist in separating the day unit and triage service at BDGH
- Support to create a quiet office space on both sites, for taking triage calls at DRI, and for confidentiality at BDGH
- Support for larger spaces on both sites to accommodate the open access required in the specification
- Development of a defined triage specific patient experience feedback approach across both sites
- Support with primary care colleagues to meet the specification requirements for pathways of care

5. Next Steps

The completed benchmarking tools represent the Trust's baseline assessment position. Following Board approval, the returns will be submitted to NHSE by 25 September 2026. The identified gaps and support requirements will be utilised as a delivery plan, with progress monitored through maternity governance and overseen by Quality Committee. A further progress update will be reviewed by Board ahead of submission to NHSE by 31 December 2026. The NHSE NEY regional team will review the Trust's 10 point plan assessment and evidence, apply a regional compliance rating, and cross-reference this with the Trust's self-assessment.

NHS England

To: NHS trust:
- chief executives
- chairs
- chief nursing officers
- medical directors
- chief operating officer
- communications directors

cc. Integrated care bard (ICB):
- chief executives
- chief nursing officers
- medical directors

NHS England:
- regional directors
- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 August 2026

Dear colleagues,

Maternity and Neonatal 10 Point Plan assurance process

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the assurance process and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.

The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with Maternity Incentive Scheme (MIS) Year 8 requirements, enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the standardised national template to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, 'Amos into action' will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out in his letter, this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a maternity

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triage benchmarking tool to support implementation of the national maternity triage specification. You can find the full detail in the Appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Professor Frankie Swords

National Medical Director

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Appendix: Maternity and Neonatal 10 Point Plan – support available

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the Model Board Report to support their reporting process.

Support will be available to help trusts and systems implement the 10 Point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided in the table below. For any queries relating to the reporting template, please contact england.maternitytransformation@nhs.net.

Action	National Support Available
Martha's Rule	Trusts should follow the implementation and reporting processes outlined by the Martha's Rule national team in NHS England. A webinar is scheduled for **Wednesday 12 August, 15:00–16:30hrs** to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication. The session will provide key information to support local implementation, including: • an overview of the three components of Martha's Rule • the national implementation approach • learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings • the implementation support, resources and tools available to local teams.

	The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team. The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email england.psimprovement@nhs.net
Maternity and Neonatal 10 Point Plan supporting webinar series	The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in **August.** The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on: 1. Listen to women and their families using real-time and transparently reported outcomes and experience, **Monday 17 August 2026, 11:30 – 12:00** 2. Clinical audit, **Wednesday 19 August 206, 15:30 – 16:00** 3. Ensuring 24/7 safety and responsiveness of services, **Wednesday 19 August 2026, 11:30 – 12:00** 4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, **Thursday 20 August 2026, 12:00 – 12:30** Further information will be shared soon.
Amos into Action staff listening exercise	This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services. Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that

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	follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.
Safe and effective maternity triage	The triage benchmarking tool has been shared by NHS England to support implementation of the maternity triage specification. Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.
Post death care	Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry

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10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governa structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission pro Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provi constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may su more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:	Bassetlaw Teaching Hospitals NHS Fo
Report prepared by:	Director of Midwifery
Report date:	1st September 2026
Reporting period covered:	To date

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	1	1	1
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	3	0	1	0	2
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	2	5
7. Trust review of homebirth services	2	1	0	0	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	3	0
9. Deliver safe and effective triage in maternity services	3	0	1	2	0
10. Post death care	2	0	0	1	1

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	EV 01 - 04	Launched on 13 July at DBTH, and is not embedded, evaluation planned.	Review in February (6 months) to assess whether embedded/ review any calls & actions taken	Waiting for national documents, and then will review against current process in place
2. Liste						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	EV 05- 11			
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV- 12 - 15	Reports taken to quality commitee as a delegated authority from the board (as per MIS standards)		Confirm whether this has to be board or can be another delegated meeting in line with the MIS standards
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust information team to identify how data can be accessed and reported and incorporate into TB reports	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	QC Mins (Aug)	None		
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV 17 - 19	The clinical director has been unable to attend meetings due to clinical commitments. This has been discussed and is being addressed	meeting dates have been shared with the clinical director and arrangements are being made to ensure his attendance at relevant meetings	The director of midwifery has attended board since 2021, since 2026 the full maternity papers goes to Quality Commitee (as a delegated duty) and interim papers go to the public board, the DoM attends both
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	EV 20-22			
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust Information team to identify how data can be accessed and reported and incorporate into Board reporting	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	EV 23- 24			
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV 25-28	Current audit shows > 80% attendance in the year		
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	EV 29			
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	EV 30 -32	Plan agreed and business case in progress.		

6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	EV 33- 38			
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV 39 - 41			
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV 43- 45	People committee receive Bi-annual workforce paper CHPPD metrics for midwivery included within Integrated Performance report reviewed at every Board Operational escalation processes are aligned to Trust OPEL and out of hours arrangements and are routinely escalated through established on-call processes		
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	Evidence to be submitted	This work needs to be undertaken and a paper submitted to the trust board with the findings Mechanisms in place for education and training around specialist midwifery activity via the REST programme SOPs and referral guidance in place.	Paper to be completed by the 3.10.26	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV 46- 47	Further update to be taken to the Trust board to address the working time directive and hours worked by on call midwives		MDT review of women requesting homebirth in place, individual plans made for women and their familes. Risk discussed and options explored using the BRAIN process. Documented in the notes. senior midwifery support avaiable 24/ 7 for all community midwives
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable		No immediate significant risks identified that need escalation		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	EV 48- 49	learning shared in board reports from PMRT. Families recieve a PMRT outcome letter or identified learning from AARs Patient safety paper to every QC, (includes Obstetrics when relevant) Thematic review of incidents received at Patient safety assurance Group (Oct 25) Updated PSIRP for 2026 is based on an externally commissioned thematic analysis of all Datix reported incidents over the last 2 years and CNST claims and includes a Maternity related priority		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	Evidence to be submitted	Themes from the Quarterly and Annual patient experience reports to QC highlight maternity specific themes Digital patient story to QC - Feb 26 - Maternity themed (also on the HIVE for wider learning) First maternity specific thematic review to go to QC in Oct and TB in Nov.		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	EV 50	Some debriefing undertaken but not consistent or high quality, DOC letters sent to timeframe		
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant		Maternity triage tool completed and on same Board agenda for consideration 1 09 2026	Complete the tool and submit tool by 25.9.26	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV 51	New board paper template adopted, and this data is now reported to the quality committed bi monthly as a delegated committee of the board		
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant		Baseline assessment completed and submitted to board on same date as this tool	Once benchmarking completed then a plan will be developed and submitted to the board for monitorin of progress	
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV 52			
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Partially compliant	EV 53	South Yorkshire pathology board undertaking required incident review in progress		

Submission B: Progress against baseline (December 2026)

This template should be completed and submitted on **Thursday 31st December 2026**. This template reports on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline assessment, trusts should not complete this information again. The baseline status will automatically update and should indicate where any progress updates are required.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Report signed off by Trust Board (named Exec):
Trust Board sign off date:

									To be completed by Regions	
No.	**Deliverable**	**Baseline Compliance Rating**	**Current Status**	**RAG**	**Evidence ID** *Please input reference number as listed in 3. Evidence Log tab*	**Key Gaps / Risks**	**Improvement action required**	**Due Date(s)**	**Regional Compliance Rating**	**Comments**
1. Listening to women and families by rolling out Martha's Rule										
1.1	Is the trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Partially compliant							Non-compliant	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level										
2.1	Has the trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant								
2.2	Is the trust board continuing to receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant								
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant								
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant								
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant								
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant								
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Non-compliant								
5.3	Is the trust board receiving reviewing and acting on (through the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	Compliant								
6. Ensuring 24/7 safety and responsiveness of services										
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant								
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant								
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant								
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant								
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	Compliant								
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?									
6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant								
7. Trust review of homebirth services										
7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Compliant								

7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable									
8. Responding to incidents, complaints and concerns with humanity and candour											
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant									
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant									
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant									
9. Deliver safe and effective triage in maternity services											
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant									
9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalitie?	Partially compliant									
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant									
10. Post death care											
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant									
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Partially compliant									

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	1	Staff briefing	Document	07/07/2026	Laura Churm	Evidence folder 1		Strong
EV-02	1	Patient Wellness questions	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-03	1	Escalation Process	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-04	1	Martha's rule posters	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-05	2.1	Engagement activity spreadsheet	Document	01/01/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-06	2.1	DBTH MNVP Workplan 2026-7	Document	01/04/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-07	2.1	Service Improvement Plan	Document	28/04/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-08	2.1	MNVP SUV Assuracne template	Document	20/05/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-09	2.1	Maternity Experience & Improvment group TOR		new	Janine Grayson	Evidence folder 2.1		Adequate
EV-10	2.1	Neonatal Services Improvement PLan	Document	01/07/2026	Sam Fawles	Evidence folder 2.1		Adequate
EV-11	2.1	Annual Plan for Service user Engagement April 202	Document	02/06/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-12	2.2	Quality Comittee Min 23 April 2026	Document	23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-13	2.2	B3 App1 - service user annual plan		23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-14	2.2	B3 - App 2 Maternity servcie annual survey action		23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-15	2.2	B3 front cover & maternity picker survey report	Document	23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-16	3.1	Aug QC						
EV-17	3.2	April QC Minutes	Document	23/04/2026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-18	3.2	June QC Minutes	Document	04/062026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-19	3.2	May Borad Minutes	Document	05/05/2026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-20	5.1	Template for PEAP	Document	07/01/2026	Janine Grayson	Evidence folder 5.1		Strong
EV-21	5.1	Allocation email	Email	08/06/2026	Janine Grayson	Evidence folder 5.1		Strong
EV-22	5.1	Information slides for participants		08/06/2026	Janine Grayson	Evidcent 5.1		Strong
EV-23	5.3	MCB template	Document	08/06/2026	Jordan Dickman	Evidence folder 5.2		Strong
EV-24	5.3	Aug QC mins	Document	08/06/2026	Trust	Evidence 5.2		Strong
EV-25	6.1	Consultant Attendance Audit Report - report June d	Document	07/03/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-26	6.1	Consultant Attendance Audit Report May 26	Document	08/05/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-27	6.1	Consultant Attendance Audit Report July 26	Document	06/03/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-28	6.1	sop-consultant-attendance-in-maternity-gynaecology	Document	21/06/2026	Lucy May	Evidence folder 6.1		Strong
EV-29	6.2	Locum Monitoring Audit	Document	ongoing	Stacey Elsworth	Evidence Folder 6.2		Strong
EV-30	6.3	Quality Committe paper	Document	06/04/2026	Lois Mellor	Evidence folder 6.3	Plan for BAPM staffing	Strong
EV- 31	6.3	QC April Minutes	Document	21/04/2026	Trust	Evidence folder 6.3		Strong
EV- 32	6.3	QC June Minute	Document	06/04/2026	Trust	Evidence folder 6.3		Strong
EV 33	6.4	Bi-annual workforce board paper 2025 Q3 and 4 fi	Document	16/04/2026	Danielle Bhanvra	Evidence folder 6.4		Strong
EV -34	6.4	Board of Directors Minutes - 27 January 2026	Document	27/01/2026	Trust	Evidence folder 6.4		Strong
EV-35	6.4	C6 - Birthrate Plus FINAL	Document	21/04/2026	Lois Mellor	Evidence folder 6.4		Strong
EV-36	6.4	Doncaster and Bassetlaw Teaching Hospitals NHS T	Document	Nov-25		Evidence folder 6.4		Strong

EV-37	6.4	FINAL People Committee Minutes - 21 April 2026	Document	21/04/2026	Trust	Evidence folder 6.4		Strong
EV-38	6.4	Public Board of Directors Minutes - 1 July 2025	Document	07/01/2026	Trust	Evidence folder 6.4		Strong
EV- 39	6.5	BDGH On call Rota 27/07/2026	Document	27/07/2026	Sam Smith	Evidence folder 6.5	One rota more avaiable (Anaes)	Strong
EV - 40	6.5	DRI Labour 30/07/2026	Document	30/07/2026	Sam Smith	Evidence folder 6.5	One rota more avaiable (Anaes)	Strong
EV - 41	6.5	ODP July Rotas	Document	Jul-26	Sam Smith	Evidence folder 6.5	One rota more avaiable (ODP)	Strong
EV- 42	6.6	Bi-annual workforce board paper 2025 Q3 and 4 fir	Document	21/04/2026	Danielle Bhanvra	Evidence folder 6.6		Strong
EV- 43	6.6	msg-78-maternity-escalation-and-suspension-plan (	Document	Mar-23	LMNS	Evidence folder 6.6		Strong
EV- 44	6.6	sop-escalation-to-on-call-maternity-manager-and-r	Document	16/07/2026	Julie Scott	Evidence folder 6.6		Strong
EV- 45	6.6	sop-utilisation-of-specialist-midwives-for-escalation	Document		Jordan Dickman	Evidence folder 6.6		Strong
EV - 46	7.1	Executive report Homebirths	Document	Feb-26	Lois Mellor	Evidence folder 7.1		Adequate
EV - 47	7.1	Perinatal QC report	Document	08/06/2026	Trust	Evidence folder 7.1		Adequate
EV-48	8.1	6.2-CORP-RISK-36-v2-Patient-Safety-Incident-Respo	Document	06/09/2026	Trust	Evidence folder 8.1		Adequate
EV-49	8.1	TOR August 2024	Document	24-Aug	Emma Merkushev	Evidence folder 8.1		Adequate
EV- 50	8.3	Patient Safety Incident response policy	Document	06/09/2026	Trust	Evidence folder 8.3	Training defined in policy	Adequate
EV-51	9.2	Aug QC mins	Document	08/06/2026	TBO			
EV- 52	10.1	Mortuary submission	Document	26/06/2026	Nick Mallaband	Evidence folder 9.1		Adequate
EV- 53	10.2	Email HTA Update	Email		Nick Mallaband	Evidence Folder 9.2		Adequate

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	•Board Report •Review report

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Doncaster and Bassetlaw Teaching Hospital

Please enter the **trust site** below:

DRI

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	9%	91%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	30%	50%	20%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	0%	100%	0%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	25%	75%	0%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	40%	40%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	60%	40%	0%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	17%	50%	25%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	40%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	29%	71%	0%	0%	£49,800.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Dashboard

Principles menu

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with the primary care to team to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self-referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Assistance with creating audion and digital translated version of information	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support to increase the footprint of the maternity traige, creating enough waiting and clinical areas to supprt an open access policy	
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Fully in place, embedded and evidenced	No further action required	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below ble post natal beds. There is a suggetion that women in latent (early phase of labour) should be admitted	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or pediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or pediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site Partially captures this data	Please outline what support you require from your trust board below Support to recuit data analyst
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site doesn't capture this data	Please outline what support you require from your trust board below support required to recuit data analyst
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site doesn't capture this data	Please outline what support you require from your trust board below as above
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site doesn't capture this data	Please outline what support you require from your trust board below as above

Total estimated cost to implement this principle

£0.00

Principles menu

Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Fully in place, embedded and evidenced	No further action required	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Fully in place, embedded and evidenced	No further action required	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact; attendance is accepted without judgement; concerns are assessed promptly and without assumptions, including latent labour and apparently non-urgent issues.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Fully in place, embedded and evidenced	No further action required	
Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support with primary care	
Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below assistance to put in place mutual support agreements with neighbouring sites	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.	Site Partially captures this data	Please outline what support you require from your trust board below Data analyst	£0.00

Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Fully in place, embedded and evidenced	No further action required	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below support with primary care and defining pathways for women between 4 - 6 weeks postnatally	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self-refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone	Fully in place, embedded and evidenced	No further action required	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below We have some open access for the most vulnerable women and need to open access to all	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below agreement for investment to create space for a quiet area	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Recording calls would support the audit of this and the qulaity of the information given	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site doesn't capture this data	Please outline what support you require from your trust board below

Estimated cost to implement this principle
£0.00

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Fully in place, embedded and evidenced	No further action required d national team that provides a broader range of feedback from all groups accessing maternity service u	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Fully in place, embedded and evidenced	No further action required	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below : maternity triage the service relies on the intercom system for the ward, and colleagues notifying them th	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below need to identify additional space at DRI	
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Fully in place, embedded and evidenced	No further action required	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Fully in place, embedded and evidenced	No further action required	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from data assessment, antenatal clinic and other scheduled care areas.	Fully in place, embedded and evidenced	No further action required	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00

Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Medical oversight / attendance can be sporadic as there is no dedicated doctor especially during the peak periods (4 -10 pm ish) recruitment of further ACPs	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below In place but no evidence at present no training documents / competency booklet yet	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing off staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Not relevant to local pathway/context	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focused on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.		
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language. Why: Helps identify variation and potential inequality in access, experience and outcomes.		

Total estimated cost to implement this principle

£0.00

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Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	£49.800 (Band 5 Analyst)
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all womne and their families	

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Total estimated cost to implement this principle

£49,800.00

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Doncaster and Bassetlaw Teaching Hospiatal

Please enter the **trust site** below:

BDGH

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	9%	91%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	30%	20%	50%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	0%	100%	0%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	25%	63%	13%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	20%	60%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	20%	30%	50%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	8%	50%	33%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	40%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	29%	71%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Dashboard

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below As per DRI requirement Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self-referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Cost associated with providing accessible facilities e.g disabled toilet, waiting area for wheelchairs etc	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support to increase the footprint of the maternity traige, creating enough waiting and clinical areas to supprt an open access policy	
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Fully in place, embedded and evidenced	No further action required	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below The waiting ares is extremely small at the moment and current MADU area is not suitable to deliver high quality triage care	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or pediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or pediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site Partially captures this data	Please outline what support you require from your trust board below Support to recuit data analyst
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site doesn't capture this data	Please outline what support you require from your trust board below support required to recuit data analyst
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site doesn't capture this data	Please outline what support you require from your trust board below as above
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site doesn't capture this data	Please outline what support you require from your trust board below as above

Total estimated cost to implement this principle

£0.00

Principles menu

Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Fully in place, embedded and evidenced	No further action required	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Fully in place, embedded and evidenced	No further action required	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact; attendance is accepted without judgement; concerns are assessed promptly and without assumptions, including latent labour and apparently non-urgent issues.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support to separate the obstetric and gynae clinics, which would realease space to separate the day assessmsent unit and triage on the BDGH site	
Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Fully in place, embedded and evidenced	No further action required	
Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Signage to the triage area (once it has been fully established after separating the clinics)	
Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support with primary care	
Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below assistance to put in place mutual support agreements with neighbouring sites	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.	Site Partially captures this data	Please outline what support you require from your trust board below Data analyst	£0.00

Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Fully in place, embedded and evidenced	No further action required	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below support with primary care and defining pathways for women between 4 - 6 weeks postnatally	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self-refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone	Fully in place, embedded and evidenced	No further action required	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below agreement for investment to create space for a quiet area	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Estimated cost to implement this principle
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Fully in place, embedded and evidenced	No further action required d national team that provides a broader range of feedback from all groups accessing maternity service u	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support required from the board to reconfigure the current spaces to give a dedciated space for triage assessment	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below As above to include private areas for assessments	
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Fully in place, embedded and evidenced	No further action required	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from data assessment, antenatal clinic and other scheduled care areas.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below BDGH day assessment and triage occupy the same area, however separation of the clinics will allow these to be located in separate areas	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00

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Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Funding for additional healthcare and the additonal twilight midwife will be rostered once the NQM start (releasing a more experienced midwife from elsewhere to support triage) - it's currently offered on NHSP	£31400
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Medical oversight / attendance can be sporadic as there is no dedicated doctor especially during the peak periods (4 -10 pm ish)	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below In place but no evidence at present no training documents / competency booklet yet	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing off staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Not relevant to local pathway/context	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below	**£0.00**
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site doesn't capture this data	Please outline what support you require from your trust board below	

Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focused on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.		
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language. Why: Helps identify variation and potential inequality in access, experience and outcomes.		

Total estimated cost to implement this principle

£0.00

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Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	£49.800 (Band 5 Analyst)
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	

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Total estimated cost to implement this principle: **£0.00**

2609 - F3 MORTUARY OVERSIGHT - BOARD ASSURANCE STATEMENT

Information Item

Dr Joseph John, Medical Director for Operational Stability and Optimisation

5 minutes

REFERENCES

Only PDFs are attached

- F3 - Mortuary Oversight - Board Assurance Statement.pdf
- F3 - Appendix 1 - System letter on mortuary oversight 26 June 2026.pdf
- F3 - Appendix 2 - Submission.pdf
- F3 - Appendix 2 - Submission.xlsx

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**NHSE letter on Mortuary Oversight as a result of the Nottingham Maternity Review Findings on Post Death Care**			
Sponsor:	Dr Nick Mallandand, Chief Medical Officer			
Authors:	Dr Joseph John, Medical Director for Operational Stability and Optimisation			
Appendices:	Appendix 1 Letter Appendix 2 Submission			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF Risk 1			

Executive Summary – Key messages and Issues

Following the findings of the Nottingham University Hospitals maternity review on post death care and the Human Tissue Authority report, NHS England issued a letter (appendix 1) highlighting the need for increased assurance regarding the dignity, security and oversight of care after death and required all NHS provider trusts to review their arrangements and submit to NHSE a Board Assurance Statement by 31st July 2026.

Boards were required to provide an assurance statement against the following:

- Review progress against the relevant recommendations arising from the Fuller inquiry and associated national guidance.
- Test the effectiveness of local governance, leadership, culture and oversight arrangements relating to care after death
- Seek assurance that deceased people are treated with dignity, security, respect and compassion.
- Ensure clear executive accountability and safeguarding oversight for arrangements relating to the deceased.
- Review compliance with national guidance including Human Tissue Authority requirements, safeguarding frameworks and the NHS Premises Assurance Model.

The submission (appendix 2) was submitted on behalf of the board by the Chief Medical Officer by the required NHS England deadline and confirmed the existing governance arrangements, including the oversight through the South Yorkshire and Bassetlaw pathology Network and the local safeguarding and governance arrangements.

Recommendations

The Board is asked to note the national requirements issued by NHS England on 26th June 2026 and the submission of the Board Assurance Statement by the deadline.

Healthier together – delivering exceptional care for all	
Patients	Supports delivery of care by ensuring dignity compassion and respect continue after death
People	Reinforces accountability and leadership arrangements for colleagues.
Partnerships	Highlights continued partnership with the South Yorkshire pathology network.
Pounds	No direct financial implications.
Health Inequalities	No decision required.
Legal/ Regulation:	Direct implications in relation to Human Tissue Authority.

Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

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Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,





Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

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Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

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For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

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safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

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Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

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Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

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Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

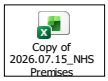
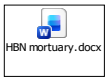
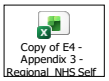
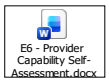
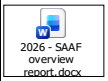
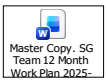
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Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

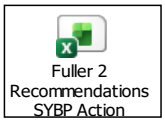
Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

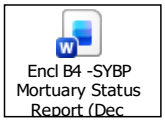
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ANNEX 1 - SUMMARY OF NATIONAL UPDATES MADE OR PLANNED IN RESPONSE TO THE FULLER INQUIRY

No.	SUBJECT	FOR ASSURANCE BY TRUST BOARDS	EVIDENCE
1	**NHS Premises Assurance Model (PAM) (15 April 2026)** The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.	*Trusts should assure themselves against the latest version of the PAM self-assessment questions.*	 Estates have assessed against PAM for public board September 2026. PAM specific for Mortuary outlined in embedded with actions in place.
2	**Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)** Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.	*Trusts should consider best practice guidance set out in the HBN for ongoing planning.*	 No planned adaptations and or new buildings for mortuary planned, however Estates aware of the HBN requirement
3	**Insightful provider board guide (November 2024)** Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).	*Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.*	
4	**Assessing provider capability: guidance for NHS Trust Boards (August 2025)** Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.	*As per Insightful provider board guide (see entry 3).*	 
5	Advanced Foundation Trust Programme (12 November 2025) For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).	*As per Insightful provider board guide (see entry 3).*	n/a unable to apply at this stage given segment
6	**NHS Safeguarding accountability and assurance framework (April 2026)** The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about safeguarding children, adults and children in care. This must be submitted to the trust board. NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026. NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.	*Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.* *In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.* *Local take-up of safeguarding training and resources requires ongoing assurance by trusts.*	   Strategic Safeguarding Group remain the governance route for safeguarding, feeding into PSAG and then to Execs. Annual report to Quality Committee. SAAF process and work plan in place for safeguarding. Exec responsible CN for Safeguarding, Sam Wilde for Estates. Safeguarding training oversighted at SSG and available on information platform (Derrick).
7	**Related Third Party Guidance** HTA Guidance The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores. Hospice UK Guidance Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.		Annette - Davis- Green is the Designated Individual with Dr N Mallaband the Executive internally


Partnership
nent (V2) - Signed


Fuller 2
Recommendations
SYBP Action


Encl B4 -SYBP
Mortuary Status
Report (Dec

ANNEX 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by 31 July 2026 to: england.nhsinquiryteam@nhs.net

Assurance Statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	SYBP managed model. DBTH EOLC team and CN oversight. Internal pathology governance and DCN sits on Quality group for pathology network
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	YES	See Annex 2 docs. The direct mortuary management sits with SYB Pathology and action plan monitoring is through the joint pathology board. An annual report on Mortuary is being produced and is due to come through the DBTH reporting structures to Board
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Chief Nurse is executive lead for safeguarding. SAAF completed and annual report to QC and board
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Chief Nurse and Deputy Chief Nurse unnanounced visits. Chief Nurse reviews all complaints. EOLC team governance process for care of deceased feeds into Patient Safety Assurance Group
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission	Yes	PAM due at Board Sept 2026, Mortuary PAM completed, actions in place SYBP and Estates

Trust Name

Doncaster & Bassetlaw Teaching Hospitals NHS FT

2609 - F4 FIRE SAFETY POLICY

Decision Item | Sam Wilde, Chief FInance Officer | 12:05

5 minutes

REFERENCES

Only PDFs are attached

F4 - Fire Safety Policy.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Fire Safety Policy (CORP/HSFS 14 v.8)**			
Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Matt Gleadall, Operational Director of Estates and Facilities (cover sheet only) Howard Timms, Deputy Director of Estates and Facilities (policy author)			
Appendices:	N/A			
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:** An effective fire safety policy is an important requirement to maintain the safety of patients while under our care. **BAF 4:** The fire safety policy outlines the measures taken by the Trust to maintain fire safety within the organisation, a critical aspect of providing the best care environment for our patients. **BAF 5:** The fire safety policy includes a commitment from the Board to allocate sufficient resources to maintain fire safety within the Trust, which has implications for the Trust's financial position. **BAF 6:** The fire safety policy demonstrates the organisation's commitment to fire safety to partner organisations and regulators.			

Executive Summary – Key messages and Issues

The Trust's Fire Safety Policy (CORP/HSFS 14 v.8) has undergone a scheduled review and been updated in accordance with Trust policy review procedures.

Following advice from the Trust's Fire Safety Authorising Engineer (independent fire safety adviser), the policy has been aligned with the exemplar contained within the Department of Health and Social Care's *Health Technical Memorandum 05-01: Managing Healthcare Fire Safety* (HTM 05-01).

The HTM 05-01 exemplar requires the Chief Executive's signature as confirmation of the Board's acceptance of the policy. To ensure this accurately reflects the Trust's governance arrangements, the policy is presented for approval by the Board.

There are no fundamental changes to the Trust's fire safety arrangements or responsibilities. Amendments from the previous version are limited to formatting and minor revisions to ensure full alignment with the HTM 05-01 exemplar. For clarity, the requirement for the Chief Executive to sign the policy existed in previous versions.

Given the fire safety risks within Doncaster and Bassetlaw Teaching Hospitals, and a change in Chief Executive since the previous review, the Finance and Performance Committee reviewed the policy on the 28th of July 2026, approving its submission to the Board for final approval.

The Fire Safety Policy establishes the Trust's strategic commitment to meeting its statutory obligations under the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum 05-01. It also confirms the Board's expectation that appropriate governance, investment, training, monitoring and fire safety management arrangements remain in place.

The revised policy reflects current national guidance and has been independently reviewed by the Trust's Authorising Engineer (Fire). It was also reviewed and approved by both the Trust Fire Safety Group and the Health and Safety Group prior to submission to the Finance and Performance Committee.

Recommendations	
The Trust Board is asked to review the revised Fire Safety Policy (CORP/HSFS 14 v.8) and approve the addition of the Interim Chief Executive Officer's signature as confirmation of the Board's acceptance of the policy.	
Healthier together – delivering exceptional care for all	
Patients	Supports delivery of a safe healthcare environment by ensuring robust fire safety governance and compliance with statutory duties.
People	Provides a clear governance framework that supports colleagues in understanding their fire safety responsibilities and promotes appropriate training and accountability.
Partnerships	Ensures continued compliance with Department of Health and Social Care guidance and supports effective working with South Yorkshire Fire and Rescue Service, the Trust's Authorised Engineer (Fire) and other external regulators.
Pounds	Supports protection of Trust assets and infrastructure by reducing fire-related risks and ensuring appropriate governance arrangements are maintained.
Health Inequalities	No direct impact has been identified. The policy applies consistently across all Trust services and supports safe care for all patients, staff and visitors.
Legal/ Regulation:	The report supports compliance with the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum 05-01: Managing Healthcare Fire Safety. The revised policy also aligns with current national guidance and recommendations made by the Trust's independent Fire Safety Authorising Engineer.
Partner ICB strategies	No direct impact. The policy supports safe, resilient healthcare delivery across the South Yorkshire Integrated Care System through compliance with statutory fire safety requirements.
Assurance Route	
Previously considered by - including date:	**Trust Fire Safety Group** – Approved 09th April 2026 **Trust Health and Safety Group** – Approved 14th May 2026 **Finance and Performance Committee** – Approved 28th July 2026
Any outcomes/next steps / time scales	The policy was approved for submission to the Trust Board for final approval by the Finance and Performance Committee, subject to a minor amendment to clarify that the Trust Board receives biannual assurance on fire safety via the Health and Safety report to the Finance and Performance Committee. This amendment has been incorporated into the version presented.

Fire Safety Policy

This document supersedes: CORP/HSFS 14 v.7 – Fire Safety Policy



Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Sam Wilde - Director of Finance
Author/reviewer: (this version)	Howard Timms - Deputy Operational Director of Estates and Facilities
Date written/revised:	March 2026
Approved by:	Trust Fire Safety Group and Trust Health and Safety Group
Date of approval:	14 May 2026
Date issued:	[to be inserted by APD Process Co-ordinator]
Next review date:	March 2029
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 8	[to be inserted by APD Process Co-ordinator]	• Change of Executive Sponsor • New format as set out in Appendix A of HTM 05-01: Exemplar Fire Safety Policy. • Updated in accordance with Authorised Engineer (Fire) Fire Safety Audit recommendations May 2025. • Updated in accordance with new HTM 05-01 (PRN02333)	Howard Timms
Version 7	Jan 2023	• Updated into the new APD format. • Change of Executive Sponsor. • Updated in accordance with AE Audit / Comments as follows: - • Revised introduction - The Trust has a commitment to continually monitor Fire Safety precautions throughout all Trust premises and ensure compliance with relevant legislation and DHSC Firecode and other guidance as appropriate. • Revised '4. Implementation' bullet point to read 'To implement **and develop** the Fire Safety Policy'.	Howard Timms
Version 6	8 June 2020	• Policy updated and amended in consultation with the Trust Authorised Engineer Fire Safety. • Policy updated in consultation with the Trust Authorised Engineer Fire Safety and in accordance with the Regulatory Reform (Fire Safety Order) 2005 and DOH HTM 05-01 Managing Healthcare Fire Safety (2015 Edition).	Howard Timms
Version 5	3 May 2016	• Policy updated in consultation with Authorised Engineer Fire Safety and in accordance with DOH HTM 05-01 Managing Healthcare Fire Safety (2015 Edition). • Policy includes reference to proposed Fire Safety Management Protocols.	Howard Timms / John Hubbard
Version 4	22 April 2014	• Purpose changed • Policy put into new format • Lock down taken from main body and added as an appendix • Procedures taken from main body and put as appendices.	David Clayton
Version 3	May 2010	• Definition of Responsible Person changed • Item 7 - Responsible Person changed to Responsible Manager • Item 10 – Reference to legal requirement to report changes in conditions to Responsible Person removed. • All references to Fire Marshals removed.	David Clayton

		• Appendix 1 – Action by Responsible person – ring 2222 and then 999 changed to "Confirm Fire and Rescue Service summoned". • Item 26 – False alarms added • Item 29 – Lockdown Unplanned Care added • Fire action – Montagu – action by telephonist – Responsible Person deleted from contact list.	
Version 2	June 2008	• Major changes made throughout in line with Regulatory Reform Order (Fire Safety) 2005 and the Fire Code HTM 05 suite of documents. • Added Appendix 5 – Arson Guidance Note. • Bleep number changes. • Responsibility for fire changed from 'Nominated Officer (Fire)' to 'responsible person' throughout.	Colin Vickers

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1. PURPOSE / POLICY AIMS

To provide an unambiguous statement of Fire Safety Policy applicable to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) and to premises where patients of DBTH receive treatment of care excluding a single private dwelling.

This Fire Safety Policy aims to minimise the incidence of fire throughout all activities provided by or on behalf of DBTH.

Where a fire occurs, this policy aims to minimise the impact of such occurrence on life safety, the delivery of patient care, the environment and property.

It is vital to the effectiveness of the policy that the policy is available to all colleagues, that they understand its contents and are aware of their own role in ensuring a fire safe environment.

All new colleagues joining the Trust, or other organisations sharing Trust premises, must be made aware of the existence and location of this Policy.

Interim Chief Executive: Date: ……

2. APPLICATION

This policy applies wherever DBTH owes a duty of care to service users' colleagues or other individuals.

3. FACILITATION

The Trust Board accepts its legal obligations to:

- Ensure compliance with its statutory duties under relevant fire safety legislation.
- Discharge its responsibilities as a provider of healthcare, to ensure that suitable and sufficient governance arrangements are in place to manage fire safety related matters.
- Provide appropriate levels of investment in the Estate and personnel to facilitate the implementation of suitable Fire Safety precautions and appropriate levels of Fire Safety Training.
- Facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of Fire Safety were reasonably practicable.

4. IMPLEMENTATION

The Trust Board expects those tasked with managing aspects of Fire Safety to:

- Disseminate the Fire Safety Policy to all staff and make freely available to all parties that are stakeholders in the organisations delivery of a fire safe environment.
- Diligently discharge their Fire Safety responsibilities as befits their position.

- Have in place a clearly defined management structure for the delivery, control, and monitoring of Fire Safety measures.
- Have in place a programme for the assessment and review of Fire Safety Risks and Evacuation Procedures and provide the appropriate levels of investment to mitigate the Risks.
- Where appropriate, ensure that buildings have in place an effective Fire Safety Strategy.
- Develop and implement appropriate Fire Safety protocols, procedures, action plans and control measures to mitigate Fire Risks, comply with relevant legislation and where practicable, codes of practice and guidance.
- Develop and disseminate an appropriate Fire Safety Strategy and Fire Emergency action plans pertinent to each department / building / area to ensure the safety of occupants, protect the delivery of service and as far as reasonably practicable, defend the property and environment.
- Develop and implement a programme of appropriate Fire Safety training for all colleagues.
- Develop and implement monitoring and reporting mechanisms appropriate to the management of Fire Safety.

5. MONITORING

The Fire Safety Policy is a strategic level document and will be reviewed every 3 years or when there has been a significant change to legislation, guidance or Trust business practice.

The Trust Board will monitor the implementation of the policy as follows:

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where reported to
Example: • Number of Fires false alarms and incident reports. • Fire Safety Training Records. • Fire Service Audits reports notices and communications. • Fire Safety Audit Reports. • Independent third-party Authorising Engineer (Fire) reports.	Trust Board	Biannually or as required	Ongoing performance against Fire Safety will be monitored and reported via the Trust Fire Safety Group and the Trust Health and Safety Group. The Trust Board receives information on fire safety through a biannual Health and Safety report to the Finance and Performance Committee.

6. ASSOCIATED TRUST FIRE SAFETY PROTOCOLS

CORP/HSFS 14v.2 Protocol 0 - Fire Safety Management and Governance
CORP/HSFS 14v.7 Protocol 1 - Fire Prevention
CORP/HSFS 14v.7 Protocol 2 - Fire Risk Assessment
CORP/HSFS 14v.7 Protocol 3 - Fire Stopping
CORP/HSFS 14v.7 Protocol 4 - Fire Doors and Door Assembly
CORP/HSFS 14v.7 Protocol 5 - False Alarms and Unwanted Fire Signals

CORP/HSFS 14v.7 Protocol 6 - Fire Strategy Concepts
CORP/HSFS 14v.7 Protocol 7 - Fire Safety Audits
CORP/HSFS 14v.7 Protocol 8 - Response Plans
CORP/HSFS 14v.7 Protocol 9 - Information for the Fire and Rescue Service
(Further Protocols will be added as developed)

7. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

8. REFERENCES

The Regulatory Reform (Fire Safety) Order 2005

Health Technical Memorandum 05-01: Managing healthcare fire safety

The above Health Technical Memorandum sets out recommendations and guidance for the management of fire safety in healthcare buildings. It should be read in conjunction with other Health Technical Memoranda in the Firecode suite.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Fire Safety Policy - CORP/HSFS 14	Estates and Facilities	Howard Timms	Existing policy	10 March 2026

1) Who is responsible for this policy? Name of Division/Directorate: Estates and Facilities

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? All Trust colleagues. The Trust must continually monitor Fire Safety Precautions throughout all Trust Premises to ensure compliance with the Regulatory Form (Fire Safety) Order and the DOH Firecode HTM 05 Series to minimise the incidence of fire.

3) Are there any associated objectives? Legislation, targets national expectation, standards: Regulatory Form (Fire Safety) Order 2005 and the DOH Firecode HTM 05 Series.

4) What factors contribute or detract from achieving intended outcomes? – Trust colleague's awareness

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] – N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: March 2029

Checked by: Sean Tyler - Head of Compliance **Date:** 10 March 26

2609 - F5 2025/26 NHS PREMISES ASSURANCE MODEL

Decision Item | Sam Wilde, Chief FInance Officer | 12:10

10 minutes

REFERENCES

Only PDFs are attached

F5 - NHS Premises Assurance Model Assessment Report 2025-26 (1).pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**NHS Premises Assurance Model (NHS PAM) Assessment Report 2025/2026**			
Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Sean Tyler, Head of Compliance (Estates and Facilities)			
Appendices:	Appendix 1: Safety Hard - Actions Appendix 2: Safety Soft - Actions Appendix 3: Estate Competency - Actions Appendix 4: Patient Experience - Actions			
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** from the outcomes of the NHS Premises Assurance Model (PAM) assessment. The assessment indicates that appropriate systems, governance arrangements and controls are in place to manage estate and facilities risk and compliance across the Trust, with areas where full compliance has not been achieved clearly identified and supported by action plans. However, achieving full compliance is dependent on future capital and revenue investment, meaning that some risks and compliance gaps are likely to remain until the Trust's financial position improves.			
Impacts on Strategic Risks (BAF 1-7)	**BAF1:** If DBTH is not a safe trust, which demonstrates continual learning and improvement, then there is a risk of avoidable harm and poor patient outcomes/experience and possible regulatory action. **BAF2:** If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted, and we would not embed an inclusive culture in line with our DBTH Way. **BAF4:** If DBTH's estate is not fit for purpose, then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues.			

Executive Summary – Key Messages and Issues

The NHS Premises Assurance Model (PAM) is a national framework that provides assurance regarding compliance with statutory, regulatory and mandatory requirements relating to Estates and Facilities services in line with the NHS Constitution right to be cared for in a clean, safe, secure and suitable environment.

The 2025/26 submission represents the first year of a revised PAM methodology from NHS England, moving from a maturity-based assessment framework to a compliance-based model. Under the new approach, organisations must now demonstrate compliance against each requirement through a binary 'Yes' or 'No' assessment, rather than a subjective assessment of their level of compliance as per the previous model. As a result, this year's submission should be viewed as the Trust's baseline position against the new national framework rather than a direct comparison with previous years.

The assessment spans four principal domains: 'Safety - Hard FM', 'Safety - Soft FM', 'Estate Competency' and 'Patient Experience', informed by a total of 47 Self-Assessment Question (SAQ) categories containing a total of 645 compliance questions. Overall, the assessment demonstrates a generally positive compliance position across Estates and Facilities services. Compliance levels achieved for each domain are detailed below:

- Safety Hard FM: 74.8%
- Safety Soft FM: 68.7%
- Estate Competency: 76.5%
- Patient Experience: 85.2%

The assessment identified areas where further improvement is required to achieve full compliance across all other domains, though as detailed within the main report, a number of individual SAQ categories within each domain did also achieve full compliance. A summary of actions required is detailed with Appendices 1 - 4.

The PAM 2026 assessment model requires a financial value to be attributed to actions required to achieve full compliance. The Trust's assessment indicates an estimated capital investment requirement of £99.16m and recurring revenue requirement of approximately £0.59m per annum.

Capital costs are derived from six-facet survey and backlog maintenance data and reflect the investment required to address compliance gaps associated with critical infrastructure risks. These figures differ from the Trust's total backlog maintenance value as they relate only to PAM assessment criteria. They also exclude associated project on costs such as preliminaries, decant requirements, contractor overheads and profit, contingency, professional fees, expenses and VAT. Consequently, the figures are likely to understate the total investment required to achieve full compliance in practice.

Revenue costs are largely attributed to requirements for additional workforce resource and consultancy support to address gaps in compliance in relation to the requirements of Department of Health and Social Care Health Technical Memorandums (HTM's). The Trust's financial position means that it has not been possible to support the business case for increased resource to address these gaps, and as a result areas of Hard FM non-compliance remains, which is reflected in the assessment.

In conjunction to the four domains within PAM, Trusts are also required to complete the UK Government's Facilities Management Standards (FMS) Maturity Assessment. Unlike the PAM assessment, the FMS retains a maturity-based approach. The Trust has retained an overall rating of 'Good' for this assessment.

In summary, the paper provides **Moderate Assurance**. The Trust has robust processes in place to manage infrastructure and Estates and Facilities services, and compliance gaps are well understood with plans in place to drive improvement. However, progress will be influenced by the availability of funding and the need to balance investment across a range of competing estate risks and priorities.

Recommendations

The Board of Directors are asked to:
- **NOTE** the information provided in the report;
- **TAKE MODERATE ASSURANCE** that robust processes are in place to manage infrastructure and Estates and Facilities services at DBTH, with gaps in compliance clearly identified via the Premises Assurance Model with actions in place to improve, while noting that the availability of funding will limit the pace at which improvement is made.; and
- **APPROVE** the submission of the Trust's PAM assessment to NHS England by the deadline of 28th September 2026.

Healthier together – delivering exceptional care for all

Patients	Effective Estates and Facilities management directly supports the Trust strategic focus on patients by ensuring a safe environment for care delivery, minimising risks to patients, colleagues and visitors. This alignment enhances patient outcomes by fostering an

	environment where effective care can be consistently provided without compromise due to safety concerns.
People	Estates and Facilities management underpins our strategic focus on people by protecting the wellbeing of our workforce, enabling staff to deliver high-quality care confidently and consistently. A safe, supported working environment is fundamental to staff engagement, retention, and overall organisational performance.
Partnerships	Continual improvement in Estates and Facilities policies, processes and procedures is evidenced through partnership working with colleagues from external agencies including: - South Yorkshire Fire and Rescue Service (SYFRS), Nottinghamshire Fire and Rescue Service (NFRS), the Health and Safety Executive (HSE), and other Regional NHS Trusts and health care providers.
Pounds	Estates and Facilities management contributes to the Trust strategic focus on finance by reducing the financial impact of accidents, incidents, and associated liabilities. Proactive measures within Estates and Facilities lower costs related to staff absence, legal claims, and service disruption, ensuring more efficient use of resources and better value for public funds.
Health Inequalities	By improving Estates and Facilities management systems, processes and procedures the Trust can directly contribute to reducing the unequal burden of adverse health events experienced by vulnerable communities, ethnic minorities, and other disadvantaged groups, therefore addressing a critical dimension of health inequalities, improving patient safety and clinical outcomes.
Legal/ Regulation:	• The Health and Social Care Act 2008 (Regulated Activities) Regulations • 2010 and the Care Quality Commission (Registration) Regulations 2009. • Health Building Note 00-08. • Health Building Note 00-08: Land and Property Appraisal. • Health and Safety at Work Act 1974 (HASAWA). • Management of Health and Safety at Work Regulations 1999. • The Workplace (Health, Safety and Welfare) Regulations 1992. • The Health and Safety (Display Screen Equipment) Regulations 1992. • The Manual Handling Operations Regulations 1992 (as amended) (MHOR). • The Personal Protective Equipment at Work Regulations 1992. • The Provision and Use of Work Equipment Regulations 1998. • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). • The Control of Substances Hazardous to Health Regulations 2002. • Safety Representatives and Safety Committees Regulations 1977. • Health and Safety (Consultation with Employees) Regulations 1996.
Partner ICB strategies	N/A
Assurance Route	
Previously considered by - including date:	None
Any outcomes/next steps / time scales	Continual Annual reporting the PAM to Board. Annual reporting to Finance and Performance and quarterly reporting to the Trust Health and Safety Group.

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1. Introduction

The paper provides an overview of the NHS Premises Assurance Model (PAM) assessment for Doncaster and Bassetlaw Teaching Hospitals (DBTH) for 2025/26. The PAM framework has undertaken a significant revision since the last assessment, moving from a maturity-based assessment to a compliance-based model. As a result, this year's submission should be viewed as the Trust's baseline position against the new national framework rather than a direct comparison with previous years.

2. Premises Assurance Model (PAM) 2025/26

2.1 What has changed

The NHS Premises Assurance Model (PAM) previously adopted a maturity-based approach, demonstrating progress even when full compliance had not yet been achieved by grading compliance on a range from 'Inadequate' to 'Outstanding'. Whilst useful for monitoring progress, the approach relied heavily on individual professional judgement, risking variation in interpretation between organisations.

The revised methodology adopts a binary approach, requiring organisations to answer either 'Yes' or 'No' against each compliance requirement. Partial compliance is no longer recognised. If a requirement is not fully met, evidenced and embedded, it cannot be recorded as compliant, regardless of how close the organisation may be to achieving full compliance.

It is important to note this change when reviewing the results of the assessment. The compliance scores should not be interpreted as measures of operational safety or service quality in isolation. Rather, they simply represent the extent to which the Trust has been able to demonstrate 'full' compliance against the assessment criteria.

The intention of the new PAM format is to provide a stronger and more objective assurance tool for Trust Boards. It aims to provide greater transparency regarding the distinction between established compliance and areas where assurance arrangements require further development.

Whilst the Premises Assurance Model has been revised, the robust approach to the assessment taken at DBTH has been maintained. Leads for each self-assessment question (SAQ) category are required to provide evidence to support compliance assessments. The rationale and rating of each SAQ is also scrutinised and challenged consistently through ongoing quarterly PAM working groups, which involve constructive challenge to ensure that a robust, accurate and transparent assessment is maintained.

Consequently, while the revised methodology has introduced a more stringent approach to assessing compliance, the Trust remains confident that its PAM self-assessment process is rigorous, evidence-based and subject to appropriate challenge. The ratings submitted therefore represent a balanced and transparent assessment of compliance against the revised standards.

2.2 Scope of the Assessment

The 2025/26 PAM assessment comprises four domains containing 47 SAQ categories and 645 individual compliance questions (table 1).

Table 1: The 2025/26 PAM Domains, SAQ's and Compliance Questions

PAM Domain	SAQ's	Compliance Questions
Safety Hard FM	23	314
Safety Soft FM	8	146
Estate Competency	12	168
Patient Experience	4	17
Total	**47**	**645**

As table 1 demonstrates, the assessment is weighted towards 'Safety – Hard FM', with almost half of all SAQ's and compliance questions attributed to this domain. These typically relate to statutory compliance and assurance in relation physical infrastructure and engineering services.

The 'Safety – Soft FM' domain primarily focuses on operational facilities services such as catering, cleaning, linen and laundry, and portering.

'Estates Competency' is a new domain, replacing 'Efficiency, Effectiveness and Organisational Governance' from the old framework. This domain focuses on how well Estates and Facilities services are managed, how robust the processes and procedures are for managing the services, and how efficient and effective these processes are.

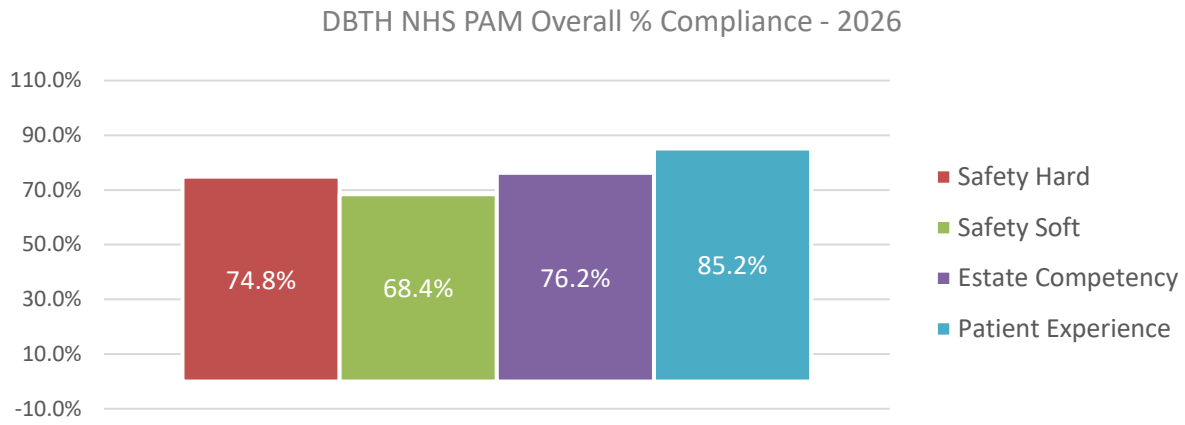
The Patient Experience domain contains fewer questions than the previous three but remains an important component of assurance because of its direct impact on patients, visitors and colleagues.

The breadth of the assessment provides assurance that the PAM assessment considers a wide range of Estates and Facilities responsibilities, encompassing statutory compliance, operational service delivery, governance arrangements and patient experience. The assessment therefore represents a significant organisation-wide assurance exercise rather than a simple compliance return.

3. DBTH PAM Assessment 2025/26

Figure 1 below provides a summary of the Trust's overall compliance against the new PAM assessment criteria. Domain compliance ratings are generated automatically from the PAM assessment upon completion of all compliance questions.

Figure 1: DBTH Overall PAM Compliance Ratings 2025/26



To reiterate, a score of less than 100% indicates that one or more assessment criteria could not be evidenced as fully compliant. It does not necessarily indicate a complete lack of compliance in those areas where the threshold for full compliance was not met. For example, a score of 74.8% simply means that the Trust was able to demonstrate full compliance against 74.8% of the assessment criteria. The revised methodology does not distinguish between elements that are close to compliance and those requiring more substantial improvement.

A summary of the actions required to improve compliance within domains scoring less than 100% is provided in Appendices 1-4. These actions provide additional context regarding the scale of the gaps identified and will inform improvement plans monitored through the relevant quarterly PAM Working Groups.

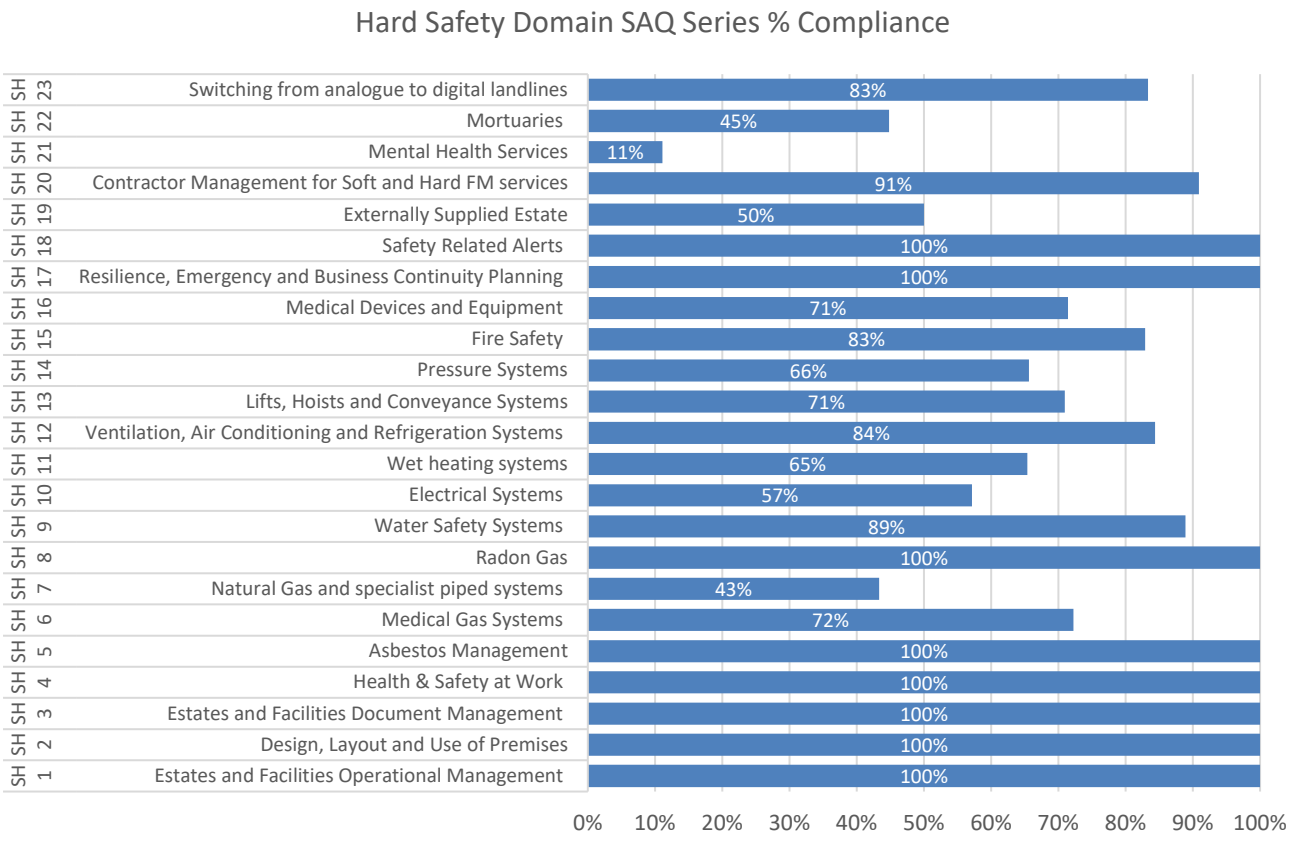
The assessment highlights the challenges associated with managing a complex and aging estate across multiple sites. A number of the compliance gaps are linked to aging infrastructure, engineering resilience, limitations in specialist workforce capacity and competency, and the need to strengthen documented assurance processes in response to increasing requirements for oversight and governance. Not all of these findings are necessarily unique to the Trust and reflect wider challenges faced across the NHS estate nationally, although the deficit in estates workforce and backlog levels at the DRI site impacts Trust scores.

Overall, the results demonstrate that the Trust is meeting many of the requirements set out within the PAM framework, whilst identifying areas where further work or investment is required to achieve full compliance. The assessment therefore provides a clear evidence base to prioritise improvement activity, support future investment decisions, and inform targeted action plans to strengthen compliance and assurance across Estates and Facilities services.

4. Safety Hard FM Domain

The ‘Safety Hard FM' domain provides assurance regarding statutory compliance and the management of critical estate infrastructure. This includes engineering systems such as electrical services, water safety, ventilation, medical gases, fire safety, pressure systems and lifts. It represents the area of PAM most closely associated with backlog, infrastructure risk, health and safety, and patient safety. Figure 2 below provides a summary of compliance against each SAQ.

Figure 2: Safety Hard FM Domain SAQ’s and Compliance Ratings 2025/26



The data confirms high levels of compliance in a number of areas, with 39% of SAQ’s (9 of 23) achieving full compliance against all elements and 57% (13 of 23) achieving full compliance against at least 80% of the assessment criteria.

The low score for SAQ 21 (Mental Health) should be viewed in context. Much of the assessment is geared towards dedicated mental health facilities, which DBTH does not provide as an acute trust. As a result, several requirements are either not applicable or cannot be fully evidenced, meaning the score reflects the limited relevance of parts of the framework rather than a significant compliance concern.

A summary of actions required to improve compliance is provided in Appendix 1. This information will now inform action plans managed via quarterly PAM Working Groups. The information will also inform future business planning initiatives in Estates and Facilities.

Whilst the assessment clearly identifies where improvement is required to achieve full compliance, resource constraints remain a barrier to progress. Several of the non-compliances within the Safety Hard FM domain relate to a shortage of suitably qualified engineering staff to undertake Authorised Person (AP) and Competent Person (CP) roles. Consequently, qualified individuals have to provide cover across multiple disciplines, reducing their capacity to fully undertake the responsibilities and assurance activities prescribed within HTM guidance. This creates an ongoing challenge in maintaining compliance and evidencing assurance across all specialist areas.

The impact of resource constraints on compliance has also been identified through an Estates service review and is routinely highlighted during external Authorising Engineer (AE) audits. A business case identifying an increase in funding of circa £800k per annum for additional resource to address these gaps was previously presented to the Trust's Corporate Investment Group (CIG) but was unable to be supported due to the Trust's financial position. Further detail is provided in the finance section of this report.

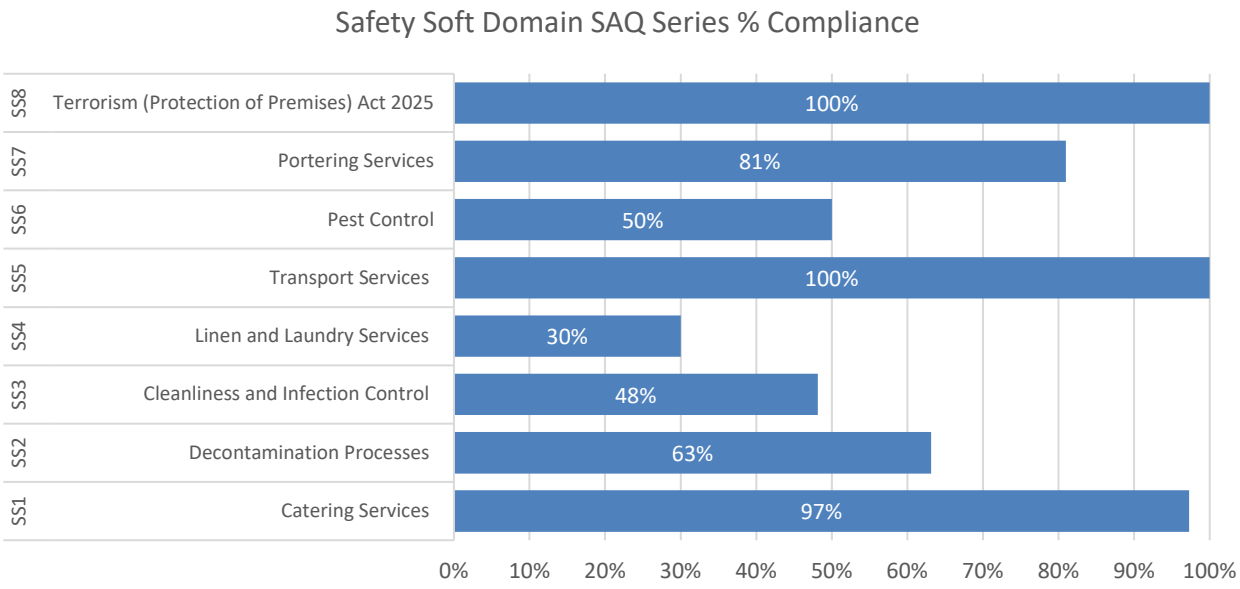
The Safety Hard FM assessment also highlights the challenge associated with aging healthcare infrastructure. Although statutory and essential maintenance regimes remain in place and risks are actively managed, some compliance requirements will only be fully resolved through continued investment in infrastructure replacement, backlog maintenance reduction, and estate modernisation programmes. Consequently, a number of actions arising from PAM are likely to align closely with existing and future capital planning and estate strategy priorities, including the ongoing development of a business case to refurbish the East Ward Block at DRI.

Overall, the assessment demonstrates a strong level of baseline compliance across the Safety Hard FM domain and provides an evidence-based understanding of the areas requiring further development. Whilst gaps in compliance remain, many are linked to resourcing limitations, aging infrastructure and the more stringent binary assessment methodology rather than fundamental deficiencies in the effectiveness of services. The findings and associated action plans will enable the Trust to target improvement activity, prioritise investment and strengthen compliance over time, whilst maintaining safe, resilient and well-managed estate and facilities services.

5. Safety Soft FM Domain

The ‘Safety Soft FM’ domain provides assurance regarding the safe delivery of facilities services that support patient care and daily operational activity across the Trust. This includes a number of SAQ’s such as catering and food safety, decontamination services, cleaning and infection prevention, linen and laundry services, transport services and portering. The full list of SAQ’s is illustrated in figure 3. These services have a direct impact on patient safety, infection prevention, service continuity and patient experience.

Figure 3: Soft Safety Domain SAQ's and Compliance Ratings 2025/26



The Trust was able to demonstrate full compliance in two of the eight SAQ's (25%), with catering only falling marginally below the required standard at 97%. In total, half of the SAQ's achieved full compliance across at least 80% of the assessment criteria.

Full compliance could not be evidenced against the revised requirements across a number of areas. The most significant gaps were identified in relation to cleaning and infection control, linen and laundry services, decontamination processes and pest control management. In most cases, services are operating effectively but improvements are required in supporting documentation, oversight and governance to reach the threshold outlined for full compliance.

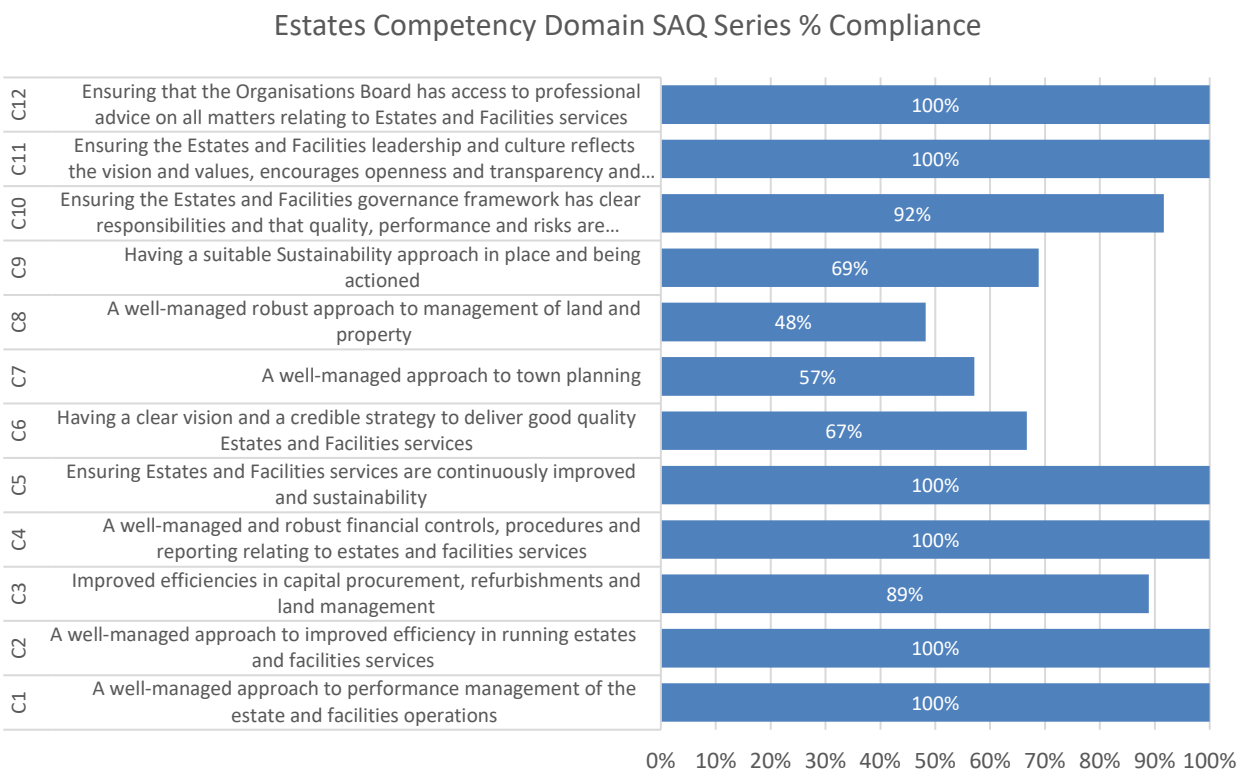
Actions required to close gaps in compliance in the Safety Soft FM domain are detailed within Appendix 2 and progress against these actions will continue to be monitored through the quarterly PAM Working Group.

Overall, the assessment demonstrates a strong level of compliance across some elements of the Safety Soft FM domain, with most requirements either fully met or requiring relatively minor improvements to achieve full compliance. Where compliance is lower, the gaps identified are largely associated with evidencing, governance and assurance processes rather than fundamental service delivery concerns. The findings provide a clear focus for targeted improvement activity and will support the continued development of safe, effective and well-governed support services across the Trust.

6. Estate Competency Domain

The Estate Competency domain evaluates the management capability required to lead, govern and continuously improve Estates and Facilities services. It focuses on leadership, governance, workforce capability, strategic planning, sustainability, financial control and broader estate management arrangements. The full suite of SAQ's included within this domain are displayed in figure 4.

Figure 4: Estate Competency Domain SAQ's and Compliance Ratings 2025/26



The assessment for this domain demonstrates strong leadership arrangements across Estates and Facilities services, with full compliance recorded in half of the SAQs (6 of 12) and at least 80% of the assessment criteria met in 67% of SAQs (8 of 12).

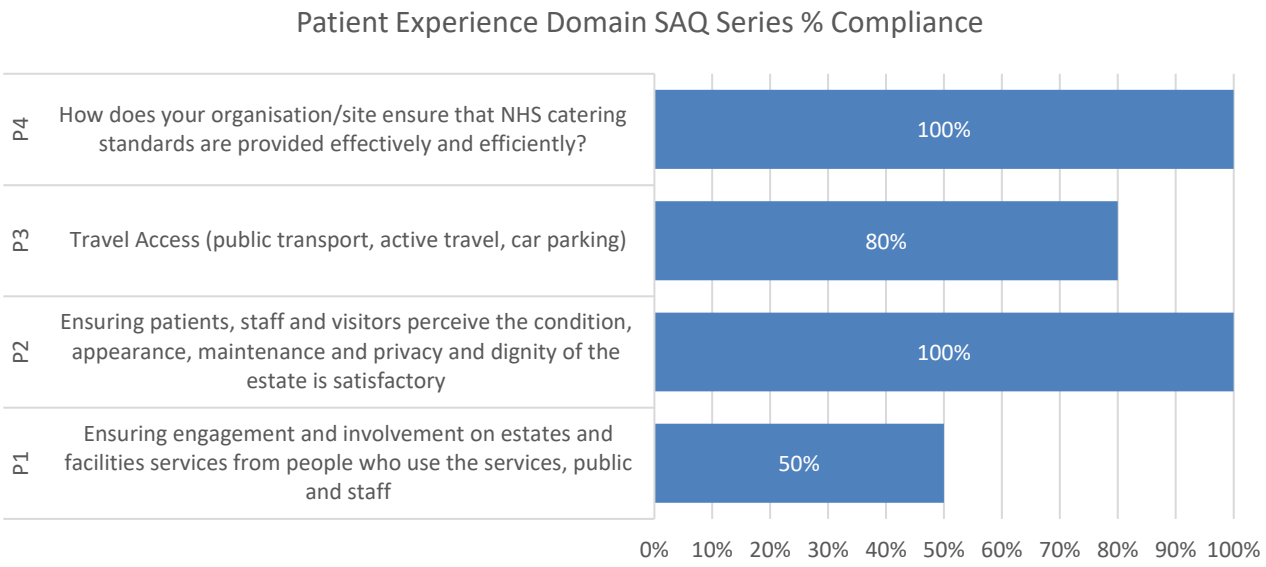
Governance structures are well established and there is evidence of appropriate Board oversight, financial control and strategic direction. The Trust also performed strongly in areas associated with sustainability, organisational leadership, and continuous improvement. These findings indicate that Estates and Facilities services are operating within a mature governance framework with clear accountability and executive visibility.

The main areas requiring further development to achieve full compliance relate to strategic estate management activities. The assessment identified opportunities to strengthen arrangements relating to land and property management, town planning processes and estate strategy documentation. Work is underway within each of these areas, but further enhancement is required to achieve the threshold for full compliance as defined within the revised assessment.

7. Patient Safety and Patient Experience Domain

The Patient Experience domain represents our strongest performing area, achieving 85.2% against all applicable assessment criteria (Figure 5).

Figure 5: Patient Experience Domain SAQ's and Compliance Ratings 2025/26



Two of the four SAQs (50%) achieved full compliance against all assessment criteria indicating that effective mechanisms are in place in relation to catering and the patient environmental. Of the remaining SAQs, Travel Access achieved compliance against four of its five SAQ's (80%), whilst Engagement and Involvement achieved compliance against two of its four SAQ's (50%). Actions required to achieve full compliance within the remaining assessment criteria are detailed within Appendix 4.

The findings also demonstrate that Estates and Facilities services continue to make a positive contribution to the Trust's wider objectives of quality, safety and patient satisfaction. This performance reflects ongoing efforts to ensure that Estates and Facilities is recognised not simply as a corporate support function, but as a key contributor to the delivery of safe and effective patient care at DBTH.

8. Financial Cost to Achieve Full Compliance

Where investment is required to achieve full compliance within an element of the assessment, the Premises Assurances Model requires estimated costs to be entered. Table 2 provides a breakdown of the estimated capital and revenue investment requirement for DBTH.

Table 2: Finance Costs for Compliance 2025/26

Area	PAM Domain	2025/26 Capital	2025/26 Revenue
SH6	Medical Gas Systems	£4,353,715	£0
SH9	Water Safety Systems	£7,077,353	£115,295
SH10	Electrical Systems	£16,046,693	£129,606
SH11	Wet heating systems	£7,734,972	£66,043
SH12	Ventilation, Air Conditioning and Refrigeration Systems	£11,555,139	£115,295
SH13	Lifts, Hoists and Conveyance Systems	£8,158,878	£49,252
SH14	Pressure Systems	£113,192	£66,043
SH15	Fire Safety	£44,020,723	£0
SH19	External Estates and Facilities Services	£0	£5,000
SH22	Mortuaries	£0	£13,000
C3	Improved efficiencies in capital procurement, refurbishments and land management	£100,000	£0
C7	Well-managed approach to town planning	£0	£10,000
C8	Well-managed robust approach to management of land and property	£0	£20,000

These costs are based on existing data sources including six facet survey information, the Estates workforce review business case and other data sources gathered throughout the PAM assessment process.

Capital costs are largely associated with the replacement of high-risk critical infrastructure and other infrastructure improvements to achieve compliance with current standards.

Costs are based on six facet survey information as reported via the Trust's annual ERIC return. It should be noted that ERIC figures exclude associated project on-costs, including preliminaries, decant requirements, contractor overheads and profit, contingency allowances, professional fees, expenses and VAT. This is because these costs cost cannot be determined accurately until a project is in development. Consequently, the reported figures do not fully describe the actual investment required to remove the identified critical infrastructure risks and achieve compliance in practice.

Revenue costs are a combination of funding requirements for resource to close gaps in Hard FM compliance as identified in the Estates workforce review business case, consultancy support to further develop town planning and land and property management, and security measures to achieve full compliance with updated requirements within mortuaries.

9. Facilities Management Standard (FMS) Maturity Frameworks – 2025/26

The UK Government Facilities Management Standards (FMS) Maturity Framework remains a component of the NHS Premises Assurance Model, providing a standardised framework for assessing Facilities Management capability, governance and asset information management within the public sector.

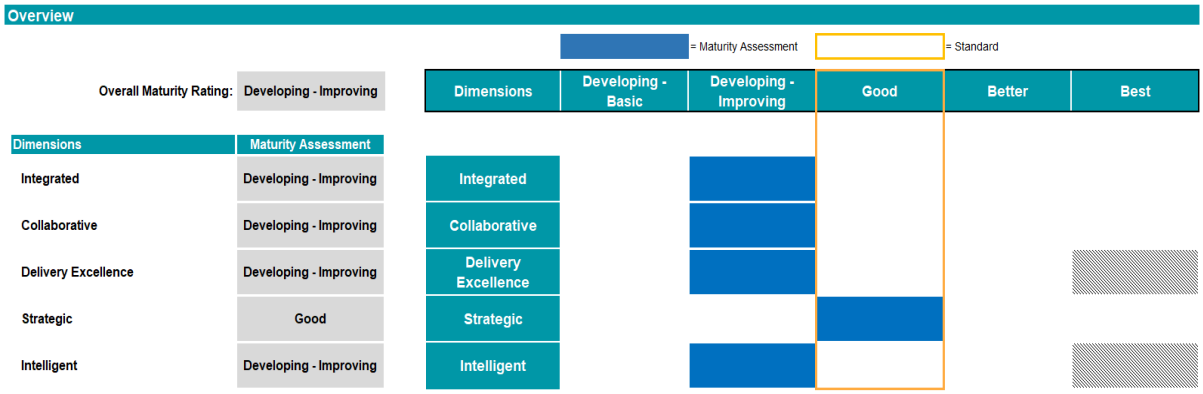
The framework consists of two self-assessment elements, FMS 001 and FMS 002. The assessments were undertaken by the Estates and Facilities Management team and peer reviewed by Southwest Yorkshire Partnership NHS Foundation Trust to provide additional assurance regarding the consistency and accuracy of scoring.

9.1 FMS 001: Management and Services Maturity

FMS 001 assesses organisational maturity across key Facilities Management disciplines, including leadership, governance, strategy, integration and service delivery.

The 2025/26 assessment remains consistent with the previous year's assessment. The Trust continues to achieve a 'Good' maturity rating within the 'strategic' category, reflecting alignment between Estates and Facilities priorities and wider organisational objectives. All other categories remain at the 'Developing/Improving' level, indicating that while effective arrangements are in place, opportunities remain to further strengthen integration, performance management and service intelligence.

Figure 6: FMS 001: Management and Services Maturity 2025/26

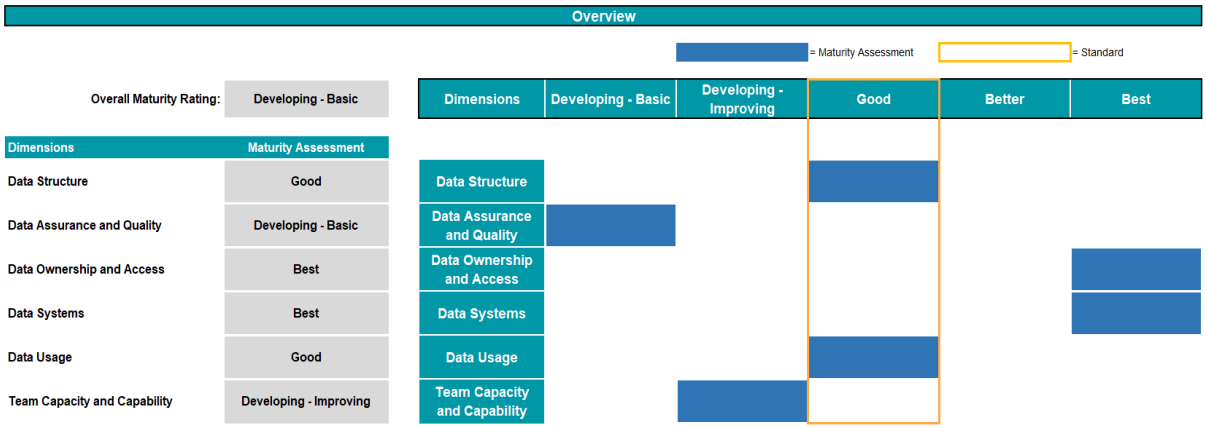


9.2 FMS 002: Asset Data Maturity

FMS 002 assesses the effectiveness of asset information management arrangements and the extent to which asset data supports operational, compliance and investment decision-making.

The 2025/26 assessment again remained unchanged from the previous year, with 'Data Ownership and Access' and 'Data Systems' achieving 'Best' ratings and 'Data Structure' and 'Data Usage' achieving 'Good' ratings.

Figure 7: FMS 002: Asset Data Maturity 2025/26



The summary ratings for both FMS 001 and FMS 002 are 'Good', represented in Figure 6 and Figure 7 by the yellow box outlining the good column. The summary is auto generated by the FMS model.

The FMS assessment findings are used during business planning to develop strategic improvement initiatives. An example of which is a current workstream to modernise the Trust's Computer Aided Facility Management (CAFM) software to ensure that the beneficial efficiencies and increased effectiveness presented by modern systems are fully utilised at DBTH in line with the Trust's strategic ambition to become a digitally enabled and mature organisation.

The Trust's long-term objective remains to achieve a minimum 'Good' maturity rating across all individual FMS elements.

10. Conclusion

The 2025/26 PAM assessment establishes the Trust's baseline position against the revised national compliance-based framework and provides a clear understanding of where further work is required to achieve full compliance.

The assessment demonstrates that established governance arrangements, management systems and assurance processes are in place to support the safe and effective delivery of Estates and Facilities services across the Trust.

The results indicate strong levels of compliance across many areas of the assessment; however, further work is required to strengthen compliance within elements of the Safety Hard FM, Safety Soft FM, Estates Competency and Patient Experience domains. The gaps identified relate primarily to workforce resilience, governance maturity, assurance documentation, policy compliance and evidencing arrangements, rather than fundamental concerns regarding service delivery or operational safety.

The assessment also highlights a number of challenges where the pace of progress will be driven to some extent by the availability of both capital and revenue funding. These include critical infrastructure risks arising from the Trust's aging estate, engineering resilience, workforce capacity

and specialist competency requirements. Whilst these factors are likely to continue to influence compliance ratings until the funding requirements outlined in the finance section of the report can be addressed, the assessment provides a clear evidence base to support future investment decisions, prioritise improvement activity and strengthen compliance over time.

Importantly, the assessment should be considered in the context of a significantly more stringent national assessment methodology. Under the revised approach, any requirement that does not meet the threshold for full compliance must be recorded as non-compliant, regardless of how minor the remaining gap may be. Consequently, the assessment should be viewed as a measure of demonstrated compliance against the national framework rather than a direct measure of service quality or operational effectiveness.

The actions identified through both the PAM and FMS assessment processes have been incorporated into existing Estates and Facilities work programmes and will continue to be monitored through local PAM Working Groups, Trust Health and Safety Group, the Finance and Performance Committee (F&P) and Board reporting arrangements throughout 2026/27.

Overall, the assessment provides Moderate Assurance that statutory and mandatory requirements relating to the Trust's estate and Estates and Facilities services are being met. Robust management and oversight arrangements are in place, and gaps in compliance are well understood, acknowledged and supported by clear action plans. Progress will continue to be monitored through existing governance arrangements, but some compliance gaps are likely to remain in the short to medium term unless the Trust's financial position improves significantly.

Appendix 1: Safety Hard - Actions

Safety Hard FM - Main Section Questions - SAQ's		SAQ Compliance %	Actions Required
SH6	Medical Gas Systems	72%	• Implement a robust business continuity and emergency response plan for Medical Gas Systems. • Complete outstanding Medical Gas training and competency updates for Estates staff and relevant Trust personnel. • Strengthen risk management arrangements, ensuring audit actions are recorded, monitored and escalated through the risk register where required. • Review and close overdue audit actions, with clear delivery timescales and governance oversight. • Maintain effective governance and compliance monitoring through the Medical Gas Working Group and Safety Group.
SH7	Natural Gas and specialist piped systems	43%	• Develop and implement a compliant management policy and business continuity arrangements for Natural Gas and Specialist Piped Systems. • Review and address training and competency requirements, including contractor assurance and competent person arrangements. • Establish formal governance arrangements, including a safety group and competent person register. • Complete and maintain risk assessments, independent audits and associated action plans. • Ensure all outstanding and high-risk actions are tracked, reported and managed through the risk register until completed.
SH9	Water Safety Systems	89%	• Close or formally manage all outstanding actions over 12 months old, recognising that some actions require capital funding and are being managed through approved action plans and the Trust risk register. • Complete all outstanding statutory PPMs and maintain compliance through ongoing performance monitoring and planned maintenance management. • Continue governance and risk register oversight to ensure delivery of long-term improvements, capital-funded actions and outstanding compliance requirements.
SH10	Electrical Systems	57%	• Complete outstanding training, competency assessments and refresher training for Electrical Authorised Persons and relevant Estates staff. • Establish/reinstate the relevant governance group with agreed terms of reference. • Maintain and develop the electrical safety governance framework, ensuring competent persons, training records and compliance arrangements are regularly reviewed. • Continue monitoring electrical systems through the asset register, business continuity arrangements and statutory maintenance programme to maintain compliance and assurance

SH11	Wet heating systems	65%	• Update and maintain site plans and system schematics for all wet heating systems. • Establish a formal Wet Heating Safety Group to provide governance and compliance oversight. • Complete and regularly review Wet Heating risk assessments to identify and manage system risks. • Strengthen incident reporting and monitoring processes for wet heating system failures and service disruptions. • Implement an annual independent audit programme, ensuring actions are tracked, monitored and completed through appropriate governance arrangements. • Clear the PPM/statutory testing backlog and confirm compliance is up to date.
SH12	Ventilation, Air Conditioning and Refrigeration Systems	84%	• Develop/update and test the relevant business continuity plan(s) within 12 months. • Produce/update site plans and system schematics and ensure they are accessible. • Complete/update risk assessments, record mitigations, and add to the risk register. • Bring the estates action plan/backlog up to date, tracking multi-year projects separately.
SH13	Lifts, Hoists and Conveyance Systems	71%	• Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Appoint and formally record the required Authorised/Competent/Responsible Persons. • Review incident data and evidence any mitigating actions taken. • Bring the estates action plan/backlog up to date, tracking multi-year projects separately.
SH14	Pressure Systems	66%	• Review, approve and reissue the relevant policy/procedure within its review timescale. • Develop/update and test the relevant business continuity plan(s) within 12 months. • Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Produce/update site plans and system schematics and ensure they are accessible. • Establish/reinstate the relevant governance group with agreed terms of reference. • Complete/update risk assessments, record mitigations, and add to the risk register. • Review incident data and evidence any mitigating actions taken. • Bring the estates action plan/backlog up to date, tracking multi-year projects separately. • Clear the PPM/statutory testing backlog and confirm compliance is up to date.
SH15	Fire Safety	83%	• Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Produce/update site plans and system schematics and ensure they are accessible. • Complete/update risk assessments, record mitigations, and add to the risk register. Ensure this complies with HTM 05-03.
SH16	Medical Devices and Equipment	71%	• Bring the estates action plan/backlog up to date, tracking multi-year projects separately. • Clear the PPM/statutory testing backlog and confirm compliance is up to date.

SH19	Externally Supplied Estate	50%	• Develop (or review and update) an approved policy/procedure for Hard FM services provided by others. • Establish (or improve) a structured, well-organised filing/document management system for Hard FM services provided by others.
SH20	Contractor Management for Soft and Hard FM services	91%	• Ensure incidents relating to contractor management are captured on the Trust's incident reporting system (Datix), reviewed, and that any resulting mitigations are actioned and fed back into the risk register, in line with HTM 00, the CDM Regulations 2015 and the Health and Safety at Work etc. Act 1974.
SH21	The built environment - Reducing harm by ligature in practice	11%	• Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Establish/update the relevant register(s) and keep them current. • Review incident data and evidence any mitigating actions taken. • Clear the PPM/statutory testing backlog and confirm compliance is up to date.
SH22	Mortuaries	45%	• Undertake/schedule the required audit(s) and retain records. • Address the specific gap identified and retain evidence to demonstrate compliance. • Review, approve and reissue the relevant policy/procedure within its review timescale. • Undertake/schedule the required audit(s) and retain records. Ensure this complies with HBN16-01. • Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records.

Appendix 2: Safety Soft - Actions

Safety Soft FM - Main Section Questions - SAQ's		SAQ Compliance %	Actions Required
SS1	Catering Services	97%	• Establish (or refresh) a training and competence programme for all management level staff trained to Level 4 hygiene within Sodexo Catering Services, aligned to the Food Safety Act 1990, Food Hygiene (England) Regulations 2006, HACCP principles and the NHS England Standards for Healthcare Food and Drink (2022). Maintain a training matrix/needs analysis, attendance registers and certificates, and schedule refresher training so records remain current.
SS2	Decontamination Processes	63%	• Review, approve and reissue the relevant policy/procedure within its review timescale, needs review to reflect outsource Steris and review endoscopy section. • Review RA and update decontamination arrangements and secure sign-off via the Decontamination Group. Ensure this complies with Health Technical Memorandum 01-01 to 06. • Review relevant contracts/SLAs and strengthen terms/KPIs where needed. • Steris contract has been desktop tested-Telephone exercise undertaken for prevention of cancelled op process but not testing of full shutdown process.
SS3	Cleanliness and Infection Control	48%	• Review, approve and issue the draft policy/procedure within its review timescale. Ensure this complies with Health Building Note 00-09. • Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Appoint and formally record the required Authorised/Competent/Responsible Persons. • Complete/update risk assessments, record mitigations, and add to the risk register. • Address the specific gap identified and retain evidence to demonstrate compliance. • Develop/update and test the relevant business continuity plan(s) within 12 months. • Undertake/schedule the required audit(s) and retain records.
SS4	Linen and Laundry Services	30%	• Review, approve and issue the draft policy/procedure within its review timescale. • Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records. • Review and update decontamination arrangements and secure sign-off via the Decontamination Group. • Complete/update risk assessments, record mitigations, and add to the risk register. • Address the specific gap identified and retain evidence to demonstrate compliance. • Review relevant contracts/SLAs and strengthen terms/KPIs where needed. • Develop/update and test the relevant business continuity plan(s) within 12 months.

SS6	Pest Control	50%	• Complete/update risk assessments, record mitigations, and add to the risk register. • Develop/update and test the relevant business continuity plan(s) within 12 months. Ensure this complies with Refer to Public Health Act 1961. • Review relevant contracts/SLAs and strengthen terms/KPIs where needed.
SS7	Portering Services	81%	• Close staff training gaps: identify affected staff, deliver/refresh training, and maintain records, medical gas training required. • Complete/update risk assessments, record mitigations, and add to the risk register. • Update and test the relevant business continuity plan(s) within 12 months. • Ensure assets, equipment and plant are routinely maintained, and complies with Safety at Work Regulations 1990, provide evidence.

Appendix 3: Estate Competency – Actions

Estate Competency - Main Section Questions - SAQ's		SAQ Compliance %	Actions Required
C3	Improved efficiencies in capital procurement, refurbishments and land management	89%	•Identification and disposal of surplus land, introduce/improve benchmarking using recognised sector metrics/KPIs. •Net Zero Carbon - heat decarbonisation plans, produce plans as required, retain evidence to demonstrate compliance.
C6	Having a clear vision and a credible strategy to deliver good quality Estates and Facilities services	67%	• Improve staff engagement/feedback mechanisms and evidence staff understanding. • Develop/refresh the relevant strategy and secure governance sign-off. • Address the specific gap identified and retain evidence to demonstrate compliance.
C7	A well-managed approach to town planning	57%	• Develop planning and development procedures aligned with HBN 00-08. • Introduce monitoring of neighbourhood planning consultations. • Develop procedures for responding to statutory planning matters. • Develop a formal heritage management procedure. • Formalise inspection and occupation review procedures. • Draft a formal process into a Policy and Procedures Document.
C8	A well-managed robust approach to management of land and property	48%	• Formalise and document the Trust's disposal process within a written procedure or policy. • Develop a policy requiring consideration of District Valuer involvement in accordance with HBN 00-08 and NHS England guidance. • Introduce routine inspections and undocumented occupation reviews. • Produce guidance for responding to CPO and TVG matters. • A Policy is needed to embody the process as no documented process exists at the time of this assessment. • Produce a Property Management Policy covering occupational agreements.
C9	Having a suitable Sustainability approach in place and being actioned	69%	• HTM07-02 compliance (Energy) – Assess and record % compliance; close gaps; keep monitoring reports and board papers as evidence. • Energy policy review – Check it's been reviewed in the last 2 years against current guidance; refresh and evidence if not. • Waste training – Maintain a training plan and needs analysis for relevant staff; keep attendance records. • Waste resilience/BC planning – Assess resilience risks, test emergency/BC plans, log results and update plans.

			• Water leak detection – Confirm it's considered in all construction/development work and after leaks; reference in the Net Zero plan. • Climate Change Risk Assessment – Complete the NHS tool; document risks, mitigations, owner, review date. • Risk register (climate) – Ensure flooding/heat risks are logged and kept current on the Trust risk register. • NHS Flood Risk Tool – Complete it and use output to inform the flood risk assessment. • Biodiversity Net Gain – Confirm it's factored into planning applications; keep compliance records and sign-off minutes. • Biodiversity Strategy – Optional; if pursued, get Board approval and an implementation plan. • Staff climate awareness – Provide training aligned to CQC Well-led; retain records and governance sign-off.
C10	Ensuring the Estates and Facilities governance framework has clear responsibilities, and that quality, performance and risks are understood and managed	92%	• Develop (or refresh) an approved strategy for estates and facilities governance, produced with stakeholder input, communicated to staff, and monitored through regular progress reporting, in line with the Trust's governance framework, corporate risk register and internal audit programme. • Commission a regular (at minimum annual) audit of estates and facilities governance, in line with the Trust's governance framework, corporate risk register and internal audit programme, and retain the audit report/certificate and audit schedule/programme as evidence of ongoing assurance.

Appendix 4: Patient Experience – Actions

Patient Experience - Main Section Questions - SAQ's		SAQ Compliance %	Actions Required
P1	Ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff.	50%	• Review current arrangements for engagement and involvement of service users and staff against NHS statutory guidance on patient and public engagement (Working Together). • Review all new patient experience related groups/subgroups and reporting structures to sub-Board committees • Review the current PEG group membership and ToR • Close any gaps identified, assign a named owner and target date for delivery. To be monitored through the PAM quarterly working groups.
P3	Travel Access (public transport, active travel, car parking).	80%	• Draft Car Parking Policy requires review and ratification. • Draft Sustainable Travel and Transport Plans require review. • Update and approval following Sustainable Travel and Transport organisational refresh survey. • Complete submission to Modeshift STARS for Travel plan accreditation on all three Trust sites DRI, MH and BH

2609 - G POUNDS

12:20

2609 - G1 2025/26 ANNUAL REPORT & ACCOUNTS

Information Item | Sam Wilde, Chief Finance Officer | 12:20

5 minutes

Link to the Annual Report & Accounts

REFERENCES

Only PDFs are attached

G1 - 2025-26 Annual Report and Accounts.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	1 September 2026
Report Title/ Ref:	**DBTH Annual Report and Accounts 2025/2026**		
Executive Sponsor:	Zara Jones, Deputy Chief Executive Sam Wilde, Chief Finance Officer		
Authors:	Yasmin Ahmed, Deputy Director of Finance Matthew Bancroft Associate Director of Finance		
Appendices:	N/A		
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information** ~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF5 - If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term.		

Executive Summary – Key messages and Issues

The final DBTH Annual Report and Accounts for 2025/26 were submitted to Parliament on Friday 17th July 2026 following completion of the external audit. The various documents were authorised by relevant Trust officers using the authority delegated to them by the Trust Board on 7th July 2026.

The Audit and Risk Committee at its meeting on 23 June 2026, approved the 2025/26 Annual Report and delegated authority to the Chair and Chief Finance Officer to approve DBTH Annual Accounts and Financial Statements 2025/26 including Going Concern Statement, subject to receipt of the complete IAS 260 report.

The final version of the DBTH 2025/26 Annual Report and Accounts submitted to Parliament is provided to the Board (via the Document Forum on Team Engine) for information and will not be publicly available until Parliament's approval, after which it will be published on the Trust's website.

The Parliament-approved Annual Report and Accounts will be presented to members at the Annual Members Meeting scheduled for 23 September 2026.

Recommendations

Board is asked to **NOTE** that:

- The Audit and Risk Committee at its meeting on 23 June 2026, approved the 2025/26 Annual Report and delegated authority to the Chair and Chief Finance Officer to approve DBTH Annual Accounts and Financial Statements 2025/26 including Going Concern Statement, subject to receipt of the complete IAS 260 report;
- The Annual Report and Accounts have been submitted to Parliament; and
- The Annual Report and Accounts will be published on the Trust's website following Parliament's approval.

Healthier together – delivering exceptional care for all

Patients	
People	
Partnerships	
Pounds	Annual Report and Accounts for 2025/26
Health Inequalities	
Legal/ Regulation:	

<table>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Draft reviewed at Audit and Risk Committee on 23rd June 2026
Final submitted reviewed at Audit and Risk Committee on 23rd July 2026</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Accounts to be laid before Parliament in due course.</td></tr>
<tr><td>Is this in line with Current risk appetite

NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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2609 - H GOVERNANCE & ASSURANCE

12:25

2609 - H1 DONCASTER & BASSETLAW HEALTHCARE SERVICES LIMITED

Discussion Item | Sam Wilde, Chief Finance Officer | 12:25

5 minutes

REFERENCES

Only PDFs are attached

H1 - Doncaster and Bassetlaw Healthcare Services Update.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Doncaster and Bassetlaw Healthcare Services Ltd Update**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer Mark Bailey, Interim Chair			
Authors:	Mark Olliver, Managing Director, Doncaster & Bassetlaw Healthcare Services Ltd			
Appendices:	None			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)				

Executive Summary – Key messages and Issues

This paper provides the Trust Board with an update on the business performance of its wholly owned subsidiary (WOS), Doncaster and Bassetlaw Healthcare Services Ltd (DBHS).

Financially, the business continues to perform strongly.

All business Key Performance Indicators and financial targets have been exceeded, and these are highlighted within the paper.

Board Members are reminded of the 5 strategic aims of Doncaster and Bassetlaw Healthcare Services and the operational priorities for 2026/27 have been highlighted.

Recommendations

Board Members are asked to **NOTE** the contents of this report.

Healthier together – delivering exceptional care for all

Patients	
People	
Partnerships	Wholly owned subsidiaries are an organisational and governance form that NHS providers can legally adopt to manage part of their organisation. Subsidiaries can deliver many benefits to the NHS, offering an alternative to outsourcing services to the private sector. Successful businesses can allow Trusts to reinvest savings back into the NHS to improve patient care, income which would otherwise transfer into the private sector. Doncaster and Bassetlaw Healthcare Services Ltd (the subsidiary) was incorporated in October 2019. The business continues to perform favourably and, as a result, has been in a position to provide routine regular dividend patients to Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (the parent).
Pounds	
Health Inequalities	
Legal/ Regulation:	

<table>
<tr><td>Partner ICB strategies</td><td></td></tr>
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Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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1. Executive Summary

This briefing document aims to provide the Trust Board with a quarterly update on the performance of Doncaster and Bassetlaw Healthcare Services Ltd.

The paper presents current financial business performance and highlights business delivery against all KPIs specified. The strategic pillars remain the same and the business continues to seek and exploit commercial opportunities, by offering more cost effective and patient centric services when compared to those being supplied by existing private partners.

2. Financial Performance

Table 1: Trading performance for Doncaster and Bassetlaw Healthcare Services Ltd – June 2026 Q1

June 2026 Year to date (£k)	Actual	Budget	Variance	Budget for the year
Turnover	3,035	3,123	- 88	12,583
Cost of Sales	- 2,710	- 2,779	69	- 11,116
Gross Profit	325	344	- 19	1,466
Admin Expenses	- 231	- 294	63	- 1,197
Profit before tax	93	49	44	269
Tax	- 23	- 10	- 13	- 61
Profit after tax	**70**	**39**	**31**	**208**

The business has delivered a pre-tax profit of £93k and has exceeded budget by £44k. It continues to demonstrate strong financial grip and control, with costs falling below budget levels set. Non-pay expenses continue to be managed efficiently and appropriately.

Table 2: Assets and Liabilities Register

	£k
Inventory	781
Accounts Receivable	2,096
Other Receivables	507
Cash	908
Total Assets	**4,292**
Accounts Payable	1,160
Other Payables	2,006
Total Liabilities	**3,166**
Total Net Assets	**1,126**
Share Capital	550
Retained Earnings	576
Total Net Assets	**1,126**

The balance sheet above provides evidence of good financial stability and the business remains fluid and agile, able to support future short-term or medium-term investment requirements.

Key Performance Indicators KPIs

Table 3: Business (Pharmacy) KPI Performance Indicators

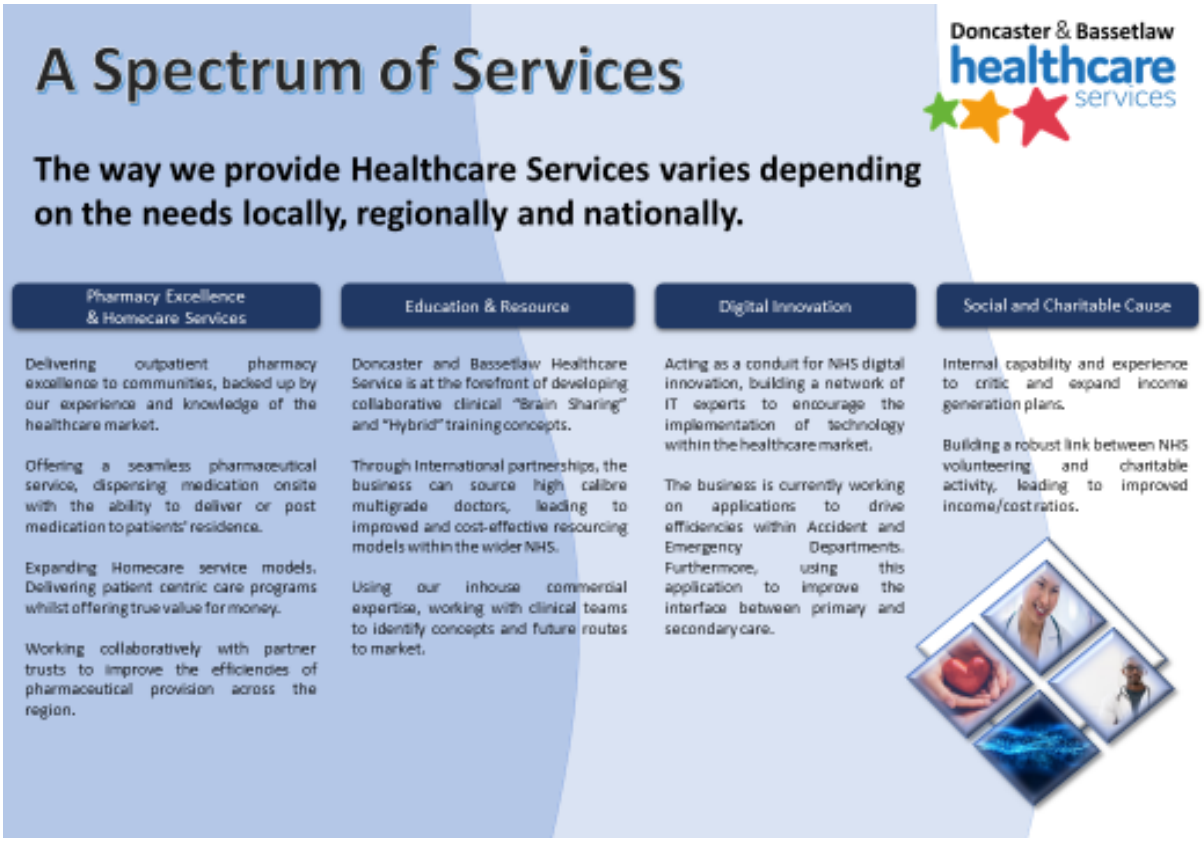
KPI Summary	Waiting time < 15 minutes	Waiting time < 10 minutes	Requested drugs not available %	Dispensing incidents
Target	95.0%	75.0%	<1.50%	< 0.02%
July 2026	96.7%	80.6%	1.41%	0.002%
Year To Date 2026/27	96.3%	81.3%	1.25%	0.004%

The table above highlights KPI scorecard performance for the month of July and YTD 2026/27. All measures have been delivered within the targets set and operational performance remains strong.

3. 5 Year Strategic Plan Summary

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





4. Operational Priorities 2026/26

Current operational priorities focus on 2 clear aims:

1. The generation of a step-change in financial performance
2. Alignment with the parent Trust, to support in the delivery of the Trust reset plan and subsequent development of initiatives that reduce both the medium and long-term financial burden.

Pharmacy Excellence and Homecare Provision

The business has been considering healthcare expansion into the virtual world. The continued enhancement and growth of e-commerce and omni-channel market expectation further supports this concept.

Working alongside external partners, a detailed Options Appraisal has been completed, and two possible entry points have been highlighted:

- The purchase and utilisation of a white labelled platform (branded as Doncaster and Bassetlaw Healthcare Services).
- A partnership with an existing pharmacy healthcare provider, where service fulfilment is completed by the partner, through a fully branded Doncaster and Bassetlaw Healthcare Services website

These options were discussed at the subsidiary board meeting in August and a decision was made proceed with the White Label option at this point. The option to switch to fulfilment partner in future remains open.

Whilst the initial service will focus on private prescription issue and dispensing, such a baseline model would allow for wider healthcare service expansion in the longer term.

To support the Trust in delivering increased productivity and financial efficiencies, the business is keen to explore further homecare options and requires Trust guidance on identifying the size of the prize. At present the business is set up to support simple homecare service provision. Working alongside the in-patient

pharmacy team, the business is currently reviewing the existing homecare portfolio, to endeavour to exploit financial savings for the Trust.

Capability and Resourcing

Board members are asked to note that the Hybrid International Emergency Medicine Programme (HIEM) is now closed. This decision was made following the announced changes to the Medical Training Initiative (MTI) process. Furthermore, an ease in the NHS resourcing burden (at equivalent doctor grade) within Accident and Emergency departments meant placements were more difficult to find.

However, the business continues to work with QIMET International and discussions are ongoing re future courses and opportunities. Conversations have taken place with tertiary education associates, to seek advice and guidance on the development of programmes to support both existing and new professional courses.

The Professional and Linguistic Assessment Board (PLAB) provides another route for doctors to seek UK registration and this pathway is now even more prominent due to MTI closure. As a result, the business is identifying commercial ways to support candidates through the process, but to also ensure that the doctors selected (for any future programme) have the skills and competencies to provide strong clinical service within the NHS. Other pathways involve clinical placements to support university masters degrees and speciality training over a period of time.

All pathways are currently being costed and further discussions have been scheduled with external partners.

Charitable and Social Cause

The business continues to provide operational leadership to the Trust's Charity. Board Members are asked to note the following operational highlights:

The charity is currently on track to deliver £1.4m income this financial year

The lottery is forecast to deliver circa £600k in unrestricted funds this financial year.

The currently number of lottery tickets (approx. 8600) per week is expected to growth to approx. 15,000 by the end of the financial year.

A new charity strategy has been signed off by The Trustee, along with a new fundraising strategy and operations plan. The charity now has a very good foundation and performance and delivery is expected to continue its upward trajectory.

Service Innovation

Smart ER

The business continues to work with external partners, exploring and developing innovative technical applications to deliver improved patient outcomes.

Smart ER introduces a 2-way digital platform into the healthcare environment, allowing robust and immediate communication between patient and clinician. Utilising a patient's own device, valuable data

can be transmitted safely and effectively at source. Furthermore, communication can continue once the patient has left the department. The updated product has been visualised by the Trust Chief Medical Officer and also a lead consultant within the department. Feedback has been consistently positive.

The SMART ER application is designed to function across multiple care environments, including same day emergency care (SDEC), Minor Injuries and Emergency Rooms.

The pilot product is nearing completion and an initial 'proof of concept' should be delivered within a controlled care setting, such as a Minor Injuries Unit. The pilot product will be demonstrated to the subsidiary board and, following review, further engagement will be initiated with wider shareholders at the Trust. A commercial model and forecast has been developed accordingly.

Radiology

The business continues to be open to collaboration with the Trust and also a select number of doctors, who are wishing to develop a Limited Liability Partnership LLP, to provide out of hours radiology services to the Trust and others.

A tripartite arrangement between the Trust, subsidiary and LLP could provide a number of measurable benefits such as improved quality and seamless patient care, improved financial grip and control and commercial scalability.

The business has sort legal advice, in terms of programme set-up, financial implications and the need for clear standard operating procedures. Both the Trust Chief Medical Officer and DBHS Managing Director have provided feedback to the proposed LLP, in terms of standard operating procedures and the need to include the following:

1. That any service provided by the LLP must be available and offered to other Trusts
2. That the LLP can and should seek member doctors outside of Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust
3. That any tax liability falls on the LLP and not any associated parties.

Recent discussions have been positive leading to a proposed meeting for early September, to gain momentum and aid robust decision making.

People

To support in the development and management of the projects highlighted above, the business has just recruited for the position of Business Operations Development Manager. Aejaz Zahid has verbally accepted the role and his start date will be announced shortly. Aejaz has good experience across international markets, healthcare, digital innovation and education. He will be a welcomed addition to the team.

Conclusion

Doncaster and Bassetlaw Healthcare Services has delivered strong financial performance and corporate liquidity remains high. The business needs to continue to focus on providing alternative healthcare solutions across the NHS and beyond, acting as a disruptor and competitor to private healthcare businesses by offering complete healthcare solutions at highly competitive price points.

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

2609 - H2 CONSTITUTION, SCHEME OF RESERVATION & DELGATION AND STANDING FINANCIAL INSTRUCTIONS

Decision Item | Sam Wilde, Chief FInance Officer | 12:30

Brenda Thomas, Interim Company Secretary

5 minutes

REFERENCES

Only PDFs are attached

- H2 - Constitution, Scheme of Reservation & Delegation and SFIs.pdf
- H2 - Appendix 1 - Constitution including Standing Orders Version 1.4 - v2.pdf
- H2 - Appendix 2 -Scheme of Reservation and Delgation Version 1.4.pdf
- H2 - Appendix 3_SFI's Version 1.2 - v2.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Constitution, Scheme of Reservation and Delegation and Standing Financial Instructions (2026)**		
Executive Sponsor:	Sam Wilde, Chief Finance Officer		
Authors:	Angela O'Mara, Deputy Company Secretary		
Appendices:	Appendix 1: Constitution including Standing Orders Version 1.4 Appendix 2: Scheme of Reservation and Delegation (SoRD) version 1.4 Appendix 3: Standing Financial Instructions (SFI) Version 1.2		
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		

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

Following a review of key governance documents, proposed amendments to the Constitution, Scheme of Reservation and Delegation and Standing Financial Instructions were presented to the Audit & Risk Committee on 23 July 2026 for review and recommendation to the Board of Directors.

Constitution

In 2025 the Trust's Constitution was re-aligned to the model core constitution, including the incorporation of the Board of Directors' Standing Orders as an annex. The most notable changes in 2026 included a reduction in the number of staff governors from six to four (above the minimum outlined in the NHS 2006 Act Schedule 7), governor quoracy for voting requirements for key appointment decisions, and the consistent use of gender-neutral language.

As a jointly owned document, the Council of Governors reviewed and approved the amendments at its meeting on 13 July 2026 and following the recommendation of the Audit & Risk Committee, the Board of Directors is asked to approve the proposed amendments. The approved version will be published and shared with NHSE in line with the NHS Provider licence NHS1 Section 4 condition 2a.

Scheme of Reservation and Delegation to the Board

Appendix 2 shows the proposed changes to the SoRD, which ensure alignment with the Standing Financial Instructions (SFIs) and the Standing Order (SO) references and amendments to executive designations.

The following changes were considered by the Audit & Risk Committee:

- 1. Management of Budgets: Approval of revenue business cases
    - deletion of *not part of agreed plan;*
    - b) Cases over £250,000 and below £500,000; Finance and Performance Committee
    - c) Cases over £500,000; Board of Directors

- 4. Non-pay Expenditure / Requisitioning / Ordering / Payment of Goods & Services, Requestions:

  Authorisations of requestions / non pay expenditure
  - d) Requisitions up to £500,000; CFO and CE
  - e) Requisitions between £500,000 to £1,000,000: Finance and Performance Committee
  - f) Requestions over £1,000,000: Board of Directors

  Authorisations of contracts for goods and services and subsequent variations to contracts
  - a) contracts up to £500,000; CFO and CE
  - b) contracts between £500,000 to £1,000,000: Finance and Performance Committee
  - c) contracts over £1,000,000: Board of Directors

The Audit & Risk Committee supported the above amendments and offered their recommendation to the Board.

Two subsequent revisions to the delegated authority were proposed by the Chief Finance Officer and supported by the Chair of the Audit & Risk Committee, as below. Subject to the Board's approval, a post meeting record of the revisions will be captured in the minutes of the Audit & Risk Committee of 23 July 2026.

Authorisations of requestions / non pay expenditure
- d) Requisitions up to £500,000; CFO and CE
- e) Requisitions between £500,000 to £1,000,000: CE
- f) Requestions over £1,000,000: CE

Authorisations of contracts for goods and services and subsequent variations to contracts
- a) contracts up to £250,000 CFO
- b) contracts £250,000 to £500,000 CE
- c) contracts between £500,000 to £1,000,000 Finance and Performance Committee
- d) contracts over £1,000,000 Board of Directors

Standing Financial Instructions

The SFI's have been updated to reflect changes to designations and values in the procurement thresholds. The Local Security Management Service (LSMS) provides a report to the Finance and Performance Committee, and this was also amended to reflect that position.

Recommendations

The Board is asked to approve:

- The Trust Constitution (appendix 1), including the Standing Orders of the Board, approved by CoG July 2026
- The Scheme of Reservation and Delegation for the Board (appendix 2)
- The Standing Financial Instructions (appendix 3)

Healthier together – delivering exceptional care for all	
Patients	These governance documents are critical for the statutory responsibility to deliver safe & effective quality care to patients.
People	These governance documents are critical for supporting innovation and transformation, within the constraints of regulatory and statutory requirements.
Partnerships	These governance documents are critical for demonstrating good corporate governance and effective working within the constraints of regulatory and statutory duties.
Pounds	These governance documents are critical for the effective control and direction of the trusts financial position and adherence to its fiscal duties.
Health Inequalities	These governance documents do not have a positive or negative impact on health inequalities; however they do consider its legislative duty to positively impact on health inequalities through the delivery of its services.

Legal/ Regulation:	These governance documents comply with the regulatory and legislative requirements outlined in the NHS Act 2006, Code of Governance for NHS providers and the NHS Provider licence.
Partner ICB strategies	These governance documents have no positive of negative impact on partner ICB strategies.
Assurance Route	
Previously considered by - including date:	Approval by Council of Governors on 13 July 2026 (Constitution only) Recommendation to the Board for approval by Audit & Risk Committee - 23 July 2026
Any outcomes/next steps / time scales	Received for information Board of Directors – 1 September 2026 Implementation across the Trust Submission of Constitution to NHSE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

CONSTITUTION

Name and title of author/reviewer:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance
Approved by The Board of Directors (subject to CoG and AMM approval):	2 September 20265
Approved by The Council of Governors and Annual members Meeting:	30 XX September 20265
Date Issued:	1 October 20265
Date of Next Review:	September 2028following legislative changes in 2027

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1. INTERPRETATION AND DEFINITIONS

In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"the 2022 Act"	means the Health and Care Act 2022 as amended from time to time;
"Accounting Officer"	is the person who from time to time discharges the functions specified in NHS England's NHS Foundation Trust Accounting Officer Memorandum;
"Annual Members' Meeting"	means the annual members' meeting of the Trust as defined in paragraph 13 of this Constitution.
"Appointed Governors"	means the Partner Governors; those Governors appointed by the Partnership Organisations;
"Area of the Trust"	means the areas of Bassetlaw District and the City of Doncaster (specified in Annex 1 as areas of the public constituency);
"Board of Directors"	means the board of directors as constituted in accordance with this Constitution;
"Chair"	means the chair of the Trust appointed in accordance with paragraph 28 of this Constitution;
"Chief Executive"	means the chief executive officer of the Trust appointed in accordance with the terms of this Constitution;
"Constitution"	means this Constitution and all annexes to it;
"Co-optee" and "Co-opted Governor"	means an individual formally appointed by resolution of the Council of Governors who has reached the end of their elected term of office to participate at meetings of the Council of Governors under the terms specified
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the council of governors in the 2006 Act and the 2012 Act;
"Deputy Chair"	means the non-executive director appointed as deputy chair of the Trust in accordance with paragraph 30 of this Constitution;
"Director"	means an Executive director or a non-executive director on the Board of Directors;

"Elected Governor"	means the Public Governors and the Staff Governors; those Governors elected by the Public Constituencies and the classes of the Staff Constituency;
“Election Scheme”	means the election scheme set out in Annex 4;
“Executive Director”	means an executive director of the Trust who have voting rights on the Board;
“Fit and Proper Person Requirements (FPPR)”	means those requirements stipulated under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations)
“Financial Year”	means a period of 12 months beginning on 1st April in a calendar year and ending on 31st March in the following calendar year;
“Governor”	means a Governor on the Council of Governors and being either an Elected Governor or an Appointed Governor;
“Health Service Body”	means a body which is a health service body for the purpose of section 9(4) of the 2006 Act;
“Independent Regulator” or “NHS England”	is the body corporate known as NHS England, as provided by Section 61 of the 2012 Act; or any successor regulator.
“Lead Governor”	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England) and to Chair any meetings of Governors when the Chair or Deputy Chair are absent, for whatever reason
"Local Authority"	means the local authorities specified in Annex 3, which are local authorities for an area which includes the whole or part of the area of the Trust;
“Local Authority Governor”	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
“Meeting”	Means a meeting of individuals for the purpose of conducting business on behalf of the Trust and where they are authorised to do. This includes face-to-face, virtual and hybrid meeting formats.
“Member”	means a member of the Trust;
"Membership	means membership of the Trust as determined in accordance with the provisions of this Constitution and as specified in Annex 3;
"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by the Department of Health and as currently set out in Annex 4;

“Non-Executive Director”	means a non-executive director of the Trust;
"Partner Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partner Organisation"	means those organisations designated as Partnership Organisations for the purposes of this Constitution specified in Annex 3;
“Public Constituencies”	means a public constituency as defined in Annex 1;
“Public Governor”	means a member of the Council of Governors elected by the Members of the Public Constituency;
“Registered Dentist”	a registered dentist within the meaning of the Dentists Act 1984;
“Registered Medical Practitioner”	a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;
"Secretary"	means the Trust Company Secretary or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary;
"Senior Independent Director"	means the non-executive director appointed by the Board as the senior independent director of the Trust;
“Staff Class”	means a class of Membership within the Staff Constituency as provided for in Schedule 7 to the 2006 Act and as set out in Annex 2;
“Staff Constituency”	means the part of the Trust’s Membership consisting of the staff of the Trust and which is divided into the classes as specified in Annex 2;
“Staff Governor”	means a member of the Council of Governors elected by a Staff Class in accordance with the provisions of this Constitution;
“the Trust”	means Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

1.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder

1.3 References to legislation include all regulations, statutory guidance and directions.

1.4 Headings are for ease of reference only and are not to affect interpretation.

1.5 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein or the law, then the provisions of this Constitution shall prevail unless the law requires otherwise.

1.6 All Annexes referred to in this Constitution form part of it.

1.7 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an Annex to this Constitution it shall be a reference to a paragraph in that Annex unless the contrary is expressly stated, or the context otherwise so requires

2. NAME

2.1 The name of the foundation trust is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust).

3. PRINCIPAL PURPOSE

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also undertake activities other than those mentioned in section 3 for the purpose of making additional income available in order better to carry on the Trust's principal purpose.

3.5 Notwithstanding the provisions of 3.1 above, the purpose of the Trust is to provide goods, and services, including education, training and research and other facilities for the provision of healthcare, in accordance with its statutory duties.

3.6 The Trust may carry out research in connection with the provision of healthcare and make facilities and staff available for the purposes of education, training or research carried on by others

4. POWERS

4.1 The powers of the Trust are set out in the 2006 Act and amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Subject to any restriction contained in this Constitution or in legislation, any of these powers may be delegated to a committee of directors or to an executive director.

5. MEMBERSHIP AND CONSTITUENCIES

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a Public Constituency; or

5.1.2 a Staff Constituency.

6. APPLICATION FOR MEMBERSHIP

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

6.2 Applications for membership will be handled by the Trust in accordance with the provisions set out in Annex 6

7. PUBLIC CONSTITUENCY

7.1 The Public Constituency comprises three areas as set out in Annex 1. Each area of the Public Constituency is to be known by the name listed in Annex 1.

7.2 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust provided that:

7.2.1 they have made an application for membership to the Trust; and

7.2.2 they are not eligible to become a member of the Staff Constituency; and

7.2.3 they are not otherwise disqualified from membership under paragraph 4 or paragraph 2 of Annex 6.

7.3 Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

7.4 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. STAFF CONSTITUENCY

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve (12) months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

8.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.3 The Staff Constituency shall be divided into four (4) classes of individuals who are eligible for membership of the Staff Constituency, each class of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION – STAFF

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate Staff Class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate Staff Class within the Staff Constituency without an application being made, unless they inform the Trust they do not wish to do so.

9.2 The process by which an individual shall be invited or shall apply to become a member of the Staff Constituency shall be in accordance with the provisions of Annex 6.

10. SECTION 10 PATIENTS CONSTITUENCY

Not Used

11. SECTION 11 AUTOMATIC MEMBERSHIP BY DEFAULT -PATIENTS

Not Used

12. RESTRICTION ON MEMBERSHIP

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual shall not be eligible for membership of the trust if they:

12.3.1 are under sixteen (16) years old at the date of their application or invitation to become a member (as the case may be)

12.3.2 fail or cease to fulfil the criteria for membership of any Public or Staff Constituency

12.3.3 has been placed on the sex offenders Register or is the subject of a Sex Offenders Order;

12.3.4 demonstrates aggression, violent or abusive behaviour at any hospital or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust and following such behaviour they have been asked to leave.

12.3.5 has been confirmed as a "vexatious complainant" in accordance with the Trusts policy for handling complaints;

12.3.6 has been removed as a member of the Trust of another NHS Foundation Trust

12.3.7 is deemed to have acted in a manner contrary to the interests of the Trust.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 6.

13. ANNUAL MEMBERS' MEETING

13.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 – Annual Members' Meeting.

14. COUNCIL OF GOVERNORS - COMPOSITION

14.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors and the Chair of the Trust.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

14.4 The Council of Governors may co-opt individuals who have reached the end of their elected term of office to remain as members of the Council of Governors but only for a time period until the next elections and will not exceed the usual term of office of an elected governor.

14.5 The agreement and removal of a co-opted governor will be subject to the approval of the Council of Governors by a majority of the Council of Governors present and voting.

14.6 Co-opted Governors shall not have voting rights at a general meeting nor be counted in the quorum but will have free access to contribute to discussions therein.

15. COUNCIL OF GOVERNORS - ELECTION OF GOVERNORS

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014.

15.2 The Model Election Rules as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

15.3 A subsequent variation of the Model Election Rules by the Department of Health & Social Care 2014 shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution).

15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

16.1 An elected governor may hold office for a period of up to three (3) years.

16.2 An elected Governor shall cease to hold office if they cease to be a Member of the Constituency or class by which they were elected.

16.3 An elected Governor shall be eligible for re-election at the end of their term, but no elected Governor may hold office for more than nine (9) years. An elected Governor may not stand for election again on completion of the maximum nine years. An elected Governor who does not complete the maximum nine-year term may stand for re-election but only for the remaining years to achieve nine (9) years in total.

16.4 An appointed governor may hold office for a period of three (3) years.

16.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

16.6 An appointed governor shall be eligible for re-appointment at the end of their term, but no appointed governor may hold office for more than nine (9) years as an appointed governor.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, ~~his~~ their creditors and has not been discharged in respect of it;

17.1.3 a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

17.1.4 a governor, whose term of office is terminated in line with Annex 5 section 3.

17.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

17.4 Provisions for the removal of governors are set out in Annex 5.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

18.1.3 as a result of the Health and Care Act 2022 governors are required to factor into their decision making a balance between serving the public interest of their constituents (i.e. the Trust and local community which elects them) with a wider (regional) public interest across the Integrated Care Systems the Trust is linked with.

18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

18.3 Governors must take up the opportunities that the Trust offers to provide them with these skills and knowledge. In the event that a Governor is deemed to not be fulfilling these roles and responsibilities, then the Trust Secretary will carry out a review with that Governor and identify any programme of support required to address the situation. In the absence of any improvement, then a Council of Governors decision could be made to remove the Governor from their role.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 below) or, in their absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 30 below), shall preside at meetings of the Council of Governors save that if the Chair and Deputy Chair are unable to preside whether for reasons of absence, conflict of interest or otherwise the Senior Independent Director or Lead Governor shall preside.

19.2 Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution.

19.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, and to be able to hold the non-executive directors to account for the performance of the Board, the Council of Governors may require one or more of the non-executive directors to attend a meeting.

19.4 Details on the standing orders for the procedure and practice of the Council of Governors is given in Annex 7

20. COUNCIL OF GOVERNORS – STANDING ORDERS

20.1 The Council of Governors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure and practice at meetings and are attached at Annex 7.

21. COUNCIL OF GOVERNORS – REFERRAL TO THE PANEL

21.1 In this paragraph, the "Panel" means a panel of persons appointed by the Regulator to which a member of the Council of Governors may refer a question as to whether the Trust has failed or is failing:

21.1.1 to act in accordance with this constitution, or

21.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

21.2 A member of the Council of Governors may refer a question to the Panel only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the referral.

22. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

22.1 Governors are required to declare any pecuniary, personal or family interest on nomination and on appointment as a governor, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

22.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed. The Chair of the meeting decides on exclusion on the facts.

23. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

23.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. For the avoidance of doubt, members of the Council of Governors are not to receive remuneration but can receive expenses incurred as part of their role as governors.

24. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. BOARD OF DIRECTORS – COMPOSITION

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and non-executive directors.

25.2 All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.

25.3 The Board of Directors is to comprise:

25.3.1 a non-executive Chair (who shall have a casting vote)

25.3.2 other non-executive directors (i.e. not including the Chair)

25.3.3 executive directors (but not exceeding the combined number of non-executive directors and the Non-Executive Chair)

25.4 One of the executive directors shall be the Chief Executive.

25.5 The Chief Executive shall be the Accounting Officer.

25.6 One of the executive directors shall be the Chief Finance Officer.

25.7 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

25.8 One of the executive directors is to be a registered nurse or a registered midwife.

25.9 For the avoidance of doubt, the Deputy Chair shall have the casting vote in the event that the Chair is not participating at the meeting where voting takes place.

25.10 The Senior Independent Director will be nominated by the Chair and approved by the Council of Governors and shall perform the role set out in the Code of Governance for NHS Provider Trusts.

26. BOARD OF DIRECTORS – GENERAL DUTY

26.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

27. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

27.1 A person may be appointed as a non-executive director only if:

27.1.1 they are a member of the Public Constituency; and

27.1.2 they are not disqualified by virtue of paragraph 33 below.

28. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

28.1 The Chair and non-executive directors are appointed for a term of up to three years. This may be extended by a further term of up to three years if the needs of the organisation so determine. The Chair and non-executive directors may not usually serve for more than six years, unless it considers such an extension is in the best interests of the Trust.

28.2 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other non-executive directors.

28.3 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors ~~attending the meeting~~.

28.4 The provisions of paragraph 5 of Annex 5 and paragraph 6 of Annex 6 shall also apply.

28.5 If any resolution to remove a non-executive director (including the Chair) is not approved at a meeting of the Council of Governors in accordance with paragraph 28.2 above, no further resolution can be put forward to remove such non-executive director, or the Chair which is based on the same reasons within 12 calendar months of the meeting of the Council of Governors at which the resolution mentioned in paragraph 28.2 above was considered.

28.6 Subject to the provisions of paragraphs 28.1 to 28.5, new non-executive directors and the Chair will be appointed using the procedures set out below:

28.6.1 only a member of a Public Constituency may be appointed as the Chair or other non-executive director; and

28.6.2 the Chair and other non-executive directors shall be appointed in accordance with paragraphs 28.7 to 28.13 below.

28.7 The Council of Governors shall establish a committee of its members to be called the Nominations and Remuneration Committee to discharge those functions in relation to the appointment of the Chair and non-executive directors described in paragraphs 28.8 - 28.11 below.

28.8 The Nominations and Remuneration Committee shall consist of no more than seven members which shall comprise of at least:

28.8.1 3 Public Governors;

28.8.2 1 Staff Governor; and

28.8.3 The Chair of the Trust, except where their performance or remuneration is being considered at which point the Senior Independent Director should assume this position.

28.8.4 The members of each Nomination and Renumeration Committee are not fixed and will be selected via email ballot for each required meeting.

28.9 The functions of the Nominations and Remuneration Committee shall be as follows:

28.9.1 to determine the criteria and process for the selection of candidates for office as Chair or other non-executive director of the Trust having first consulted with the Board of Directors as to those matters and having regard to such views as may be expressed by the Board of Directors;

28.9.2 where the Nominations and Remuneration Committee considers that either the Chair or the non-executive director coming to the end of their term of office should be reappointed for a further term, the Nominations and Remuneration Committee shall make a recommendation to the Council of Governors to that effect, save that the Nominations and Remuneration Committee may not make any such recommendation other than for a first re-appointment of the Chair or the non-executive director in question;

28.9.3 Where:

(a) the Nominations and Remuneration Committee does not make a recommendation that the Chair or a non-executive director should be reappointed in accordance with paragraph 28.9.2 above; or

(b) the Chair or (as the case may be) the non-executive director in question does not want to be reappointed; or

(c) the Council of Governors rejects a recommendation that the Chair or (as the case may be) a non-executive director should be reappointed in accordance with paragraph 28.9.2 above,

(d) the Nominations and Remuneration Committee shall initiate a process of open competition for the appointment of the Chair or (as the case may be) the non-executive director, and the post will be advertised. Further, the Nominations and Remuneration Committee shall assess and select for interview such candidates as are considered appropriate and in doing so the Nominations and Remuneration Committee shall be at liberty to seek advice and assistance from persons other than members of the Nominations and Remuneration Committee or the Council of Governors;

28.9.4 on a regular and systematic basis monitor the performance of the Chair and other Non-executive directors and make reports thereon to the Council of Governors from time to time when requested to do so or when in the opinion of the Nominations and Remuneration Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors; and

28.9.5 to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair and other non-executive directors.

28.10 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the Board of Directors and of the Nominations and Remuneration Committee as to the suitability of the available candidates.

28.11 The Council of Governors will not consider nominations for membership of the Board of Directors other than those made by the appropriate Nominations and Remuneration Committee.

29. SECTION 29 (INITIAL FOUNDATION TRUSTS~~'S~~)

Not used

30. BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chair. The Deputy Chair will be the Deputy Chair of the Council of Governors.

30.2 The Deputy Chair shall be appointed for a term of 3 years and shall be eligible for re-appointment at the end of that term but may not serve as Deputy Chair for more than a total of 6 years, unless it considers such an extension is in the best interests of the Trust.

31. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER NS

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other Executive directors.

32. SECTION 32 (INITIAL FOUNDATION TRUSTS'S)

Not used

33. BOARD OF DIRECTORS – DISQUALIFICATION

33.1 The following may not become or continue as a member of the Board of Directors:

33.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

33.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and who has not been discharged in respect of it;

33.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

33.1.4 a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

33.1.5 The Regulator has exercised its powers to remove them as a director of the Trust or has suspended them from office or has disqualified them from holding office as a director of the Trust for a specified period or the Regulator has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS foundation trust or

33.1.6 a person who falls within the further grounds for disqualification set out in Annex 6.

34. BOARD OF DIRECTORS – MEETINGS

34.1 Meetings of the Board of Directors shall be open to members of the public as observers. Members of the public may be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

34.2 Before holding a meeting, the Board of Directors must make available the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must make available the approved minutes of the meeting to the Council of Governors.

35. BOARD OF DIRECTORS – STANDING ORDERS

35.1 The Board of Directors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, and are given in Annex 8.

36. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

36.1 The duties that a director of the Trust has by virtue of being a director include in particular:

36.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

36.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

36.2 The duty referred to in sub-paragraph 36.1.1 is not infringed if:

36.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 The matter has been authorised in accordance with the constitution.

36.3 The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.4 In sub-paragraph 36.1.2, "third party" means a person other than –

36.4.1 The Trust, or

36.4.2 A person acting on its behalf.

36.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or, arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

36.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

36.9 A director need not declare an interest –

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

36.9.2 if, or to the extent that, the directors are already aware of it;

36.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) By a meeting of the Board of Directors, or

(b) By a committee of the directors appointed for the purpose under the constitution.

36.10 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

37. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

37.2 A committee of non-executive directors shall be established to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive directors.

38. REGISTERS

38.1 The Trust shall have:

38.1.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

38.1.2 a register of members of the Council of Governors;

38.1.3 a register of interests of governors;

38.1.4 a register of directors; and

38.1.5 a register of interests of the directors.

39. ADMISSION TO AND REMOVAL FROM THE REGISTERS

39.1 The process of admission to and removal from the registers shall be as set out in Annex 6.

40. REGISTERS – INSPECTION AND COPIES

40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

40.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

40.3 So far as the registers are required to be made available:

40.3.1 they are to be available for inspection free of charge at all reasonable times; and

40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution;

41.1.2 a copy of the latest annual accounts and of any report of the auditor on them;

41.1.3 a copy of the latest annual report;

41.1.4 a copy of the latest annual quality report.

41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

41.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

41.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

41.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

41.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

41.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England), 65KB (Secretary of State's response to NHS England decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

41.2.8 a copy of any final report published under section 65I (administrator's final report),

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

41.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with access to a copy.

41.4 If the person requesting access to a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. AUDITOR

42.1 The Trust shall have an external auditor.

42.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

43. AUDIT AND RISK COMMITTEE

43.1 The Trust shall establish a committee of non-executive directors as an audit and risk committee to perform such monitoring, reviewing and other functions as are appropriate.

44. ACCOUNTS

44.1 The Trust must keep proper accounts and proper records in relation to the accounts.

44.2 The Regulator may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

44.3 The accounts are to be audited by the Trust's external auditor.

44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as the Regulator may with the approval of the Secretary of State direct.

44.5 The functions of the Trust with respect to the preparation of the annual accounts as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

45. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

45.1 The Trust shall prepare an Annual Report and send it to the Regulator.

45.2 The Trust shall give information as to its forward planning in respect of each financial year to the Regulator.

45.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

45.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so.

45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

45.6.2 notify the directors of the Trust and its determination.

45.7 Where the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

46. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

46.1.1 the annual accounts;

46.1.2 any report of the external auditor on them; and

46.1.3 the annual report.

46.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. INSTRUMENTS

47.1 The Trust shall have a seal.

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. AMENDMENT OF THE CONSTITUTION

48.1 The Trust may make amendments to its Constitution only if:

48.1.1 more than half of the members of the Council of Governors voting at a meeting approve the amendments; and

48.1.2 more than half of the members of the Board of Directors voting at a meeting approve the amendments.

48.2 Amendments made under paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

48.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

48.3.1 At least one member of the Council of Governors most likely the Lead Governor must attend the next Annual Members' Meeting and present the amendment, and

48.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

48.4 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect, and the Trust must take such steps as are necessary as a result.

48.5 Amendments by the trust of its constitution are to be notified to the Regulator. For the avoidance of doubt, the Regulator's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

49. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

49.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors voting at a general meeting.

49.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting at a general meeting approve entering into the transaction.

49.3 For the purpose of paragraph 49.2, "significant transaction" means a transaction which meets any one of the following criteria:

49.3.1 where the *gross assets subject to the transaction are greater than or equal to 25% of the gross assets of the Trust;

49.3.2 where the income attributable to the assets or the contract associated with the transaction is greater than or equal to 25% of the income of the Trust;

49.3.3 where the **gross capital of the company or business being acquired or divested, or the effects on the ***total capital of the Trust resulting from a transaction, is greater than or equal to 25% of the total capital of the Trust following completion of the transaction.

* Gross assets are the total of fixed assets and current assets
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets

*** Total capital of the Trust equals taxpayers' equity

ANNEX 1 – THE PUBLIC CONSTITUENCY

Table 1

1	2	3	4
Name of the Public Constituency	**Area of the Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**	**Number of Governors to be Elected**
Bassetlaw	Bassetlaw District Council (or any successor organisation)	20	3
Doncaster	City of Doncaster (or any successor organisation)	20	8
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	20	1
Total	Public Governors		12

ANNEX 2 – THE STAFF CONSTITUENCY

Table 1

Staff Class	Minimum Number of Members	Number of Governors to be elected
Medical and Dental Practitioners Staff Class	20	1
Nurses and Midwives Staff Class	20	21
Other Healthcare Professionals Staff Class	20	1
Non-Clinical Staff Class	20	21
TOTAL	12080	64

1. CLASSES OF THE STAFF CONSTITUENCY

1.1 The Staff Constituency shall be divided into four classes as follows:

1.1.1 Medical and Dental Practitioners Staff Class;

1.1.2 Nurses and Midwives Staff Class;

1.1.3 Other Healthcare Professionals Staff Class; and

1.1.4 Non-Clinical Staff Class.

1.2 Medical and Dental Practitioners Staff Class

1.2.1 The Members of the Medical and Dental Staff Class are individuals who are Members of Staff Constituency who:

(a) are fully registered persons within the meaning of the Medicines Act 1956 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 8 of the Constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.3 Nurses and Midwives Staff Class

1.3.1 The Members of the Nurses and Midwives Staff Class are individuals who:

(a) are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be members of the Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 8 of the constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.4 Other Healthcare Professionals Staff Class

1.4.1 Members of the Other Healthcare Professionals Staff Class are clinical staff who do not fall within paragraphs 1.2 or 1.3 of this Annex 2, including clinical therapists, scientists and technical staff, who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 8 of the constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.5 Non-Clinical Staff Class

1.5.1 Members of the Non-Clinical Staff Class are Members of the Staff Constituency who do not come within paragraphs 1.2, 1.3 or 1.4 of this Annex 2.

2. MINIMUM NUMBERS AND NUMBERS OF GOVERNORS

2.1 The minimum number of members in each staff class and the number of governors to be elected by each such staff class are given in Table 1.

3. CONTINUOUS EMPLOYMENT

3.1 For the purposes of paragraph 7.1.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1. INTRODUCTION

1.1 The Council of Governors shall comprise:

1.1.1 The Chair of the Trust

1.1.2 Governors who are:

(a) elected by the respective constituencies in accordance with the provisions of this constitution; or

(b) appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of governors who are elected by members of the Public Constituency.

2. BODIES ENTITLED TO APPOINT A MEMBER TO THE COUNCIL OF GOVERNORS

2.1 The Trust may appoint partnering governor or governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Local Authority Governors

2.2.1 City of Doncaster Council (or its successor organisation) shall be entitled to appoint one governor in accordance with a process of appointment agreed by it with the Trust.

2.2.2 Bassetlaw District Council (or its successor organisation) shall be entitled to appoint one governor in accordance with a process of appointment agreed by each of them with the Trust.

2.3 Partner Governors

2.3.1 In addition to the organisations listed in 2.1 and 2.2, the following organisations have also been nominated by the Trust as Partnership Organisations for the purposes of this constitution:

(a) University of Sheffield;

(b) Sheffield Hallam University;

2.3.2 In addition to the organisations listed above (2.2 and 2.3), the Trust may nominate 2 further organisations to appoint governors (1 per organisation).

2.3.3 Each of the partnering organisations shall be entitled to appoint a governor in accordance with a process of appointment agreed by it with the Trust.

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

	Electing / Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		**12**
	1.1 Bassetlaw District	3	
	1.2 City of Doncaster	8	
	1.3 Rest of England and Wales	1	
2.	**Staff Constituency**		64
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	21	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	21	
3.	**Appointed Governors**		up to 6
	3.1 City of Doncaster Council	1	
	3.2 Bassetlaw District Council (or its successor organisation)3.3	1	
	3.34 University of Sheffield	1	
	3.45 Sheffield Hallam University	1	
	Provision available for further two (2) appointed governors from partnership organisations appointed by the Trust	2	
	Total Elected Governors		**165**
	Total Maximum Appointed Governors		**6**
	Total Number of Governors including appointed		**221**

4. FURTHER PROVISIONS

4.1 Further provisions relating to the composition of the Council of Governors are at Annex 6.

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this Constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"the Regulator" means the Independent Regulator for NHS Foundation Trusts

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor elected by the Council of Governors to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTION

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) Saturday or Sunday.
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of their functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that they are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,
(b) for a member of the public constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as

required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after ~~he or she has~~they have received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the

Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer may order a new election to fill any vacancy which remains unfilled, on a day appointed by him/her in consultation with the corporation unless the Council of Governors at a meeting agrees to co-option.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted, and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts ~~his~~ their ~~or her~~ vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts ~~his or her~~their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to

be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or hertheir vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (including a voter who casts his or hertheir ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituency)

21.1 The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that they have not marked or returned any other voting information in the election, and

(c) the particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held, ("declaration of identity") and

(d) the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail

and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.2 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:
(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.3 The corporation may determine that any member of the corporation shall:
(a) only be sent e-voting information; or
(b) only be sent postal voting information; or
(c) be sent both postal voting information (only if no e-mail) and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter their voter ID number; and
  (ii) where the election is for a public constituency, make a declaration of identity;
  in order to be able to cast their vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter's voter ID number;
  (ii) the voter's declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting

system provided will:

(a) require a voter to

(i) enter ~~his or her~~their voter ID number in order to be able to cast their vote; and

(ii) where the election is for a public constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide their voter ID number; and

(ii) where the election is for a public constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) prevent a voter from voting for more candidates than they are entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with ~~his or her~~their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

(a) are satisfied as to the voter's identity; and

(b) have ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter on a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter on a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(e) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless they:
(a) are satisfied as to the voter's identity,
(b) have no reason to doubt that the voter did not receive the original voting information,
(c) have ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter on a list ("the list of lost ballot documents"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they have also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter on a list ("the list of tendered voting information"):
(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public constituency)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter ~~his or her~~their voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote, the voter will need to key in a mark on the screen opposite the particulars

of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast their vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:
(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper on a list of disqualified documents (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled they are to:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

cast a vote in the election ~~he or she~~they shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper on the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes

of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the Board of Directors and the Council of Governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(i) ballot papers that have been returned; and

(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him/her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any

continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with

the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47

(including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value ~~he or she~~they shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until ~~he has~~they have dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
    (i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which ~~he~~ they obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be

transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

Council of Governors

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~they have declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~they have declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting record, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
  (v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

  (i) that their vote was given, and
  (ii) that the Regulator has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before

the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement/England under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings, whether online or face-to-face, to enable the candidates to speak and respond to questions, or to themselves gain further

information.
as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:
(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting (face-to-face or online) to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, in their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor or successor body (NHS England) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor or successor body (NHS England) by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by the Regulator.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 The Regulator shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:
(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

ANNEX 5– ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section 14)

a Governor shall:

1.1 be elected or appointed for a term of three years;

1.2 be eligible for re-election or re-appointment at the end of that term; but may not serve as a governor for more than a total of 3 terms;

1.3 shall cease to hold office if:

1.3.1 in the case of an elected governor, they cease to be a member of the constituency they represent or where relevant, the class of the constituency they represent and in the case of an appointed governor, the sponsoring organisation withdraws its sponsorship of them.

1.3.2 their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or are otherwise ineligible to hold office as a governor; or

1.3.3 they resign by notice in writing to the Trust.

1.4 A governor shall cease to hold office on death.

2. Council of Governors: **Eligibility to be on the Council of Governors**

2.1 A person shall not be eligible to become or continue in office as a Governor if:

2.1.1 In the case of an elected governor, they cease to be eligible to be a Member of the constituency or class within the constituency which they represent

2.1.2 in the case of an appointed governor, the appointing organisation withdraws its sponsorship of them;

2.1.3 any of the grounds contained in paragraph 17 of the Constitution apply to them;

2.1.4 they have within the preceding two years been lawfully dismissed otherwise than by reason of redundancy, by the coming to the end of a fixed term contract, by retirement or through ill health from any paid employment with a Health Service Body;

2.1.5 they are a person whose term of office as the Chair or as a member or director of a Health Service Body has been terminated on the grounds that their continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

2.1.6 they are a person who by reference to information revealed by a Disclosure and Baring Service (DBS) check is considered by the Trust to be inappropriate

on the grounds that their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

2.1.7 they have failed to make, or have falsely made, any declaration as required to be made under Section 60 of the 2006 Act or have spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and they are judged to have acted so by a majority of the Council of Governors voting at a meeting;

2.1.8 they are subject to a direction made under section 142 (prohibition from teaching) of the Education Act 2002 (as amended);

2.1.9 They are a person who is the subject of a disqualification order made under the company Directors Disqualification Act 1986;

2.1.10 The Regulator has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or the Regulator has exercised any of those powers in relation to them on any other occasion whether in relation to DBTH or some other NHS Foundation Trust;

2.1.11 they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff in the preceding 10 years;

2.1.12 they have at any time been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended);

2.1.13 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

2.1.14 their term of office is terminated pursuant to paragraph 3 below;

2.1.15 they are a Member of a Staff Class and any professional registration relevant to their eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six 6 months;

2.1.16 they are a person incapable by reason of mental disorder, illness or injury in managing and administering their property and/or affairs;

2.1.17 They area a person who is an immediate family member of a Director or Governor

2.1.18 they are a person who has refused without reasonable cause to undertake training which the trust and /or the Council of Governors requires Governors to undertake;

2.1.19 They are a person who has failed to sign and deliver to the Company Secretary a statement form required by the Trust confirming acceptance of the Governors' Code of Conduct

2.1.20 the relevant organisation which they represent ceases to exist;

2.2 Where a person has been elected or appointed to be a Governor and they become disqualified from that appointment they shall notify the Company Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered them disqualified or removed.

2.3 If it comes to the notice of the Company Secretary that a Governor is disqualified, the Company Secretary shall immediately declare the Governor disqualified and shall give them notice in writing to that effect as soon as practicable.

2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Governor and their name shall be removed from the Register of Governors.

2.5 If a complaint is received against a member of the governing body, it shall follow the same process as members of the Trust;
2.5.1

3. Council of Governors: Termination of Tenure

3.1 A Governor's term of office shall be terminated:

3.1.1 by the Governor giving notice in writing to the Company Secretary of their resignation from office at any time during that term of office;

3.1.2 by the Trust if it becomes aware of the Governors ineligibility to continue in office for any of the previously stated reasons;

3.1.3 by the Council of Governors if they have failed to attend two consecutive meetings of the Council of Governors unless within one month of the second meeting, the Council of Governors is satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

3.1.4 if the Council of Governors resolves to terminate their term of office for reasonable cause on the grounds that in the reasonable opinion of the majority of Governors present and voting at a meeting of the Council of Governors that their continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(f) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and their continuance in office would not be in the best interests of the Trust; or

(g) They have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor by a date six months from the date of their election or appointment; or from a date when they have been asked to undertake additional training or development for any reason;

(h) Their conduct as a Governor has failed to comply and support in a material way with the values and principles of the National Health Service or the Trust, and the Constitution; or

(i) They have committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors Standing Orders;

3.2 Upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

3.3 A Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of 3 years from the date of their resignation or removal from office. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.

3.4 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out above, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below.

4. Council of Governors Vacancies

Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the following provisions apply:

4.1 In the case of an Elected Governor, where a vacancy arises within 12 months of the election then the candidate who secured the next highest number of votes for that Constituency will be appointed. In the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4.2 If the vacancy arises during the last 11 months of office, the office will remain vacant until it is filled at the next scheduled election.

4.3 If a vacancy arises at any other time, it will be filled at the next scheduled election, in accordance with the Election Scheme.

4.4 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

5. Council of Governors: Role and Responsibilities of Governors

5.1 The general duties of the Council of Governors are:

5.1.1 At a general meeting:

(a) To appoint or remove the Chair and the other non-executive directors. The removal of a non-executive director requires the approval of three quarters of the members of the Council of Governors.

(b) To decide the remuneration and allowances, and the other terms and conditions of office of the Chair and the non-executive directors;

(c) To appoint or remove the Auditors

(d) To be presented the annual accounts, any report of the Auditor on them and the Annual Report;

(e) To consider resolutions to remove a governor or a member pursuant to paragraph 17 of this constitution.

(f) To consider and give/withhold approval for applications for a merger, acquisition, separation or dissolution. Approval requires approval; of more than half the Council of Governors.

(g) To consider and give/withhold approval for the Trust to enter a significant Transaction. Approval requires the approval of more than half of the members of the Council of Governors of the Trust present and voting at a meeting of the Council of Governors.

5.1.2 At a general meeting or otherwise

(a) Approve an appointment of the Chief Executive. Approval requires the approval of more than half of the Council of Governors present and voting at the meeting.

(b) Give the views of the Council of Governors to the Directors for the purpose of the preparation (by the Directors) of the Forward Plan in respect of each Financial Year to be given to the Regulator.

5.2 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

5.3 Subject to the requirements specified above, each Governor shall exercise their own skill and judgement in their conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring an appropriate perspective of the constituency or organisation by which they were was elected or appointed.

5.4 The general duties of the Council of Governors are;

5.4.1 to hold the non-executive directors to individually and collectively to account for the performance of the Board of Directors;

5.4.2 to represent the interests of the Trust as a whole and the interests of the public.

6. Council of Governors: Meetings

6.1 The Council of Governors shall hold not less than 3 general meetings each financial year.

6.2 The Council of Governors may appoint sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

7. Council of Governors: Declarations

7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of ~~his~~ their qualification to vote as a Member and that they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme.

8. Council of Governors: Lead Governor

8.1 No person may serve as the Lead Governor for more than a total of nine years.

8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if they cease to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

9. Council of Governors: Appointment of Senior Independent Director

9.1 A majority of the Governors shall at a general meeting of the Council of Governors agree the appointment of one of the non-executive directors as recommended by the Board of Directors to be the Senior Independent Director for a term of three years. The Senior Independent Director shall be eligible for re-appointment at the end of that term but may not serve as Senior Independent Director for more than a total of six years.

9.2 The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of the Chair or Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate.

9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if they cease to be a non-executive director and the Senior Independent Director's term of office may be

terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors on the recommendation of the Chair.

ANNEX 6 – FURTHER PROVISIONS

1. Eligibility for Membership

It is the responsibility of members to ensure their eligibility and not the Trust, but if the Trust is on notice that a member may be disqualified from membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

2. Public Constituency

2.1 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

2.1.1 their name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

2.1.2 the Trust is otherwise satisfied that the individual lives in the said area.

2.2 An individual who is a member of the Public Constituency shall cease to be eligible to continue as a member if they cease to live in the area of the Public Constituency of which they are a member save as may otherwise be provided in this paragraph 2.

2.3 Where a member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which they are a member they shall forthwith advise the Trust that they are no longer eligible to continue as a member and the Trust shall forthwith remove their name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter, treat that individual as a member of that other Public Constituency and amend the register of members accordingly provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

2.4 Where a member ceases to live temporarily in the area of the Public Constituency of which they are a member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the member will either return to live in the area of that Public Constituency of which they are a member or will live in some other part of the area of the Trust in which case the provisions of paragraph 2.1 shall apply as appropriate.

3. Staff Constituency

3.1 A member of a Staff Class will cease to be eligible to be a member of that Staff Class if they no longer meet the eligibility requirements of paragraph 8 of the constitution and of Annex 2.

3.2 Where an individual is a member by virtue of their eligibility to be a member of a Staff Class and they cease to be eligible for membership of that Staff Class but are eligible for membership of some other Staff Class then the Trust may give notice to

that member of its intention to transfer him/herthem to that other Staff Class on the expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

4. Membership Termination of Tenure

4.1 A member may be expelled from membership of the Trust by a resolution approved by the majority of Governors voting at a meeting of the Council of Governors. The following procedure is to be adopted:

4.1.1 any member may complain to the Company Secretary that another member has acted in a way detrimental to or contrary to the interests of the Trust, or is otherwise disqualified as set out section 12 above; and

4.1.2 subject to paragraphs 12.2 to 12.6 below, if a complaint is made, the Council of Governors will consider the complaint, having taken such steps as it considers appropriate, to ensure that each member's point of view is heard and may either:

(a) dismiss the complaint and take no further action;

(b) arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors; or

(c) determine that the complaint should be investigated by an agreed investigating body. For the avoidance of doubt, not every complaint received should result in investigation.

4.1.3 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4.1.4 At the meeting, the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

4.1.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

4.1.6 A person expelled from membership will cease to be a member upon the declaration by the person chairing the meeting in question that the resolution to expel them is carried.

4.1.7 No person who has been expelled from membership pursuant to the provisions of paragraph 4.1 above is to be re-admitted as a member except by a resolution of the Council of Governors carried by the majority of governor votes present and voting at a meeting of the Council of Governors.

4.2 A member shall cease to be a member if:-

4.2.1 they cease to be entitled under this constitution to be a member of any of the public constituencies or one of the classes of the Staff Constituency;

4.2.2 they resign by notice in writing to the Company Secretary;

4.2.3 they die;

4.2.4 they are expelled under this constitution;

4.2.5 if it appears to the Company Secretary that they no longer wish to be involved in the affairs of the Trust as a member, and after enquiries made in accordance with a process approved by the Council of Governors they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a member.

4.3 All members of the Trust shall be under a duty to notify the Company Secretary of any change in their particulars which may affect their entitlement as a member.

5. Board of Directors: Disqualification

5.1 In addition to the grounds of disqualification set out in Sections 28 -31 of the constitution, a person may also not be or continue as a director of the Trust if:

5.1.1 in the case of a Non-executive director, ~~s/he~~they no longer ~~satisfies~~ satisfy the relevant requirements for appointment;

5.1.2 ~~s/he~~they are ~~is~~ a person whose tenure of office as a chair or as a director of a Health Service Body has been terminated on the grounds that ~~his/her~~their appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

5.1.3 ~~s/he has~~they have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body;

5.1.4 information revealed by a DBS check is such that it would be inappropriate for ~~him/her~~them to become or continue as a director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

5.1.5 in the case of an executive director, ~~s/he is~~they are no longer employed by the Trust;

5.1.6 ~~s/he is~~they are a person who has had their name removed by a Direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and have not subsequently had their name included on such a list;

5.1.7 ~~s/he is~~they are the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

5.1.8 ~~s/he has~~they have failed to sign and deliver to the Company Secretary in the form required by the Board of Directors confirmation that ~~s/he~~they accept~~s~~ the Trust's Standards of Business Conduct Policy;

5.1.9 s/he hasthey have failed or refused to undertake any training which the Board of Directors requires all Directors to undertake.

5.1.10 s/he isthey are a partner or spouse of an existing director.

6. Governors and Directors: Communication and Conflict

6.1 Summary

This paragraph describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

6.2 Informal Communications

6.2.1 Informal and frequent communication between the Lead Governor, governors and the directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

6.2.2 The Chair shall use their reasonable endeavours to encourage effective informal methods of communication including:

(a) participation of the Board of Directors in the induction, orientation and training of governors;

(b) development of special interest relationships between Non-executive directors and governors;

(c) discussions between governors and the Chair and/or the Chief Executive and/or directors through the office of the Chief Executive or their nominated officer; and

(d) involvement in membership recruitment and briefing at public events organised by the Trust.

6.3 Formal Communication

6.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

6.3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

(a) specific requests by the Council of Governors will be made through the Company Secretary to the Chair to the Board of Directors;

(b) any governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair. Such issues should be raised with the Chair (or, if it involves the Chair then the Deputy Chair) no less than 10 working days before the meeting in order to be included in the

agenda. In the event of disagreement, two thirds of the Governors present must approve the request. The Chair will raise the matter with the Board of Directors and provide the response to the Council of Governors;

(c) joint meetings will take place as and when, as, appropriate between the Council of Governors and the Board of Directors.

6.3.3 The Board of Directors may request the Chair to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

6.3.4 Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:

(a) the Board of Directors' proposals for the strategic direction the annual report and forward plan;

(b) the Board of Directors' proposals for developments;

(c) Trust Performance;

(d) involvement in service reviews and evaluation relating to the Trusts services; and proposed changes, plans and developments for the Trust other than those covered above.

6.3.5 The Board of Directors shall also present to the Council of Governors the Annual Accounts, Annual Report and any report of the auditors in accordance with the terms of this constitution and of the 2006 Act and any subsequent legislation or regulation.

6.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:

(a) attendance by the Board of Directors at a meeting of the Council of Governors; or

(b) provision of formal reports or presentations by executive and/or non-executive directors to a meeting of the Council of Governors;

(c) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

(d) reporting the views of the Council of Governors to the Board of Directors through the Chair, the Deputy Chair or the Senior Independent Director;

6.4 Resolving Conflict between the Council of Governor and the Board of Directors

6.4.1 The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

6.4.2 If the Chair cannot achieve resolution of a disagreement or dispute between the Council of Governors and the Board of Directors through informal efforts the Chair will follow the dispute resolution process described below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

(a) the Chair will call a joint meeting (Resolution Meeting) of equal numbers of governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. The resolution meeting will be held in private. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b) if the Resolution Meeting fails to resolve the conflict, the dispute will be deferred back to the Board of Directors who shall make the final decision;

7. Resolving Disputes about the Entitlement to Membership of the Trust and Eligibility for Membership of the Council of Governors

7.1 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other director of the Trust as the Chief Executive may, in their absolute discretion, nominate) as soon as reasonably practicable thereafter, and in any case, within 14 days of the Trust's decision.

7.2 The Chief Executive (or their nominated representative) shall:

7.2.1 view the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

7.2.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which they have considered; and

7.2.3 communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

7.2.4 Where a governor is declared ineligible or disqualified from office or their term of office as a governor has been terminated (for any reason other than expiry of their term of officer or as a consequence of their own resignation) and that person disputes the decision, they shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive, who shall use their reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

8. Indemnity

8.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board

functions, save where they have acted recklessly. Any reasonable costs arising in this way will be met by the Trust.

8.2 The Trust may purchase and maintain insurance against the liability for its own benefit of members of the Council of Governors, the Board of Directors and the Company Secretary.

8.3 The Trust may take out insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority (NHS Resolution) or successor body, in respect of directors' and officers' liability, including liability arising by reason of the Trust acting as corporate trustee of an NHS Chairty or director of a wholly owned subsidiary.

9. Validity of Actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any action taken by them.

10. Registers

10.1 The Company Secretary shall be responsible for compiling and maintaining the Registers. Removal from any register shall be in accordance with the provisions of this constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days.

10.2 Register of Members

10.2.1 Members must complete and sign an application in the form prescribed by the Company Secretary; and

10.2.2 the Company Secretary shall maintain the register of members will be in two parts. Part 1 shall include the name of each Member Registers (see section 32 and 33) and the Constituency or class to which they belong and shall be open to inspection by the public in accordance with paragraph 33 of this Constitution. Part 2 shall contain all the information from the individual's application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Trust is representative of those eligible for Membership.

10.3 Register of Members of the Council of Governors

The register shall list the names of members of the Council of Governors, their category of membership (public, staff or organisation represented) and an address through which they may be contacted which may be the Company Secretary.

10.4 Register of Interests of the Members of the Council of Governors

Each member of the Council of Governors shall complete and sign a form as prescribed by the Company Secretary setting out interests to be declared in accordance with the Standing Orders and the register shall contain the names of all members of the Council of Governors and any interests declared including no interests.

10.5 Register of Interests of Directors

The register shall list the names of members of the Board of Directors, their capacity on the Board and an address through which they may be contacted which may be the Company Secretary.

Each member of the Board of Directors shall complete and sign a form as prescribed by the Company Secretary setting out any interests to be declared in accordance with the Standing Orders for the Board of Directors and the register shall contain the names of all members of the Board of Directors and any interests declared including no interests.

11. Auditor

11.1 A person may only be appointed auditor if they (or in the case of a firm each of its members) is a member of one or more of the following bodies:

11.1.1 the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

11.1.2 any other body of accountants established in the United Kingdom and approved by the Regulator.

12. Accounts

12.1 The following documents will be made available to the Comptroller and Auditor General for examination at their request:

12.1.1 the accounts;

12.1.2 any records relating to them; and

12.1.3 any report of the auditor on them.

12.2 In preparing its annual accounts, the Trust is to comply with any directions given by the Regulator with the approval of the Treasury as to:

12.2.1 the methods and principles according to which the accounts are to be prepared; and

12.2.2 the information to be given in the accounts.

12.3 The Trust must:

12.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

12.3.2 once it has done so, send copies of those documents to the Regulator.

12.4 Annual reports and forward plans

12.4.1 The annual report submitted by the Trust to the regulator in accordance with paragraph 39.1 is to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies is representative of those eligible for such membership; and

(b) any other information the regulator requires.

12.4.2 The Trust is to comply with any decision the regulator makes as to:

12.4.3 the form of the reports;

12.4.4 when the reports are to be sent to it; and

12.4.5 the periods to which the reports are to relate.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND THE PROCEDURE OF THE COUNCIL OF GOVERNORS

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1. Introduction

1.1 Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire, DN2 5LT.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Council of Governors of the Trust to adopt Standing Orders for the regulation of its proceedings and business and to adhere at all times to the Code of Conduct for Governors.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

2. Definitions

In these Standing orders the definitions outlined in the constitution paragraph 1.

3. Meetings of the Council of Governors

3.1 Admission of the Public

3.1.1 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from a meeting on the grounds that:

a) any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

b) for other reasons stated in the resolution and arising from the nature of the business or the proceedings, that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the constitution.

c) Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.2 Calling Meetings

3.2.1 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 3 meetings in any year including:

a) an annual meeting no later than the 30 September in each year apart from the first year, when the Council of Governors are to receive and consider the annual accounts, any report by the auditor and the annual report; and

b) any other meetings required of the governors in order to fulfil their functions in accordance with the constitution.

3.2.2 The Company Secretary may call a meeting of the Council of Governors at any time. If the Company Secretary refuses to call a meeting after a requisition for that purpose, signed by at least three quarters of the members of the Council of Governors and specifying the business to be transacted at the meeting, has been presented to the Company Secretary, or if, without so refusing, the Company Secretary does not call a meeting within 5 clear days after such requisition has been presented to the Company Secretary at the Trust's Headquarters, such three-quarters or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

3.2.3 The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

3.2.4 The Council of Governors may agree that its governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 2.17 (Quorum).

3.3 Notice of Meetings

3.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf, shall be delivered to ~~or sent by post to the usual place of residence of~~ every governor, so as to be available to them at least 7 days before the meeting, save in the case of emergencies.

3.3.2 Before each meeting of the Council of Governors, a public notice of the time and place of the meeting, and if possible, the public part of the agenda, shall be advertised on the Trust's website at least 7 days before the meeting, save in the case of emergencies.

3.3.3 Want of service of the notice on any one governor shall not affect the validity of a meeting but failure to serve such a notice on more than three governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of emailing.

3.3.4 In the case of a meeting called by governors in default of the Chair, the notice shall be signed by those governors, and no business shall be transacted at the meeting other than that specified in the requisition.

3.3.5 Agendas will be sent to governors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than 5 Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chair to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

3.3.6 In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SO 3.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 Annual Meeting of the Council of Governors

3.4.1 The Council of Governors shall hold an annual meeting of the Council of Governors in every calendar year so that there is no more than fifteen calendar months between one meeting and the next and no more than 6 months from the end of the previous financial year (30 September) and shall present to that meeting:

a) A report on the proceedings of its meetings held since the last annual meeting;

b) A report on the progress since the last annual meeting in developing the membership strategy including the steps taken to ensure that the actual membership of its Public

Constituency and Service Users' and Carers' Constituency is fully representative of the persons who are eligible to be members under the constitution;

c) A report on any change to the governors which has taken place since the last annual meeting; and

d) A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding financial year and the future service development plans of the Trust.

3.5 Setting the Agenda

3.5.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A member of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make his their request in writing to the Chair or the Company Secretary at least 21 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 21 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

3.7 Chair of Meeting

3.7.1 At any Council of Governors meeting, the Chair, if present, shall preside. If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair shall preside.

3.7.2 If the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another non-executive director or the Lead Governor as shall be appointed by the Council of Governors shall preside.

3.8 Agenda

3.8.1 Where a governor has requested inclusion of a matter on the agenda in accordance with SO 3.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 3.8 shall apply in respect of the proposition:

3.8.2 The mover of the proposition shall have a right of reply at the close of any discussion on the proposition or any amendment thereto.

3.8.3 When a proposition is under discussion or immediately prior to discussion it shall be open to a governor to move: an amendment to the proposition;

a) the adjournment of the discussion or the meeting;

b) that the meeting proceeds to the next business;

c) the appointment of an ad hoc committee to deal with a specific item of business;

d) that the motion be now put;

e) that the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 3.1.

3.8.4 In the case of sub-paragraphs SO 3.8.3.c and SO 2.8.3.e above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

3.8.5 No amendment to the proposition shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the proposition.

3.8.6 The mover of a proposition shall have a maximum of five minutes to move and five minutes to reply. Once a proposition has been moved, no Governor shall speak more than once or for more than five minutes.

3.9 Report from the Board of Directors

3.9.1 Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Chief executive or nominated representative shall present a report on the Trust's progress and forward planning.

3.10 Chair's Ruling

3.10.1 Statements of governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.11 Voting

The Council of Governors will endeavour to ensure that decisions taken are by consensus and without recourse to voting, except where a vote is formally required under the constitution. Where however consensus is not achieved, the following process of voting will be applied.

3.11.1 A governor may not vote at a meeting of the Council of Governors unless, within 7 clear days prior to the commencement of the meeting they have made a declaration in the form specified within Schedule A of these Standing Orders, that they are a member of the constituency which elected them and are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

3.11.2 Subject to SO 3.11.4 below, matters requiring the conduct of a vote shall be determined by a majority of the votes of the governors present and voting on the question.

3.11.3 Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal, have a casting vote.

3.11.4 A resolution for the removal of the Chair or a non-executive director shall be passed only in accordance with the provisions of 28.2 to 28.5 of the constitution.

3.11.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

3.11.6 If at least one-third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained.

3.11.7 If a governor requests, ~~his~~ their vote shall be recorded by name upon any vote (other than by paper ballot).

3.11.8 A governor may only vote if present at the time of the vote on which the question is to be decided; no governor may vote by proxy, but a governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.

3.12 Special Provisions relating to Termination of Governor's Tenure:

3.12.1 Where a person has been elected or appointed to be a governor and they become disqualified from office under paragraph 16 or paragraph 17 of the constitution, they shall notify the Company Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of the first becoming aware of those matters which render them disqualified. The Company Secretary shall forthwith remove them from the Register of Governors.

3.12.2 If it comes to the notice of the Company Secretary that the governor is disqualified pursuant to SO 2.12.1, whether at the time of the governor's appointment or later, the Company Secretary shall immediately declare that the individual in question is disqualified and give them notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the governor disputes that they are disqualified, the governor may refer the matter to the dispute resolution procedure set out in paragraph 7 of Annex 6 within 28 days of the date upon which the notice was given to the governor.

3.13 Minutes

3.13.1 The minutes of the proceedings of a meeting shall be drawn up by the Company Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the Chair presiding at it.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.13.2 Minutes of meetings will be taken and circulated in accordance with governors' wishes.

3.14 Suspension of Standing Orders

3.14.1 Except where this would contravene any statutory provision or any direction made by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the governors are present, and that a majority of those present vote in favour of suspension.

3.14.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and governors.

3.14.4 No formal business may be transacted while Standing Orders are suspended.

3.14.5 Record of Attendance; the names of the Chair and governors present at the meeting shall be recorded in the minutes.

3.15 Variation and Amendment of Standing Orders

3.15.1 Subject always to paragraph 3.14 of Annex 7 of the constitution, these Standing Orders shall be amended only if:

a) a notice of proposal under Standing Order 3.5 has been given; and

b) at least two thirds of the total number of governors is present; and

c) the majority of governors present vote in favour of amendment; and

d) the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision, guidance issued by the Regulator or the Constitution.

3.16 Record of Attendance

3.16.1 The names of the Chair and governors present at the meeting shall be recorded in the minutes.

3.17 Quorum

3.17.1 No business shall be transacted at a meeting unless at least one third of the total number of governors are present with the majority of those present being Public Governors.

3.17.2 If at any meeting there is no quorum present within 15 minutes of the time scheduled for its commencement, the meeting shall stand automatically adjourned for a period of seven days and the Chair shall give or procure the giving of notice to all governors of the date, time and place of that adjourned meeting. Upon reconvening, those present shall constitute a quorum.

3.17.3 If a governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.18 Urgent Decisions

3.18.1 Where such a decision is required to be taken by the Council of Governors and which cannot await the next scheduled formal meeting of the Council of Governors, a section of the next Council of Governors development session be formally designated a formal general meeting for this specific purpose.

3.18.2 For decisions required to be taken in situations where the approach above does not result in a quorate meeting it is proposed that:

a) A decision to be taken, where justified, by the Lead Governor and Chair following consultation with the Deputy Lead Governor where elected.

b) Where the decision to be taken is one which would ordinarily be required under the constitution to be subject to a vote by the Council of Governors, that such a vote be conducted electronically outside of the meeting and overseen by the Company Secretary ~~(for those Governors who do not have access to or preference would be not to utilise IT, a paper vote would be enabled).~~ .

3.18.3 Any decision taken under such an approach would be reported to the next meeting of the Council of Governors.

3.18.4 The use of the above approach will only be utilised in exceptional circumstances, with the expectation that all business will be conducted at the formal Council of Governor meetings.

4 Lead Governor and Deputy Lead Governor

4.1 In accordance with the code of governance for NHS provider trusts the Council of Governors shall elect a Lead Governor and if required a Deputy Lead Governor who must be a governor. The Lead Governor (or in their absence a Deputy Lead Governor) has a role in facilitating direct communication between NHS England (or its successor) and the Council of Governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Company Secretary.

4.2 Without prejudice to the rights of any governor to communicate directly with the Chair, the Lead Governor shall be responsible for receiving from governors and communicating to the Chair any comments, observations and concerns expressed to the Chair by governors other than at meetings of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

4.3 The Deputy Lead Governor (where elected) shall be responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor whenever they are known to be unavailable.

4.4 Each governor shall communicate any comment, observation or concern which they may have to the Lead Governor in the first instance and only to the Deputy Lead Governor if the Lead Governor is known to be unavailable.

4.5 These appointments shall be made from those governors who have been elected as governors from the Public Constituency or appointed by a Partner Organisation

4.6 The Lead Governor and the Deputy Lead Governor so elected shall hold office for a period of three years provided that they continue to hold the governor seat to which they were duly elected or appointed. They may subsequently seek re-election for one more three-year period of office, provided that they continue to hold the governor seat to which they were duly elected or appointed.

4.7 Nominations for appointment as Lead Governor and Deputy Lead Governor shall be sent out with the papers for the first meeting or annual meeting of the Council of Governors as the case may be. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the principal place of business of the Trust addressed to the Company Secretary to arrive by a stipulated date.

4.8 There shall be separate forms of nomination for appointment to the position of Lead Governor and the position of Deputy Lead Governor and eligible governors may be nominated for both positions. In the event of there being two or more nominations for either appointment a secret postal ballot shall be held of all the governors with each governor having one vote for each contested appointment. The governor whose nomination receives the largest number of votes for each position shall be appointed.

4.9 In the event of the number of votes in any election being equal, a draw will take place overseen by the Company Secretary. The nomination whose name is drawn will be elected to the role.

4.10 The result of the ballot shall be announced at the meeting.

5 Committees

5.1 Subject to such guidance as may be issued by the Regulator, the Council of Governors may appoint committees of the Council of Governors to assist it in the proper performance of its functions under the constitution and the Regulatory Framework, consisting wholly or partly of the Chair and governors.

5.2 All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the governors attending the meeting.

5.3 A committee appointed under SO 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.4 These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chair" to be read as a reference to the Chair of the committee, and the term "governor" to be read as a reference to a member of the committee as the context permits.

5.5 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Regulator, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Where committees are authorised to establish sub-committees, they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.7 Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, provided that the financial and other implications of seeking outside advisors have been discussed and agreed by the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out at paragraph 6.4 of Annex 6.

5.8 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.9 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, such appointments are to operate in accordance with applicable statute and regulations and with guidance issued by the Regulator.

5.10 Where the Council of Governors determines that persons who are neither governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

6 Declarations of Interests and Register of Interests

6.1 Declaration of Interests

6.1.1 The Regulatory Framework and the constitution require each governor to declare to the Secretary:

a) any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

b) any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust which is under consideration or is to be considered by the Council of Governors, as described in SOs 6.2.2 and 6.2.3; and

c) any actual or potential family interest, direct or indirect, of which the governor is aware, as described in SO 6.2.5.

6.1.2 Such a declaration shall be made either at the time of the governor's election or appointment or within 28 days thereof, or otherwise as soon as they become aware of the existence of that interest, and in a form prescribed by the Company Secretary from time to time.

6.1.3 In addition, if a governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4 Subject to SO 6.2, if a governor has declared a pecuniary interest (as described in SOs 6.2.2 to 6.2.5) they shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the Council of Governor's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.5 This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a governor).

6.1.6 The interests of governors in companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.2 Nature of Interests

6.2.1 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

a) directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; or

c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS; or

d) a position of authority in a charity or voluntary organisation in the field of health and social care; or

e) any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

f) any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks; or

g) research/funding grants that may be received by an individual or their department; or

h) interests in pooled funds that are under separate management.

6.2.2 A governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) they, or a nominee of theirs, are a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, or which has a direct pecuniary interest in the other matter under consideration; or

b) they are a partner of or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.3 A governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

b) of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

c) of any travelling or other expenses or allowances payable to a governor in accordance with the constitution.

6.2.4 Where a governor:

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

d) the governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however it is their duty to disclose the interest.

6.2.5 A family interest is an interest of the spouse or partner or any parent, child, brother or sister of a governor which if it were the interest of that governor would be a personal interest or a pecuniary interest of theirs.

6.2.6 If governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Company Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including General Practitioners should also be considered.

7 Standards of Business Conduct

7.1 Members of the Council of Governors shall comply with the Trust's Code of Conduct for Governors and any guidance or best practice advice issued by the Regulator.

8 Appointments and Recommendations

8.1 A governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a governor from giving written testimonial of a candidate's appointment.

8.2 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4 The Chair and every governor shall disclose to the Trust Secretary any relationship between themself and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Company Secretary to report to the Council of Governors any such disclosure made.

8.5 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

8.6 Where the relationship to a member of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9 Remuneration and Expenses

9.1 Governors are not to receive remuneration.

9.2 The Trust will pay travelling expenses to governors in accordance with the relevant Trust policies for attendance at the Council of Governors, or any other business authorised by the Company Secretary as being under the auspices of the Council of Governors.

9.3 Expenses will be authorised and reimbursed through the Company Secretary's office on receipt of a completed and signed expenses form provided by the Company Secretary.

9.4 A summary of expenses paid to governors will be published in the Annual Report.

10 Miscellaneous

10.1 The Company Secretary shall provide a copy of these Standing Orders to each governor and endeavor to ensure that each governor understands their responsibilities within these Standing Orders.

10.2 These Standing Orders including all documents having effect as if incorporated in them shall be reviewed regularly by the Board of Directors and the Council of Governors.

10.3 Any written notice required by these SOs shall be deemed to have been given on the day the notice was sent to the recipient.

10.4 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All governors have a duty to disclose any non-compliance with these SOs to the Chair as soon as possible.

10.5 A governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

Schedule A: Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

I hereby declare that I am at the date of this declaration a member of the Public/Staff/Constituency (delete as necessary), and I am not prevented from being a member of the Council of Governors by reason of any provision of the Constitution.

Signed:

Print name:

Date:

Schedule B: Prescribed Form of Declaration of Interests

Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

Date

To the Secretary **of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust**

Dear

In fulfilment of the obligations imposed on me by paragraph 22 of the Constitution of the Foundation Trust and the provisions of Standing Order 6 of the Standing Orders for the Council of Governors generally, and in particular Standing Order 6.1.2, I hereby give notice to the Trust of my interest in:

[insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non-pecuniary, direct, indirect, actual, potential, etc.)**]**

as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's Register of Interests of the Members of the Council of Governors.

Yours faithfully
[name]

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. INTRODUCTION
2. THE BOARD OF DIRECTORS
3. MEETINGS OF THE TRUST
4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
5. COMMITTEES
6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS
7. STANDARDS OF BUSINESS CONDUCT
8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS
9. SIGNATURE OF DOCUMENTS
10. MISCELLANEOUS

1. Introduction

Statutory Framework

1.1 Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 35 of the Constitution requires the Board of Directors to adopt Standing Orders for the regulation of its proceedings and business.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

1.5 The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1.6 The Trust shall deal with the Regulator in an open and co-operative manner and shall promptly notify the Regulator of anything relating to the Trust of which the Regulator would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its authorisation or any financial or performance thresholds which the Regulator may specify from time to time.

1.7 The Chair, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Nolan Committee, now the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service. They will also ensure that they follow the best practice advice set out in the Code of Governance for NHS Provider Trusts.

1.8 Delegation of Powers – Scheme of Delegation

Under the Standing Orders relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

1.9 In these Standing orders the definitions outlined in the constitution paragraph 1 shall apply.

2. The Board of Directors

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to be made to the Charity Commission.

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided for in SO 3.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

3. Meetings of the Trust

3.1 Admission of the Public and the Press

3.1.1 Subject to SO 3.1.2, meetings of the Board of Directors shall be held in public, unless the Board of Directors in their absolute discretion determine that any part of a meeting of the Board of Directors shall be held in private.

3.1.2 Where the Board of Directors determines that meetings of the Board of Directors will be held in public, the public and representatives of the press may, at the absolute discretion of the Chair, be afforded facilities to attend a meeting of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" (Section1(2) Public Bodies (Admission to Meeting) Act 1960).

3.1.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on

grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

3.1.4 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.2. Calling Meetings

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of Directors, and this has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's Headquarters, such one third or more members of the Board of Directors may forthwith call a meeting.

3.2.3 The Trust will publicise and hold an Annual Public Meeting, which shall be on or before 30 September every year.

3.3. Notice of Meetings

3.3.1 Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an Officer of the Trust authorised by the Chair to sign on ~~his~~ their behalf, shall be delivered to every Director, by email so as to be available to ~~him~~ them at least 7 days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

3.3.3 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those directors, and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite 7 days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4. Agendas

3.4.1 Agendas will be accessible to members of the Board of Directors six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be accessible no later than three days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.4.2 A public notice of the time and place of the meeting, and the agenda (excluding any part of the agenda for which members of the public may be excluded from for special reasons), shall be displayed on the Trusts website at least three days before the meeting

3.5. Setting the Agenda

3.5.1 The Chair, or in their absence the Deputy Chair, shall determine the agenda for each meeting of the Board of Directors, being advised in this regard by the Chief Executive and the Company Secretary.

3.5.2 A Director desiring a matter to be included on an agenda shall make ~~his~~ their request to the Chair at least ten clear days before the meeting, subject to SO 3.3. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Chair. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6. Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

3.7. Chair of Meeting

3.7.1 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if there is one who is present, shall preside. If the Chair and Deputy Chair are absent, such non-executive director (and who is not also an Officer of the Trust) as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the members of the Board of Directors present shall choose, shall preside.

3.8. Chair's Ruling

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9. Notices of Motion

3.9.1 Subject to the provisions of SO 3.11 and SO 3.12, a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chair.

3.9.2 The notice shall be delivered at least 10 clear days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these SOs and the appropriate Regulations. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10. Emergency Motions

3.10.1 Subject to the agreement of the Chair, and subject also to the provision of SO 3.11, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.11. Motions: Procedure at and during a meeting

3.11.1 Who may propose

i) A motion may be proposed by the Chair of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 Contents of motions

i) The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

a) the reception of a report;

b) consideration of any item of business before the Board of Directors;

c) the accuracy of minutes;

d) that the Board of Directors proceed to next business

e) that the Board of Directors adjourn; or

f) that the question be put now.

3.11.3 Amendments to motions

i) A motion for amendment shall not be discussed unless it has been proposed and seconded.

ii) Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors

iii) If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.4 Rights of reply to motions

i) Amendments

a) The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

ii) Substantive/original motion

a) The member of the Board of Directors who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 Withdrawing a motion

i) A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11.6 Motions once under debate

i) When a motion is under debate, no motion may be moved other than:

a) an amendment to the motion;

b) the adjournment of the discussion, or the meeting;

c) that the meeting proceeds to the next business;

d) that the question should be now put;

e) the appointment of an 'ad hoc' committee to deal with a specific item of business;

f) a motion under SO 3.1.2 resolving to exclude the public (including the press); and

g) that a member be not further heard.

ii) In the cases of a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d), in the interests of objectivity, such a motion should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

iii) If a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

iv) The mover of a motion shall have a maximum of five minutes to move and five minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak for more than five minutes.

3.12. Motion to Rescind a Resolution

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate. This provision shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13. Voting

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

13.3.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

13.3.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each director present voted or abstained.

13.3.4 If a director so requests, ~~his~~ their vote shall be recorded by name upon any vote (other than by paper ballot).

13.3.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

13.3.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An Officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14. Minutes

3.14.1 The minutes of the proceedings of a meeting shall be drawn up by the Company Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained via electronic form and archive.

13.14.3 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.15. Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chair and the directors.

3.15.4 No formal business may be transacted while SOs are suspended.

3.15.5 The Audit and Risk Committee shall review every decision to suspend SOs.

3.16. Variation to Standing Orders

3.16.1 Subject always to paragraph 3.15 of Annex 8 of the constitution, these SOs shall be amended only if:

(i) relevant notice of a meeting has been served in accordance with SO 3.3;

(ii) a notice of motion under SO 3.9 has been given;

(iii) no fewer than half the total of the Trust's non-executive directors vote in favour of amendment;

(iv) at least two-thirds of the Board of Directors are present; and

(v) the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by the Regulator.

3.17. Record of Attendance

3.17.1 The names of the Chair and the directors present at the meeting shall be recorded in the minutes.

3.18. Quorum

3.18.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director and the Chair.

3.18.2 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.18.3 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Appointment and Terms of Service Committee).

3.19. Meetings: Electronic Communication

3.19.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.19.2 A director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Board of Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the directors attends by way of electronic communication is deemed to be held at such a place as the directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present ***and maintained*** throughout the meeting.

3.19.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the directors were all able to hear each other and were present throughout the meeting.

4 Arrangements for the Exercise of Functions by Delegation

4.1 Subject to SO 2.6 and such guidance as may be given by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.4 below, or by a director or an officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 Notwithstanding the provisions of SO 4.1, the provisions of paragraphs 4.2 to 4.3 of the Constitution apply.

4.3 Emergency Powers

4.3.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.4 Delegation to Committees

4.4.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.5 Delegation to Officers

4.5.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

4.5.2 The Chief Executive shall prepare a Scheme of Delegation identifying ~~his~~ their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.5.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer or other Executive director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

4.5.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.6 Duty to Report Non-Compliance with Standing Orders

4.6.1 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these SOs to the Company Secretary as soon as possible.

5. Committees

5.1 Appointment of Committees

5.1.1 Subject to SO 2.6 and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator, shall appoint committees of the Trust consisting wholly or partly of directors of the Trust or other Health Service Bodies or wholly of persons who are not directors of the Trust or other health service bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to such guidance as may be given by the Regulator, the Board of Directors or the other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of Directors (whether or not they are Directors of the Trust in question) or wholly of persons who are not directors of the Trust or the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any relevant legislation and/or regulations, and such guidance or best practice advice issued by the Regulator. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees, they may not delegate Executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 The committees and sub-committees established by the Board of Directors are:

i) Audit and Risk Committee;

ii) Nominations and Remunerations Committee;

ii) Finance and Performance Committee;

iv) Quality Committee; and

v) People Committee.

vi) as Trustees on behalf of DBTH of the Trust Charity – The Charitable Funds Board

5.1.8 The terms of reference of those Committees in paragraph 5.1.7 above shall be agreed by the Board of Directors.

5.1.9 The Board of Directors may also operate as a committee in accordance with SO 5.1.2. Any decisions taken by the Board of Directors in committee (i.e. Seminar meeting of the Board of Directors) must be brought to the next meeting of the Board of Directors.

5.2 Confidentiality

5.2.1 A member of a committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.2.2 A director or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. Interface between the Board of Directors and the Council of Governors

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the constitution.

6.2 The directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to the regulator.

6.3 The directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the auditor on them, and the annual report.

6.4 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 48 and 49 of the constitution is included on the agenda for a meeting of the Board of Directors.

6.5 If the Council of Governors so desires, such a matter as described within SO 6.4 to be included on an agenda item, they shall make their request in writing to the Chair at least 14 clear days before the meeting of the Board of Directors, subject to SO 3.3. The Chair shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 14 clear days before a meeting may be included on the agenda at the discretion of the Chair.

7. Declarations of Interests and Register of Interests

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Company Secretary:

7.1.1 any pecuniary interest in any contract, proposed contract or other matter which is under consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust irrespective of whether those interests are direct or indirect, actual or potential.

7.2 All existing members of the Board of Directors should declare such an interest as soon as the director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Company Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within seven clear days of becoming aware of the existence of a relevant and material interest.

7.4 In addition, if a director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.5 If a director has declared a pecuniary interest in accordance with SO 7, they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Board of Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.6 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

7.6.1 Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.6.2 ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.6.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

7.6.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.6.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.6.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks;

7.6.7 any other commercial interest in the decision before the meeting.

7.7 Any travelling or other expenses or allowances payable to a director in accordance with the constitution shall not be treated as a pecuniary interest.

7.8 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.9 A director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.9.1 they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, or which has a direct pecuniary interest in the other matter under consideration; or

7.9.2 they are a partner of or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.10 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.10.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.10.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.11. Where a director:

7.11.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.11.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.11.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.12 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of the constitution and the SOs to be also an interest of the other.

7.13. If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Company Secretary. Influence rather than the immediacy of the

relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships should also be considered.

7.14. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.15. SO7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a director).

7.16 Register of Interests

7.16.1 The Register of Interests shall contain the names of each director, whether they have declared any interests and, if so, the interests declared in accordance with the constitution or these SOs.

7.16.2 It is the obligation of the Director to inform the Company Secretary in writing within seven clear days of becoming aware of the existence of a relevant or material interest. The Company Secretary must amend the appropriate Register of Interests upon receipt of new or amended information as soon as is practical and, in any event, within fourteen clear days.

7.16.3 The Register of Interests will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register of Interests to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register of Interests must be provided to members free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests

7.16.4 The details of directors' interests recorded in the Register of Interests will be kept up to date by means of a regular review as necessary of the Register of Interests by the Company Secretary during which any changes of interests recently declared will be incorporated.

8. Standards of Business Conduct Policy

8.1 Policy

8.1.1 Directors and officers should comply with the Code of Governance for NHS Provider Trusts, the Trust Code of Conduct and any guidance and/or best practice advice issued by the Regulator. This section of SOs should be read in conjunction with these documents.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Company Secretary of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A director or officer must also declare to the Chief Executive or Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the Register of Directors interests.

8.3. Canvassing of, and Recommendations by, Directors in Relation to Appointments

8.3.1 Canvassing of directors or members of any committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4. Relatives of Directors or Officers

8.4.1 Candidates for any staff appointment shall when making an application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The directors and every member and officer of the Trust shall disclose to the Chief Executive any relationship between themhimself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an officer or another director of the Trust is disclosed, SO 8 shall apply.

8.5. External Consultants

8.5.1 SO 7 and SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Trust's Scheme of Delegation should be adhered to at all times.

9. Custody of Seal and Sealing of Documents

9.1 Custody of Seal

9.1.1 The common seal of the Trust shall be kept by the Company Secretary in a safe at Trust Headquarters. The seal shall only be released from the safe to enable it to be affixed to a document in accordance with these Standing Orders.

9.2 Sealing of Documents

9.2.1 The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

9.2.2 Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of two directors or a director and the Secretary duly authorised by the Chief Executive and not also from the originating department and shall be attested by them.

9.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an Officer nominated by ~~him/her~~them) and authorised and countersigned by the Chief Executive (or an Officer nominated by ~~him/her~~them who shall not be within the originating Directorate).

9.3 Register of Sealing

9.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least annually (The report shall contain details of the seal number, the description of the document and date of sealing).

9.3.2 Every contract for building and engineering works, which exceeds the sum of £250,000 shall be executed under the common seal of the Trust.

9.3.3 The officer responsible for the register of the opening of tender/quotation envelopes shall retain this under secure custody and will make it readily available to external and internal audit for inspection as required.

9.3.4 Trust officers issuing and receiving the tender/quotation documents shall retain those documents and envelopes under secure custody, for the following periods:

i) for documents under seal, 12 years; and

ii) for documents under hand, 6 years.

10. Signature of Documents

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document

(not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11. **Miscellaneous**

11.1 Standing Orders to be given to members and officers

11.1.1 It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to Officers designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies, where appropriate, of SOs.

11.2 Documents having the standing of Standing Orders, Standing Financial Instructions and the Scheme of Delegation shall have the effect as if incorporated into SOs.

11.3 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

ANNEX 9 –ANNUAL MEMBERS' MEETING

1. ANNUAL MEMBERS' MEETING

1.1 The Trust shall publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year (unless the circumstances of para 16.5 apply).

1.2 The following documents are to be presented to the members and governors of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

1.2.1 the annual accounts;

1.2.2 any report of the external auditor on them; and

1.2.3 the annual report.

1.3 There may be times and reasons that the Annual Members' Meeting may be held "virtually online" and not face to face. The Chair will decide these times in consultation with the Lead Governor and Board of Directors.

2. ADMISSION OF THE PUBLIC AND PRESS

4.3 Members, the public and representatives of the press shall be afforded facilities to attend the Annual Members' Meeting.

4.4 The Chair (or Deputy Chair) shall give such directions as ~~s/he~~they think~~s~~ fit in regard to the arrangements for meetings and accommodation of members, the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption.

4.5 Members, the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography, or use of social media.

5. CHAIR

5.1 The Chair, if present, shall preside at the annual members meeting. If the Chair is absent from the meeting the Deputy Chair shall preside.

5.2 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

6. NOTICE OF MEETING

6.1 The Company Secretary shall give at least fourteen days' notice of the date and place of the Annual Members' Meeting to all governors. Notice will also be published in communications to Trust members and on the Trust's website.

6.2 The notice of the meeting will specify the business proposed to be transacted at it

6.3 Lack of service of the notice on any governor shall not affect the validity of a meeting.

6.4 Before the Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, shall be placed on the Trust's website and shall be delivered to every governor by e-mail, or sent by post to the usual place of residence of such Governor if e-mail facility not available, so as to be available to him/herthem at least three clear days before the meeting.

Where the AMM is held virtually, members will have opportunities to ask questions on the business transacted before and after the meeting presentations by submitting directly to the AMM website and/or via the Trust Board Office.

7. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS

7.1 The following documents are to be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

7.1.1 the annual accounts;

7.1.2 any report of the auditor on them; and

7.1.3 the annual report.

8. AMENDMENT OF THE CONSTITUTION

8.1 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

8.1.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment(s), and

8.1.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

8.2 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect, and the trust must take such steps as are necessary as a result.

9. QUORUM

9.1 There may be times and reasons why the AMM is held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor and quoracy arrangements dependant on the nature of the business transacted.

9.2 In extremis (*see para 16.5*), the Chair may decide to review the terms of the meeting.

9.3 Where the Annual Members' Meeting is combined with a Council of Governors meeting for the purpose of receiving the annual accounts and reports, the quorum of the Council of Governors shall apply.

10. VOTING

10.1 Every question for decision at a meeting will be determined by a majority of the votes of the members present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

10.2 As members, governors may vote at the Annual Members' Meeting except where the matter under consideration is a constitution amendment regarding the powers or duties of the Council of Governors, (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

10.3 With the exception of the Chair, directors may not vote at the Annual Members' Meeting.

10.4 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands.

10.5 If a majority of the members present so request, the voting on any question may be recorded to show how each member present voted or abstained.

10.6 If a member so requests, ~~his/her~~their vote shall be recorded by name upon any vote

10.7 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

11. MINUTES

11.1 The names of governors, directors and members present at the meeting shall be recorded. However, if meeting is held virtually then monitoring of "virtual views" will be performed by a member of the Communications team and information given to both Chair and Company Secretary.

11.2 The minutes of the proceedings of a meeting shall be drawn up and maintained as a public record and submitted for final agreement at the next ensuing meeting where they will be signed by the person presiding at it.

11.3 They may be circulated for information prior to the next year's meeting and interim agreement of accuracy acknowledged by the Council of Governors (CoG).

11.4 Minutes shall be made available to the public in draft (interim CoG accuracy approved) format and then once finally approved at the next AMM, unless AMM was held virtually where agreement of accuracy will be acknowledged by the Council of Governors.

11.5 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

12. AGENDA

12.1 A governor or member desiring a matter to be included on an agenda shall make ~~his/her~~their request in writing to the Chair at least ten clear days before the meeting is notified to governors and members. Requests made less than ten days before a meeting is notified to governors may be included on the agenda at the discretion of the Chair.

13. MOTIONS

13.1 A governor or member of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting is notified to governors to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being

permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved without notice during the meeting, on any business mentioned on the agenda.

13.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

13.3 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

13.4 When a motion is under discussion or immediately prior to discussion it shall be open to a governor or member to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceeds to the next business. *

(v) That the motion be now put to a vote. *

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a governor who has not previously taken part in the debate.

13.5 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

14. CHAIR'S RULING

14.1 Statements of governors and members shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Scheme of Reservation and Delegation of Powers to the Board
June 2026



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Name and title of author/reviewer:	Rebecca Allen – Company Secretary Sam Wilde Chief Finance Officer
Date written/revised:	June 2026
Approved by (Committee/Group):	The Board of Directors
Date of approval:	August Board of Directors 2026
Date issued:	
Next review date:	January 2027 (in line with governance timetable)
Target audience:	Trust-wide

Scheme of Reservation and Delegation of Powers of the Board

Amendment Form

Please record brief details of the changes made alongside the next version number.
If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
Version 15		• Updated on SO and SFI references. Updated on executive designations,	Rebecca Allen
Version 14	April 2025	• Updated on authors • Expanded introduction • Removed duplicated clauses	Rebecca Allen Sam Wilde Matthew Bancroft Richard Somerset
Version 13	September 2024	• Updated minor typographical and formatting errors • Included reference to Grip and Control meetings • Updated Procurement terminology from EU to UK law • Clarity on losses and compensation decisions and above delegated limits • Replacing gender referenced language	Matthew Bancroft Richard Somerset Rebecca Allen
Version 12	July 2023	• Resetting Director of Finance and Deputy Chief Executive limits to pre-interim arrangements in 2022 • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 11	July 2022	• Introduction of the Deputy Chief Executive role within the delegation limits • Updated job titles • Removed reference to NHS Improvement • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 10	July 2021	• Replaced DoN with Chief Nurse • Updated references to NHS Improvement/NHS England • Reference to e-signing of contracts • Ensure Directors sign-off levels are consistent	Matthew Bancroft
Version 9	July 2020	Renaming names of structures/meetings	Matthew Bancroft
Version 8	November	Renaming names of structures/meetings	Jon Sargeant

	2018		
Version 7	September 2017	Various	Jon Sargeant and Matthew Kane
Version 6	September 2016	• Update to ensure consistency with the SFIs • Update for consistency with new committee structure • Various changes	Maria Dixon / Andrew Thomas
Version 5	March 2015	• Updated to reflect changes to Standing Orders relating to e-tendering and Working Together Group thresholds	Andrea Smith
Version 4	November 2013	• References throughout to Director of Finance, Information and Procurement / DoFIP amended to Director of Finance and Infrastructure / DoFI; • References throughout to Director of Human Resources amended to Director of People and Organisational Development; • Updated references and amendments for consistency to revised Standing Orders section 11 and tendering annex; • Clarification added to the posts included in role of 'Senior Officer'.	Robert Paskell

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1. Introduction

1. Arrangements for the Exercise of Functions by the Trust and its Officers

1.1 The Code of Governance for NHS providers requires the Board of Directors to draw up a schedule of decisions reserved to the Board of Directors only, and to ensure that management arrangements are in place to enable the clear delegation of other responsibilities. This document sets out the powers reserved to the Board of Directors, and the powers which may be delegated, and it should be referred to as the "Scheme of Reservation and Delegation".

1.2 Within the Licence Conditions issued by the Regulator, the Trust is required to demonstrate the existence of comprehensive governance arrangements which may be delegated in accordance with Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. These arrangements are to be read in conjunction with and subject to the Constitution, the Standing Orders and Standing Financial Instructions adopted by the Trust.

1.3 This document, sets out the powers reserved to the Board, the powers delegated to committees of the Board and to specific officers of the Trust. The document sets out the delegation derived from the code of conduct and accountability and from the Standing Orders for the Board of Directors. The document does not duplicate the extensive delegated powers and responsibilities set out within the Standing Financial Instructions. Therefore, the Scheme of Delegation must be read in conjunction with the Standing Financial Instructions.

1.4 In the absence of a named officer or committee, decisions may only be exercised by the Board of Directors in formal session.

1.5 The Board remains accountable for all of its functions; even those delegated to the Chair, individual Chiefs, or Officers, and would therefore expect to receive information about the exercise of those delegated functions to enable it to maintain a monitoring role.

2. Key Points

2.1 Role of the Chief Executive

2.1.1 All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated.

2.1.2 The Chief Executive will establish appropriate management arrangements to ensure that senior Officers pursue the Trust's policies in a corporate manner. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

2.1.3 The Chief Executive is the Accounting Officer of the Trust (Paragraph 16(1) of Schedule 7 to the 2006 Act) and is responsible and accountable for discharging the functions specified in the NHS Foundation Trust Accounting Officer Memorandum.

2.2 Caution over the Use of Delegated Powers

Powers are delegated to Chiefs and Officers on the understanding that they would not exercise delegated powers in a matter which, in their judgement, was likely to be a cause for public concern.

2.3 Chiefs and Officers Ability to Delegate their own Delegated Powers

2.3.1 The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.3.2 To assist the Chief Executive in their duties, and in accordance with the principle of holding individual Officers accountable for specific duties, they will delegate such functions as they consider appropriate, and in turn adjust such delegations as they deems necessary.

2.3.3 Individual Officers will have the opportunity to delegate such functions to their subordinates with the agreement of the Chief Executive, but such further delegation, if agreed, does not remove the accountability for the correct discharge of the function from the Senior Officer.

2.4. Absence of Chiefs or Officers to Whom Powers have been Delegated

In the absence of a director to whom powers have been delegated those powers shall be exercised by that Chiefs or officers superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive

3. Reservation of Powers to the Board

3.1 **The Code of Accountability** which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 3.2 to 3.9 below:

3.2 General Enabling Provision

The Board may determine any matter it wishes for which it has delegated or statutory authority in full session within its statutory powers.

3.3 Regulations and Control

3.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFI's) for the regulation of its proceedings and business.

3.3.2 Approval of a scheme of delegation of powers from the Board to officers or other bodies.

3.3.3 Suspension of Standing Orders in accordance with SO 3.15.

3.3.4 Variation or amendment of Standing Orders in accordance with SO 3.16.

3.3.5 Requiring and receiving the declaration of Executive and non-executive directors' and governor interests which may conflict with those of the Trust and determining the extent to which that director/governor may remain involved with the matter under consideration.

3.3.6 Requiring and receiving the declaration of officers' interests which may conflict with those of the Trust.

3.3.7 Disciplining members of the Board of Directors who are in breach of statutory requirements or the SOs.

3.3.8 Approval of the disciplinary procedure for officers of the Trust.

3.3.9 Approval of arrangements for dealing with complaints.

3.3.10 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to. For Clarity this would comprise details of the structure of the Board of Directors and its committees, plus the directorate structure of the Trust only.

3.3.11 To receive reports from committees including those which the Trust is required by the Secretary of State, independent regulator or other regulation to establish and to take appropriate action on.

3.3.12 To confirm the recommendations of the Trust's committees where the committees do not have executive powers and to establish terms of reference and reporting arrangements of all committees established by the Board of Directors.

3.3.13 Ratification of any urgent decisions taken in accordance with SO 6.10.

3.3.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

3.3.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

3.3.16 Authorise Use of the Seal in accordance with SO 9.

3.3.17 Approval of the Trusts Resilience Plan

3.3.18 Specification of its financial and performance reporting requirements

3.4 Appointments

3.4.1 The appointment and dismiss committees (and individual members) that are directly accountable to the Board of Directors.

3.4.2 The appointment, discipline and dismissal of Chiefs.

3.4.3 The appointment of members to committees of the Board of Directors and as representatives of the Trust on any outside bodies.

3.4.4 Appointment, discipline and dismissal of the Company Secretary

3.5 Policy Determination

3.5.1 To approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so received shall be listed.

3.6 Strategy, Plans and Budgets

3.6.1 Definition of the strategic aims and objectives of the Trust.

3.6.2 Approval of budgets, the Trusts Annual Plan, and Cost Improvement Plans submitted by the Chief Executive at least annually.

3.6.3 Approval of the capital programmes and determine guidelines within which the Chief Executive Officer may approve variations to the programme.

3.6.4 Approval in principle to the content and cost of individual capital schemes or single items of equipment over the expenditure limit of £1 million and to accept tenders for such, including tenders for any management consultancy.

3.6.5 Approval of proposals for ensuring quality and the developing clinical governance in services provided by the Trust, having regard for guidance issued by the Secretary of State or Independent Regulator

3.6.6 To identify key strategic risks, evaluate them and ensure adequate risk

management responses are in place and monitored through the Board of Directors and its committees

3.6.7 To consider advice from any other advisory committees as the Board of Directors may establish or recognise

3.6.8 To approve written evidence on behalf of the Trust to be submitted to statutory or other official bodies. Where urgent action is required, the Chief Executive Officer should act on behalf of the Trust and consult with the Chair of the Trust (or Deputy Chair in their absence) and report action taken at the next meeting of the Board of Directors.

3.6.9 Approval of the workforce plans set out within the Annual Plan

3.7 Direct Operational Decisions

3.7.1 Acquisition, disposal or change of use of land and/or buildings.

3.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000.

3.7.3 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1 million over the period of the contract

3.7.4 Approval of individual compensation payments made outside any legal/statutory or mandatory requirements after treasury approval received.

3.7.5 Approval of proposals for action on litigation against or on behalf of the Trust.

3.7.6 Approval of proposals in individual cases for the write off of losses or making special payments above the delegation limits (for losses and special payments)

3.7.7 Approval of business cases requiring additional revenue resources of over £1 million per annum

3.8 Financial and Performance Reporting Arrangements

3.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Chiefs, committees, and officers of the Trust as set out in management policy statements and delegated powers. All monitoring returns required by NHS England and the Charity Commission shall be reported, to the Board of Directors.

3.8.2 Approval of the opening or closing of any bank or investment accounts and

insurance brokers.

3.8.3 Receipt and approval of a schedule of NHS contracts to be signed in accordance with arrangements approved by the Chief Executive.

3.8.4 Consideration and approval of the Trust's Annual Report including the annual accounts.

3.8.5 Receipt and approval of the Annual Report(s) for funds held on trust.

3.8.6 Receipt of reports from the Chief Finance Officer on financial performance against plan

3.8.7 To authorise payments which due to their value require prior approval from the Board of Directors under the SOs and SFIs

3.9 Audit Arrangements

3.9.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit and Risk Committee meetings and take appropriate action.

3.9.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

3.9.3 The receipt of the annual report received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

4. Delegation of Powers to Committees of the Board

4.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS England and or the Charity Commissioners (including the need to appoint an Audit Committee and a Nomination and Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.1.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

5. Scheme of Authorisation to Officers

5.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Chief Finance Officer (CFO)

and other Chiefs and Officers. These responsibilities are summarised below.

> [**NOTE** It should be noted that the SFIs generally specify officers responsible for various matters whereas SOs only do this occasionally].

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Chief Finance Officer – with operational responsibility delegated to the Chief Information Officer
Health and Safety Arrangements	Chief Finance Officer – with operational responsibility delegated to the Director of Infrastructure

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each Chief Officer is responsible for the delegation within their area of responsibility. They should produce a scheme of authorisation for matters. In particular the scheme of authorisation should include how budget management and procedures for approval of expenditure are delegated.

A more detailed scheme of delegation including financial limits is given in Section 5.

As part of the scheme of delegation, senior officers are accountable back to the Board of Directors. To enable the Directors to assist with this delegation, financial oversight meetings are in place at a Divisional level. This helps Directors have oversight on the day to day powers that are delegated to senior offices, but also allows for both challenge and support, to help senior officers make decisions that are consistent across the Trust, supporting the Trust to function in a manner that is as efficient as possible.

6 – SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SCHEME OF DELEGATION DERIVED FROM THE BOARD OF DIRECTORS STANDING ORDERS ANNEX 8

SO REF	DELEGATED TO	DUTIES DELEGATED
2.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
4.1	CHAIR	Chair all board meetings and associated responsibilities.
3.2	CHAIR/DEPUTY CHAIR OR 1/3RD OF THE BOARD OF DIRECTORS	Calling meetings of the Board of Directors.
3.8	CHAIR	Give final ruling in questions of order, relevancy and regularity (including procedure on handling motions) of meetings and the interpretation of any SO or SFI. 'Chairs ruling'
3.13.1	CHAIR	Have a second or casting vote
3.15	BOARD OF DIRECTORS	Suspension of the Standing Orders
3.16	BOARD OF DIRECTORS	Review variation or amendment of the Standing Orders
4	BOARD OF DIRECTORS	Formal delegation of powers to committees, sub-committees or joint committees, and approval of their constitution, specific executive powers and terms of reference of such committees.
7	BOARD OF DIRECTORS	Declare relevant and material interests including any pecuniary interest in any contract, proposed contract or other matter under consideration by the Board of Directors.
5.1.5	BOARD OF DIRECTORS	The Board of Directors shall agree from time to time the delegation of executive powers.
7.16	COMPANY SECRETARY	Register(s) of interests.
4.5	CE	Prepare a scheme of delegation which shall be considered and approved by the Board of Directors
3.15.3	AUDIT AND RISK COMMITTEE	Review every decision to suspend the SOs (power to suspend the SOs is reserved to the Board of Directors),
11.1.1	CHIEF EXECUTIVE	Ensuring that existing Chiefs and Officers and all new appointees are notified of and understand their responsibilities within the SOs and the SFIs.

SCHEME OF DELEGATION DERIVED FROM THE BOARD OF DIRECTORS STANDING ORDERS ANNEX 8

SO REF	DELEGATED TO	DUTIES DELEGATED
9	COMPANY SECRETARY	Keep seal in safe place and maintain a register of sealing.
6.3.2	CE/CFO OR NOMINATED OFFICERS	Approve and sign under seal all building, engineering, property or capital documents exceeding the sum of £250,000.
10.1	CE	Approve and sign all documents which will be necessary in legal proceedings
10.2	CE OR THEIR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.

7 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	CHIEF FINANCE OFFICER (CFO)	Responsible for implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	CFO	Form and adequacy of financial records of all departments.
2.1.1	AUDIT AND RISK COMMITTEE	Provide independent and objective view on internal control and risk management.
2.2	CFO	Monitor and ensure compliance with directions on fraud and corruption.
2.5	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.6	COUNCIL OF GOVERNORS	Appoint external auditors.
3	CFO	Prudential Borrowing Requirement Control – Not used
4.1.3	CFO	Submit budgets.
4.1.4	CFO	Monitor performance against budget; submit to Board financial estimates and forecasts.
4.2	CE	Delegate budget to budget holders and submit monitoring returns.
4.3	CFO	Devise and maintain systems of budgetary control.
5	CFO	Annual accounts and reports.
6	CFO	Banking arrangements.

7 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
7	CFO	Income systems, fees charges, security of case, cheques and other negotiable instruments.
8.1	CE	Negotiating contracts for provision of patient services.
8.3	CFO	Regular reports of actual and forecast contract expenditure.
9.1	NOM. & REMUN. COMMITTEE	Remuneration & Terms of Service of directors and those employees not on Agenda for Change or Medial and dental contracts.
9.2	CE	Variation to funded establishment of any department.
9.3	CE	Renumeration of workforce, including agency staff, appointments.
9.4	CHIEF PEOPLE OFFICER	Processing of all aspects of Payroll
10.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.2	CFO	Be responsible for the Prompt payment of accounts.
10.2.3	CFO	Systems and process in place to ensure the Choice, requestioning , ordering and procurement of goods and services is in line with legislative requirements and best value for the Trust
10.2.5	CE	Authorise officers for the use of official orders.
10.2.7	CFO	Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance.
10.3	CFO	Legally binding agreements
10.3	CFO	Grants for provision of patient services.

7 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
11	CFO	Advise Board on borrowing and investment needs and prepare procedural instructions.
12	CE	Capital investment programme
12.3	CE	Maintenance of asset registers.
12.3.8	CFO	Calculate and pay capital charges in accordance with NHS England requirements.
12.4.1	CE	Overall responsibility for fixed assets.
12.4.4	DIRECTORS	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
13	CFO	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supply Chain Warehouses.
14.1	CFO	Responsible for systems and controls for the disposal of assets
14.2	CFO	Prepare procedures for recording and accounting for losses and special payments and informing NHS Counter Fraud Authority and the External Auditor of all frauds and informing police in cases of suspected arson or theft.
15	CFO	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' liability for their own money and property and any procedures on admission.
17	CFO	Shall ensure each fund held on trust is managed appropriately and maintain such records and accounts necessary and in line with audit requirements and legislation
18	CE	Retention of document procedures
19.1	CE	Has systems and processes in place for an effective Risk management programme

7 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
19.1.2	THE BOARD OF DIRECTORS	Insurance arrangements: Risk Pooling schemes administered by NHS Resolution
20	THE COMPANY SECRETARY	Acceptance of Gifts

8 - DETAILED SCHEME OF DELEGATION & AUTHORISATION

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. The delegation and authorisation shown below is the lowest level to which authority is given. Delegation and authorisation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising, consult with other Directors as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

Key: CE - Chief Executive, DCEO Deputy Chief Executive Officer, CMO- Chief Medical Officer, CN – Chief Nurse – CFO – Chief Finance Officer,
CPO – Chief People Officer, COO - Chief Operating Officer,
DoCM Director of Communications and Engagement
CoSec – The Company Secretary

Directors for the purpose of SO/SFI and Scheme of Delegation are Executive Directors.
For the avoidance of doubt: In the absence of the Chief Executive – the Deputy Chief Executive will be authorised to the same level of the Chief Executive within this document.
Senior officers are staff employed in the post of Divisional Director, General Manager, Deputy Director or Head of a department.

Delegated Matter	Authority Delegated To	Reference Document
1. Management of Budgets		SFIs Section 4
Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Budget Holder	
b) At service level	Divisional Director or Executive Director	
c) For the totality of services covered by Functional Director	Executive Director or CE	
d) For all other areas:	CFO or Appropriate Delegated Manager	
Budgetary or virement limits		
a) Up to £250,000 per request	Executive Director	
b) Up to £500,000 per request	CFO	
c) Over £500,000 per request	Executive Team	
Approval for the carry forward of funds into a different budgetary period	CFO	
Approval of revenue business cases		
a) Cases up to £250,000	Corporate Investment Group	
b) Cases over £250,000 and below £500,000	Finance and Performance Committee Board of Directors	

Delegated Matter	Authority Delegated To	Reference Document
C) Cases over £500,000		
2. Maintenance / Operation of Bank Accounts Maintenance / Operation of Bank Accounts	 CFO	SFIs Section 6 & Appendix 1
3. Quotation, Tendering & Contract Procedures **Authority to obtain at least:** a) To obtain best value for goods/services between £10,000 and £35,000 – three informal quotes b) 3 written quotations via e-tendering portal for goods/services from £35,000 to UK threshold (Find a Tender Service) currently ££112,515 excluding VAT with one quote where possible from a local supplier. c) Competitive tenders via e-tendering portal for works goods/services for tenders above UK threshold (Find a Tender Service) d) Single quotation approval between £10,000 to UK Threshold (Find a Tender Service) (single quotation above UK threshold (Find a Tender Service) is not permitted)	 Buyers & Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) or Executive Director Head of Procurement	SFIs Section 10 Appendix 4
4. Non Pay Expenditure/Requisitioning/Ordering/ Payment of Goods & Services Authorisation of requisitions/non pay expenditure: a) Requisitions to £2,000 b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £500,000 e) Requisitions between £500,000 to £1,000,000 f) Requisitions over £1,000,000 Authorisation of contracts for goods & services and subsequent variations to contracts a) Contracts up to £250,000 b) Contracts over £250,000 to £500,000 c) Contracts between £500,000 to £1,000,000 c) Contracts over £1,000,000 (this includes electronic signing of contracts) * These figures are the maximum allowed, but can be lower for staff as agreed within the Financial system	 Authorised Signatory for Budget* Head of Dept. General Manager or Divisional Director* Executive Director* CFO CE CE CFO CE Finance & Performance Committee Board of Directors	SFIs Section 10 & Appendix 4

Delegated Matter	Authority Delegated To	Reference Document
5. Capital Schemes		
Business Cases		SFIs Section 12
a) Production of case of need for every capital expenditure proposal	CFO	
b) Certification of costs and revenue consequences	CFO	
c) Approval of business cases to £1,000,000	Corporate Investment Group	
d) Approval of business cases over £1,000,000	Board of Directors	
Capital Programme		
a) Production of draft capital programme	CFO	
b) Confirmation of capital funds available	CFO	
c) Approval of capital programme	Board of Directors	
Capital Expenditure		
a) Issue authority to commit expenditure and proceed to tender up to budget approved in capital programme	CFO	
b) Responsibility of keeping expenditure within scheme budget	Scheme Manager	
c) Responsibility of keeping expenditure within total capital budget	CFO	
d) Approval of variations to scheme budgets from plan:		
i) To 10% of original scheme budget, a maximum of £50,000	CFO	
ii) To 20% of original scheme budget, a maximum of £250,000	CE	
iii) Above £250,000 or 20% of original scheme budget	Board of Directors	
e) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within UK regulations	CFO	
f) Financial reporting on all capital scheme expenditure	CFO	
g) Financial monitoring of all capital scheme expenditure	CFO	
h) Granting and termination of leases with annual rent <£100k	CFO	
i) Granting and termination of leases of annual rent >£100k	CE	
6. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	CFO	SFIs Section 7
b) Price of all NHS Contracts	CFO	SFIs Section 8

Delegated Matter	Authority Delegated To	Reference Document
7. Engagement of Staff Not On the Establishment (Within NHS England price caps)		SFIs Section 9
a) Management Consultancy	CFO	
b) Engagement of Trust's Solicitors	Relevant Executive lead	
c) Booking of Bank or Agency Staff		
i) Medical Locums	General Manager or Divisional Director	
ii) Nursing	Divisional Nurse	
iii) Clerical	Divisional General Manager for Divisions / Relevant Executive Director for corporate areas	
Outside NHSE price caps	Executive Director	
8. Expenditure on Charitable and Endowment Funds		SFIs Section 17
Up to £25,000 per request	CFO	
Over £25,000 per request	CEO or CFO after authorisation from the Charitable Funds Board	
9. Agreements/Licences		SFIs Section 10
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	CFO and CPO	
b) Extensions to existing leases	CFO	
c) Letting of premises to outside organisations	CFO	
d) Approval of rent based on professional assessment	CFO	
10. Condemning & Disposal		SFIs Section 14
a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Divisional General Manager, Department Manager and Condemning Officer	
b) disposal of x-ray films	Superintendent Radiographer	
c) disposal of controlled drugs	Chief Pharmacist	
11. Losses, Write-off & Compensation		SFIs Section 14
a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000	Two Executive Directors	
b) Fruitless Payments (including abandoned Capital Schemes)		
Up to £100,000	Two Executive Directors	
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other	Cash Committee	
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to:		
Culpable causes (e.g. fraud, theft, arson) or other		
Up to £50,000	Two Executive Directors	

Delegated Matter	Authority Delegated To	Reference Document
e) Compensation payments made under legal obligation	Two Executive Directors	
f) Extra Contractual payments to contractors Up to £50,000	Two Executive Directors	
<u>Ex-Gratia Payments</u> g) Patients and staff for loss of personal effects Up to £50,000	Two Executive Directors	
h) For clinical negligence up to £1,000,000 (negotiated settlements) i) Negotiate settlement up to £50,000 ii) £50,000 to £100,000 i) over £100,000 iv) Authorise payment (up to £1,000,000)	 MD CE Board of Directors CE or Nominated Director and CFO	
i) For personal injury claims involving negligence where legal advice has been obtained and guidance applied i) Negotiate settlement up to £25,000 ii) £25,000 to £100,000 iii) over £100,000 iv) Authorise payment (up to £1,000,000)	 CPO CE Board of Directors CE or Nominated Director and CFO	
j) Other, except cases of maladministration where there was no financial loss by claimant £50,000	 CE or Nominated Director and CFO	
Losses, Write-Off & Compensation above delegated limits	Audit & Risk Committee	
<u>12. Reporting of Incidents to the Police</u> a) Where a criminal offence is suspected (other than theft or fraud) b) Where a theft is involved c) Where a fraud is involved	 Director with managerial responsibility for the area CFO or CPO CFO	SFIs Sections 2 & 14
<u>13. Petty Cash Disbursements</u> a) Not permitted ordinarily, and no cash office in place currently. Disbursements to be processed through payroll expenses system only	Budget holder	SFIs Section 10
<u>14. Receiving Hospitality</u> Applies to both individual and collective items of hospitality (Including transport and accommodation costs, nominal fees etc) received **or offered and declined**, in excess of £50.	Declaration required by the individual in Trust's Hospitality Register	SFIs Section 20
<u>15. Implementation of Internal and External Audit Recommendations</u>	CFO	SFIs Section 2

Delegated Matter	Authority Delegated To	Reference Document
16. Maintenance & Update on Trust Financial Procedures	CFO	SFIs Section 1
17. Investment of Funds (including Charitable & Endowment Funds)	CFO	SFIs Section 17
18. Personnel & Pay		
a) Authority to fill funded post on the establishment with permanent staff.	Budget holder (after vacancy control approval)	SFI's Section 9
b) Authority to appoint staff to post not on the formal establishment.	CE and CFO	
c) Additional Increments		
The granting of additional increments to staff within budget	CPO	
d) Upgrading & Regrading		
All requests for upgrading/regrading shall be dealt with in accordance with Trust procedure	CPO	
e) Establishments		
i) Additional staff to the agreed establishment with specifically allocated finance	Budget holder (after vacancy control approval)	
ii) Additional staff to the agreed establishment without specifically allocated finance	CE and CFO	
f) Pay		
i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Senior Officer or relevant Executive Director	
ii) Authority to authorise overtime	Senior Officer or relevant Executive Director	
iii) Authority to complete and authorise positive reporting forms	Senior Officer or relevant Executive Director	
iv) Authority to authorise travel & subsistence expenses	Senior Officer or relevant Executive Director	
v) Approval of Performance Related Pay Assessment	Nomination and Remuneration Committee/CE	
g) Leave		
i) Approval of annual leave	Senior Officer or relevant Executive Director	
ii) Annual leave - approval of carry forward (up to maximum of 5 days).	Senior Officer or relevant Executive Director	
iii) Annual leave - approval of carry over in excess of 5 days.	relevant Executive Director	
iv) Compassionate leave up to 3 days	Senior Officer or relevant Executive Director	
v) Compassionate leave over 3 days	Relevant Executive Director	
vi) Special leave arrangements	Relevant Executive Director	
paternity leave	Senior Officer or relevant Executive Director	
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence	MD and CE	
paid and unpaid	General Manager or Divisional Director	
ix) Time off in lieu	Automatic approval with guidance	
x) Maternity Leave - paid and unpaid	Automatic approval with guidance	
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with CPO	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with CPO	
iii) Extension of sick leave on full pay	CPO or CE	

Delegated Matter	Authority Delegated To	Reference Document
i) Study Leave i) Study leave outside the UK ii) Medical staff study leave (UK) iii) All other study leave (UK) j) Removal Expenses, Excess Rent and House Purchases Authorisation of payment of removal expenses incurred by Directors taking up new appointments (providing consideration was promised at interview) k) Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief People Officer must be sought when the grievance reaches the level of Associate/Dept. Manager l) Authorised Car & Mobile Phone Users Requests for new posts to be authorised as car users Requests for new posts to be authorised as mobile telephone users m) Renewal of Fixed Term Contract n) Redundancy o) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health p) Dismissal q) Development of personnel, industrial relations & training strategies and procedures r) Authorisation of expenditure on recruitment advertising s) Day to day management of Consultants' contracts t) Excellence Awards to Medical staff.	 CPO or MD Divisional Director / Chief Medical Officer Senior Officer or Executive Director CPO CPO CPO CPO Senior Officer or Executive Director CPO CPO Appointing Officers Executive Directors CPO CMO / Divisional Directors CE	
19. Authorisation of New Drugs Estimated total yearly cost up to £25,000 Estimated total yearly cost above £25,000	 Medicines Management Group CE (Subject to consultation with the above)	SFIs Section 10
20. Authorisation of Sponsorship deals	CE	
21. Authorisation of Research Projects	CE or CMO or Chief Nurse	
22. Authorisation of Clinical Trials	CE and CMO	
23. Insurance Policies and Risk Management	CFO CMO	SFIs Section 19
24. Patients & Relatives Complaints		

Delegated Matter	Authority Delegated To	Reference Document
a) Overall responsibility for ensuring that all complaints are dealt with effectively under regulations. b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico - Legal Complaints Co-ordination of their management.	CE Senior Officer and PALS Rep. CMO	
25. Relationships with Press a) Non-Urgent General Enquiries Within Hours Outside Hours b) Urgent Within Hours Outside Hours	 DoCM Executive Director on call DoCM Executive Director on call	
26. Infectious Diseases & Notifiable Outbreaks	CNO or Consultant Microbiologist or Control of Infection Nurse	
27. Extended Role Activities Approval of any professions to undertake duties / procedures which can properly be described as beyond the normal scope of practice.	Clinical Governance Committee	
28. Patient Services a) Variation of operating and clinic sessions within existing numbers Outpatients Theatres Other b) All proposed changes in bed allocation and use (excluding critical care) **Temporary Change** **Permanent Change** Contract monitoring & reporting	 COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director In hours COO with Head of Patient Flow advice. Out of hours Executive on call with Clinical Site Manager advice CE with advice from COO & Chief Nurse CFO	

Delegated Matter	Authority Delegated To	Reference Document
c) Critical Care	CE or Executive Director on call	
29. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience students	CPO	
30. Review of fire precautions	CE	SFIs Section 19
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	CE	SFIs Section 19
32. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	CE	
34. Review of Trust's compliance with the Data Protection Act, including GDPR	CFO	SFIs section 15
35. Monitor proposals for contractual arrangements between the Trust and outside bodies a) Monitor proposals for contractual arrangements between the Trust and other healthcare bodies b) Monitor proposals for contractual arrangements between the Trust and non-healthcare bodies	 CFO CFO	
36. Review the Trust's compliance with the Access to Records Act	CMO	
37. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	CMO	
38. The keeping of a Declaration of Interests Register	Company Secretary	SFIs Section 20
39. Attestation of sealings in accordance with Standing Orders	CE and CFO	Constitution Para 47
40. The keeping of a register of Sealings	Company Secretary	Constitution Annex 8, para 8
41. The keeping of the Hospitality Register	Company Secretary	Constitution Para 7

Delegated Matter	Authority Delegated To	Reference Document
42. Retention of Records	CE	Section 18
43. Clinical Audit	CMO	
44. Nominated Fire Director Within Hours Outside Hours	 CE Executive Director on call	
45. Agreement of Policies a) To recommend the adoption of new policies to the Board of Directors b) To approve policies where authorised to do so by the Board of Directors	The appropriate sub-committee of the Board e.g. Finance and Performance for finance related policies	
46. Working Together Partnership Committee in Common All functions agreed to be delegated by the Board and listed in the DBTH Committee in Common terms of reference.	Committee in common consisting of CEO and Chair or nominated deputies	DTH CiC TORs
47. Intellectual Property The disposal of intellectual property rights	Executive Team	

9. ROLES AND RESPONSIBILITIES OF GOVERNORS

The Constitution states that at general meetings, the Council of Governors shall discharge the following responsibilities:

9.1 The appointment or removal of the Chair and the other Non-Executive Directors (Trust Constitution; section 28, para 28.2 and Annex 5, para 5).

9.2 Approve an appointment (made by the Non-Executive Directors) of the Chief Executive (Trust Constitution; section 31, para 31.2 An Annex 5; para 5).

9.3 The appointment or removal of the Trust's auditors (Trust Constitution; Annex 5; para 5.1.1(c)).

9.4 Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors (Trust Constitution; Annex 5; para 5.1.1(b)).

9.5 Approve any significant transaction, as defined in the constitution (Trust Constitution; Annex 5; para 5).

9.6 Approve any merger, acquisition, separation or dissolution proposed (Trust Constitution; Annex 5; para 5).

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Scheme of Reservation Delegation CORP/FIN 1 (C) 14	CE/Finance	Rebecca Allen	Existing Policy	February 2025

1) Who is responsible for this policy? Name of CSU/Directorate – Chief Executive Office

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards of business conduct

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: February 2026

Checked by: Rebecca Allen Date: February 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Standing Financial Instructions

~~April 2025~~June 2026



Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Matthew Bancroft – Head of Financial Control
Date written/revised:	~~April 2025~~June 2026
Approved by (Committee/Group):	Board of Directors
Date of approval:	August 2026 (BDS)
Date issued:	
Next review date:	~~April 2026~~January 2027 (governance timetable)
Target audience:	Trust-wide

Standing Financial Instructions

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 14		• Update to:	Rebecca Allen Matthew Bancroft
Version 13	April 2025	• Amending limits for invoice approval so they mirror those in the Standing Orders/SoD • Amending responsibility for notification for staff who leave employment without giving notice • Clarified wording confirming that Deputies have the same invoice sign-off levels as the substantive postholder, when the substantive post holder is on leave.	Matthew Bancroft
Version 12	September 2024	• Minor typographical/layout changes • Updated guidance with regards to petty cash not being used within the Trust • Updated Procurement guidelines	Matthew Bancroft
Version 11	July 2023	• Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 10	July 2022	• Removed references to NHS Improvement • Updated job titles • Introduction of IFRS 16 within capital section • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 9	July 2021	• "Chairman" replaced by "Chair" • Updated reference to NHS Improvement/NHS England. • Clarified Procurement process for £25k-£50k	Matthew Bancroft
Version 8	July 2020	• Updated job titles throughout • Updated the NHS Logistics provider details • Updated references to NHSI/NHSE throughout. • Updated references to procurement legislation and the impact of leaving the EU • Updated references to "Estate code" • Updated references to "NHSLA"	Matthew Bancroft

Version 7	March 2019	• Updated names of structures/meetings • Updated sections relating to PBL, Data Protection, Health & Safety and budget virements.	Jon Sargeant
Version 6	30 January 2018	• Updated sections on Audit, Budgets, funded/ budgeted establishment, Banking, Payment of Directors and Employees, Non Pay Expenditure, Funds Held on Trust • Procurement and Tendering Appendix added	Winston Weir

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FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1. INTRODUCTION

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of ~~Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust~~Reservation and Delegation. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2. These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer subject to review by the Finance and Performance Committee.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4. **Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.**

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

“the Board”	means the board of directors as constituted in accordance with the Trust Constitution;
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
"Budget Holder"	means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;
“Chair”	means the Chair of the Trust appointed in accordance with the Trust Constitution;
“Chief Executive”	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Constitution"	means the Trust Constitution and all annexes to it;

"Director"	means a director on the Board of Directors;
"Chief Finance Officer"	means the Chief Finance Officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"NHS England"	means the body corporate known as NHS England;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Officer"	means an employee of the Trust;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

1.2.2. Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the ~~'Reservation of Powers to the Board'~~'Scheme of Reservation and Delegation' document.

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as ~~Accountable~~ Accounting Officer to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

And, without prejudice to any other functions of directors and employees to the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to the Trust and its directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8. All directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook.

The Board has established the Audit and Risk Committee to perform the role of the Audit Committee along with additional responsibilities in relation to risk management and assurance. The sub-committee will provide an independent and objective view of internal controls and risk management by:

(a) overseeing Internal and External Audit services;

(b) reviewing all internal audit reports;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) ensuring that there are adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work;

(f) assessing and providing assurance to the Board on the validity of the control environment within the Trust

(g) reviewing schedules of losses and compensations and making recommendations to the Board;

(a) reviewing controls assurance systems, including disseminating relevant information to governors; and

(b) reviewing risk management arrangements.

The Board shall satisfy itself that at least one member of the committee has recent and relevant financial experience.

2.1.2 Where the committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chair of the committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England. (To the Chief Finance Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 Fraud and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with directions on fraud and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS).

2.2.3 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist will provide a written report to the Audit and Risk Committee, at least annually, on counter fraud work within the Trust and national context.

2.3 Security Management

2.3.1 The Chief Executive will monitor and ensure compliance with directions on NHS security management.

2.3.2 The Board shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).

2.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated by the Chief Executive to the Director responsible for Security Management (SMD) and the appointed Local Security Management Specialist (LSMS).

2.3.4 The LSMS shall work with the staff in NHS Counter Fraud Authority.

2.3.5 The LSMS will provide a written report, at least annually, to the ~~Audit and Risk Committee~~Finance and Performance Committee on security management work within the Trust.

2.4 Chief Finance Officer

2.4.1 The Chief Finance Officer is responsible for;

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the mandatory audit standards;

(c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:

(i) a clear statement on the effectiveness of internal control,
(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

2.4.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.5 Role of Internal Audit

2.5.1 Internal audit will provide an independent and objective opinion on risk management, control and governance arrangements by measuring and evaluating their effectiveness. The Head of Internal Audit will provide an annual opinion on the whole system of internal control.

2.5.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the integrity, reliability and suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.5.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

2.5.4 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all committee members, the Chair and Chief Executive of the Trust.

2.5.5 The Head of Internal Audit shall be accountable to the Audit and Risk Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit and Risk ~~Sub-~~Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.6 External Audit

2.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust, in accordance with paragraph ~~35~~ 42 of the constitution. The auditor must be a member of one or more of the bodies referred to in ~~paragraph 11,~~ Annex 6, paragraph 11 of the constitution.

2.6.2 The Council of Governors must ensure that the auditor meets the criteria included by the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General at the date of appointment and on an ongoing basis throughout the term of their appointment.

3. PRUDENTIAL BORROWING REQUIREMENT CONTROL

No longer required

4. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 In addition the Chief Finance Officer will annually compile, and submit to the Board, such financial plans as required by NHS England.

4.1.3 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the annual business plan;
- accord with workload and staffing plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks; and
- comply with NHS England requirements and other regulations

4.1.4 The Chief Finance Officer shall monitor financial performance against budget and business plan monthly and report to the Board and Financial Oversight Committee appropriately.

4.1.5 All budget holders must provide information in a timely manner as required by the Chief Finance Officer to enable budgets to be compiled.

4.1.6 All Budget Holders will sign up to their allocated Budgets at the commencement of each financial year.

4.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer. In defining what is either non-recurring or recurring the Chief Finance Officer will have the final decision.

4.3 Budgetary Control and Reporting

4.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

- income and expenditure to date showing trends, forecast year-end position, and variances against budget;
- balance sheet;
- cashflow;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- movements in reserves;
- details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and staffing budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers or virements.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

4.3.3 Detailed rules relating to budgetary virement are set out in Appendix 3.

4.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and other parties as required and in line with G1 (1-4) of the NHS provider licence.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the Trust's accounting policies, Government Accounting Manual and international financial reporting standards (IFRS);

(b) prepare and submit annual financial reports in accordance with current guidelines; and

(c) submit financial returns for each financial year in accordance with the guidance and timetable prescribed by NHS England.

5.2 The Trust's audited annual accounts and auditor's report and Quality Accounts must be presented to the Board of Directors for approval or to Audit and Risk Committee by delegation from the Board and to a general meeting of the Council of Governors.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at the Annual Members' Meeting. The document will comply with NHS England's Annual Reporting Manual (ARM).

6. BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

6.1 General

6.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by NHS England.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and Government Banking Service Accounts

6.2.1 The Chief Finance Officer is responsible for:

(a) Setting arrangements in place that NHS Shared Business Service compiles with its contract with the organisation for bank and banking services

(b) Commercial bank accounts and accounts operated through the Government Banking Service (GBS);

(c) establishing separate bank accounts for the Trust's non-exchequer funds;

(d) ensuring payments made from commercial banks or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

(e) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Procedures

6.3.1 The Chief Finance Officer will prepare detailed instructions (agreed with NHS Shared Business Services) on the operation of commercial bank and GBS accounts which must include:

(a) the conditions under which each commercial bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 Payments over £10,000 shall be supported by more than one authorised signature on the cheque or authority to pay as appropriate.

6.3.4 The Chief Finance Officer shall nominate members of ~~his~~ their staff who are authorised to

act as signatories in respect of commercial bank and GBS accounts.

6.4 Tendering and Review

6.4.1 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.2 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.3 The Chief Finance Officer shall be responsible for implementing any such guidance issued by NHS England in relation to the costing and pricing of services, and in particular services provided to NHS Commissioning bodies.

7.3 Debt Recovery

7.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. Where receipt of such indemnities is problematic or unclear no such items shall be held in Trust safes.

7.4.5 A cheque and payable order register shall be kept in which all cheque and payable order stocks ordered, received and issued shall be recorded and signed for by nominated officers.

8. CONTRACTING FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

8.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

8.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income (linked to contract activity) with a detailed assessment of the impact of the variable elements of income and an assessment of any significant risks faced.

8.4 This also includes both partnership and provision of facilities arrangements to private

healthcare providers in their provision of health care and diagnostic services to patients.

9. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 Nomination, Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders, the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

(i) Identify and appoint candidates to fill Executive Director positions when they arise.

(ii) Identify and nominate a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

(iii) Decide any matter relating to the disciplining or the continuation in office of any Executive Director and the company secretary at any time including the suspension or termination of service of an individual as an employee of the Trust.

(iv) Monitor and evaluate the performance of individual Executive Directors on an annual basis.

(v) Decide and review the terms and conditions of office of Executive Directors and senior managers on locally-determined pay in accordance with relevant Trust policies, including:

a. Salary, including any performance-related pay or bonus;
b. Provisions for other benefits, including pensions and cars; and
c. Other allowances.

(vi) Decide all contractual arrangements for Executive Directors, including, but not limited to, termination payments.

9.1.3 The Committee shall report to the Board regarding its recommendations.

9.1.4 The Trust will remunerate the Chair and Non-executive Directors in accordance with instructions issued by the Council of Governors.

9.2 Funded/Budgeted Establishment

9.2.1 The staffing plans incorporated within the annual budget will form the funded / budgeted establishment. The funded/ budgeted establishment will list out the grade, amount, whole time equivalent for the relevant department(s) and must be set out and agreed each financial year.

9.2.2 The funded/budgeted establishment of any department may be varied in line with Appendix 3 Budgetary Virement~~may not be varied without the approval of the Chief Executive. and Director of People & OD~~.

9.2.3 The funded/budgeted establishment of any clinical department will take account of the required safe levels of clinical staff as necessary for the running of those services.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief People Officer is responsible for:

(a) ensuring that arrangements in place so that the Trust receives an effective and efficient payroll service

(b) specifying timetables for submission of properly authorised time records and other notifications;

(c) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

9.4.2 The Chief People Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for pension, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payments to employees;

(i) procedures for the recall of bank credits

£ (j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Divisional General Manager must be informed immediately.

9.4.4 Where the Chief People Officer has contracted with another body to administer the Trust's payroll service responsibility for compliance with the above requirements remain with the Chief People Officer.

9.4.5 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.6 Directors and Staff Expenses

9.6.1 Claims for expenses should be submitted in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

9.6.2 All claims should be submitted for authorisation, along with any accompanying receipts, as

soon as possible after the end of the month concerned. However, all claims must be submitted within three months of the month in which the claim arose. Any claim periods in excess of this deadline will not usually be paid.

9.6.3 Once authorised, claims will be paid in accordance with current guidelines and regulations.

9.6.4 Claimants must not make duplicate claims for expenses from any other body in addition to that from the Trust.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Wherever appropriate, the supply of goods and services shall be covered by a contract following a competitive exercise.

10.2.2 The Trust's Head of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

10.2.3 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 4);

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) be responsible for ensuring that all payments made by the Trust fall within its powers.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV) and the intention is not to

circumvent cash limits;

(b) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet ~~his~~ their commitments;

(c) the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered, even where electronically generated;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with public procurement regulations);

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHS England/NHS Improvement;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered in advance on an official order as outlined in

the Procurement Policy. All invoices received where an order is not already in place will be returned;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. All such instances shall be reported to the Chief Finance Officer and followed up with an official purchase order;

(h) No orders shall be issued retrospectively of the items being received or the service being delivered;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are not permitted and any such expenditure should be performed on an exception basis, and reclaimed through the payroll expenses system.

10.2.7 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Legally Binding Agreements (e.g. leases)

10.3.1 Any leases or rental agreements must be vetted by the Chief Finance Officer prior to final agreement, to enable insurance issues and technical accounting treatment to be determined. In addition, all leases entered into on behalf of the Trust should represent value for money.

10.3.2 All lease agreements must be signed on behalf of the Trust by the Chief Finance Officer (or ~~his~~ their deputy) in addition to being accompanied by the usual order and duly authorised in accordance with these SFIs.

10.4 Grants to Local Authorities and Voluntary Bodies

10.4.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

10.4.2 The financial limits for officers' approval of grants are set out in the Scheme of Delegation.

11. EXTERNAL BORROWING AND INVESTMENTS

11.1 External Borrowing

11.1.1 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS England for NHS Foundation Trusts. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning Public Dividend Capital debt and all loans and overdrafts.

11.1.2 Any application for PDC, a loan or overdraft will only be made by the Chief Finance Officer or by an employee so delegated by him. Also, such applications must however first be authorised by the Board.

11.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.

11.1.4 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan. Where there is a need to vary from this principle due to unforeseen in year events a revised business plan will be prepared and provided to the Board to support its deliberations when considering the need to borrow.

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board and within such government guidance as may be in place from time to time. The need to prudently manage public funds from unnecessary risk will be a key factor in any decision making regarding what bodies to deposit such funds with.

11.2.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

(d) shall ensure that processes and procedures are in place to monitor, record and report spend against each element of the Capital programme.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "The efficient management of healthcare estates and facilities" (previously "Estatecode") and other official guidance that may become available from time to time.

The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "The efficient management of healthcare estates and facilities" guidance and the Trust's Standing Orders.

12.1.5 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.1.6 Due to the introduction of IFRS 16, for the avoidance of doubt, leases of over 12 months in length should follow the process for capital projects.

12.2 Private Finance

12.2.1 Where appropriate the possibility of attracting private finance will be investigated for capital expenditure proposals.

12.2.2 The Chief Executive will consider such proposals along with all other bids received, in line with the Trust's priorities.

12.2.3 Where the proposal is approved the private sector will be invited to submit their bids based upon clear, high level, service based objectives.

12.2.4 Once the private sector bids have been received the Chief Finance Officer will provide or commission any specialist assistance to allow the bids to be appraised on a like for like basis.

12.2.5 The Chief Executive shall be responsible for deciding upon the preferred shape of the proposed contract and inviting the bidders to tender.

12.2.6 The Chief Finance Officer shall ensure that all privately financed proposals represent value for money and genuinely transfer risk to the private sector.

12.2.7 Proposals which include the lease of equipment and/or buildings will be tested for Value for Money and the Transfer of Risk by the Capital Accountant.

12.2.8 To allow this appraisal of the lease to take place the following financial details shall be obtained:

(a) Capital value of asset(s) supplied;
(b) Minimum lease period;
(c) Minimum lease payment;
(d) Frequency of lease payment, including details as to whether required in arrears or advance;
(e) Premium for payment by non-direct debit method if applicable;

(f) Interest rate implicit in the lease (if available).

12.2.9 Figures shall be requested for a number of different lease periods, to identify the option, which gives the best returns for the Trust, and be exclusive of VAT.

12.2.10 For comparative purposes the capital value of the asset supplied will be the value at the start of the contract plus the discounted value of any enhancements during the minimum lease term less the discounted value of any disposal proceeds at the end of the lease term.

12.2.11 The fundamental requirements of a PFI proposal with regards risk are that it is allocated to the party which is best able to manage it and that it is genuinely transferred to the private sector.

12.2.12 By achieving optimum risk transfer between the parties to the PFI proposal there is a greater likelihood that value for money will also be achieved.

12.2.13 The risks associated with a project typically fall under the following headings:

(a) Design and Construction Risks;

(b) Commissioning and Operating Risks;

(c) Demand, Volume or Usage Risks;

(d) Technology and Obsolescence Risks;

(e) Regulation and Other Risks;

(f) Project Financing Risks.

12.2.14 The Value for Money attributable to a project is tested by comparing the net present value (or cost) of the estimated annual cash flows over an appraisal period equivalent to the PFI contract term.

12.2.15 In addition the PFI proposal shall be assessed for its affordability. This will show whether the proposal is affordable to the Trust and that the impact on prices can be afforded by the Trust's main commissioner.

12.2.16 The Chief Finance Officer will be notified in advance of all lease and PFI agreements before any commitment is made.

12.2.17 The Chief Executive will ensure that all proposed agreements are scrutinised by either in-house experts or the Trust's Solicitors to ensure that the agreements are comprehensive and are not disadvantageous to the Trust.

12.2.18 The Board must specifically agree all PFI proposals before any contracts are signed.

12.2.19 When comparing the financials of the various options VAT shall be included within the calculation in so far as it is irrecoverable. The Chief Finance Officer shall engage professional

VAT advisers to facilitate this where it is felt necessary.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. Where systems are in place to monitor these on an ongoing basis a rolling programme of checks and/or sampling will be acceptable.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be based on good accounting practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with good accounting practice and NHS England guidelines. A periodic revaluation of land and buildings will be undertaken, by an independent professional valuer, as required by accounting guidelines.

12.3.7 The value of each asset shall be depreciated using methods and rates as specified in accounting standards.

12.3.8 The Chief Finance Officer or ~~his~~ their nominated representatives shall calculate capital charges.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines –to apply such appropriate routine security practices in relation to property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and similar items of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. Where stock control systems allow this may be undertaken on a rolling or sample basis as is felt best to ensure the accurate control and recording of stock.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain Coordination Limited (SCCL) central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy ~~himself~~ themself that the goods have been received before accepting the recharge.

13.9 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification.

13.10 The issue of stores shall be supported by an authorised requisition note and a receipt for the stores issued shall be returned to the Procurement Department, Issuing Department, or Chief Finance Officer.

13.11 Where a 'topping up' system is used a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variances.

13.12 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Chief Finance Officer.

13.13 Breakages and other losses of goods in stores shall be recorded as they occur and a summary shall be presented to the Chief Finance Officer at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain food stuffs and natural deterioration of certain goods.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

The Trust may not dispose of any protected property without the approval of NHS England in line with the provider licence CoS 2.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS, who will then inform NHS Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer must ensure that NHS Counter Fraud Authority and the External Auditor are notified of all frauds.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Finance Officer must immediately notify:

(a) the Board, and

(b) the External Auditor.

14.2.4 The Board shall approve the writing-off of losses. The level of delegation to Senior Officers of the Trust are set out in the Reservation of Powers to the Board and Delegation of Powers ~~section~~ Table ~~5~~8, ~~paragraph~~ section 11.

14.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

14.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 All losses and special payments must be reported to the Audit and Risk Committee at every meeting although the identities of individuals should not be reported unless requested.

15. INFORMATION TECHNOLOGY

15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

15.2 The Chief Finance Officer shall satisfy ~~himself~~ themself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 In the case of computer systems which are proposed General Applications, all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

15.6 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.7 The Chief People Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the verbal advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where it is a requirement for the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) or other statue, the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the duel accountabilities to the Charity Commission for charitable funds held on trust and to NHS England for all funds held on trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust. Any further guidance is set out in the Charitable Funds Policy (approved by Board of Directors on an annual basis).

17.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.5 The Chief Finance Officer shall maintain such accounts and records, including an investment register, as may be necessary to record and protect all transactions and funds of the Trust as trustees of funds held on trust.

17.2 Existing Trusts

17.2.1 The Chief Finance Officer shall make arrangements for the administration of all existing funds held on trust and shall produce instructions covering every aspect of the financial management of the funds.

17.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make

recommendations to the Board regarding the potential for rationalisation, within statutory guidelines.

17.3 New Trusts

17.3.1 The Chief Finance Officer shall arrange for the creation of a new trust where funds and/or other assets are received and cannot be adequately managed as part of an existing trust.

17.3.2 When making such as assessment as outlined in 17.3.1 above the needs for simplicity of administration and therefore downward pressure on costs shall also be considered.

17.4 Sources of New Funds

17.4.1 In respect of donations, the Chief Finance Officer shall:

(a) provide guidelines to officers of this Body as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 The Chief Finance Officer shall deal with all Legacies and Bequests.

17.4.3 In respect of Fundraising, the Chief Finance Officer shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of this Body and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Chief Finance Officer shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) for alerting the Board to any irregularities regarding the use of this Body's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

17.4.4 In respect of Trading Income, the Chief Finance Officer shall:

(a) be primarily responsible with other designated officers, for any trading undertaken by this Body as corporate trustee; and

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 Investment Management

17.5.1 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) the formulation of investment policy within the powers of this Body under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Chief Finance Officer shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to approve;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 Disposition Management

17.6.1 The exercise of this Body's dispositive discretion shall be managed by the Chief Finance Officer in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Body; and

(f) the definitions of "charitable purposes" as agreed by the Charity Commission.

17.7 Banking Services

17.7.1 The Chief Finance Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Body as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

17.8 Asset Management

17.8.1 Assets in the ownership of or used by this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Chief Finance Officer shall ensure:

(a) that appropriate records of all assets owned by this Body as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust are accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for;

(e) all share and stock certificates and property deeds shall be deposited either with the Trust's bankers or, where this is not practicable, held securely at trust premises.

17.9 Reporting

17.9.1 The Chief Finance Officer shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Chief Finance Officer shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board.

17.10 Accounting and Audit

17.10.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Chief Finance Officer on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

17.11 Administration Costs

17.11.1 The Chief Finance Officer shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

17.12 Taxation and Excise Duty

17.12.1 The Chief Finance Officer shall ensure that this Body's liability to taxation, duties and other such charges is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17.13 Authorisation Levels of Expenditure from Trust Funds

17.13.1 The Board has established levels of authorisation necessary for expenditure from the funds held on trust, these are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 8.

These will be reviewed on a regular basis to ensure that they remain at an appropriate financial level.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained following good practice under the direction contained in Department of Health guidelines.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 Programme of Risk Management

19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to complete the annual governance statement within the Annual Report and Accounts.

19.1.3 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

19.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (previously NHS Litigation Authority) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3 Insurance Arrangements with Commercial Insurers

19.3.1 The Board shall decide if the Trust will insure with commercial insurers to supplement or replace the cover available through the risk pooling schemes. If the Board decides to use commercial insurers this decision shall be reviewed annually.

19.4 Arrangements to be followed by The Board in Agreeing Insurance Cover

19.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

19.4.3 The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.4.4 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Board Company Secretary shall ensure that all staff are made aware of the Trust Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the department of health standards of business conduct for NHS staff set out in "Code of Conduct for Directors and employees".

APPENDIX 1 - INVESTMENTS

INVESTMENTS

1. The Chief Finance Officer shall ensure that all funds are invested in the name of the Trust. No officer other than the Chief Finance Officer shall open accounts to invest funds on behalf of the Trust.

2. The Chief Finance Officer shall advise bankers and other approved deposit facilities in writing of the conditions under which each account shall be operated.

3. Transfers of funds from bank and GBS accounts to investment accounts must be authorised by two signatories.

APPENDIX 2 – SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

1. All cash, cheques postal orders and other forms of payments received by an officer other than a cashier shall be entered immediately on an approved form. All cheques and postal orders shall be crossed immediately "Not negotiable -A/c Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust". The remittances shall be passed to the cashier from whom a signature shall be obtained.

2. The opening of coin operated machines and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Chief Finance Officer and the coin box keys shall be held by a nominated officer.

3. Where amounts of cash have to be transported, special arrangements shall be made by the Chief Finance Officer with a specialist security firm. Under no circumstances shall cash in excess of (£500) be transported by only one officer and the route travelled and times of collection shall be varied as far as practicable.

4. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in ~~his~~ their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

5. All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

6. Staff shall be informed on appointment, by the appropriate departmental or senior officers, of their responsibilities and duties for the collection, handling or disbursement or cash, cheques, etc, in line with appropriate financial procedures. This must be in writing, acknowledged, and acknowledgement retained.

7. Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned shall be reported immediately to the Chief Finance Officer

APPENDIX 3 – BUDGETARY VIREMENT

BUDGETARY VIREMENT

1. Virement is the term used to define the movement of funds from one budget heading to another.

2. Virement within Individual Budgets:

2.1 Where a budget holder is expected to be under spent at the year-end, the budget holder may be allowed to offset this under spending against overspendings elsewhere in his/her budget, subject to the criteria itemised below.

2.2 Budget holders are not allowed to use non-recurrent savings for recurrent commitments, for example, savings on equipment purchased cannot be used to appoint new permanent staff.

2.3 Subject to the overall financial position of the individual Division and the Trust, virement will be allowed using the following criteria:

(a) Efficiency/CIP targets are being achieved;
(b) The predicted year end expenditure will be within budget;
(c) The predicted year end income will at least achieve the target;
(d) The proposed expenditure is within overall policy, i.e. virement cannot be used to initiate a development of a new / existing service, which is not policy;
(e) All other targets are being achieved;
~~(f) Approval has been obtained from the Chief Finance Officer.~~

2.4 Virement between Divisions:

Expected underspend~~ing~~s can be transferred to another Division subject to the agreement of both budget holders and the same constraints as above.

2.5 Virement between Revenue and Capital:

This can only be done in exceptional circumstances when approved in advance by the Chief Finance Officer.

2.6 Budgetary and Virement Limits of the Chief Executive:

Budgetary or virement limits of the Chief Executive delegated by the Board are outlined in the Scheme of Delegation.

APPENDIX 4 - PROCUREMENT AND TENDERING

1 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to procurement and tendering.

1.3 The Chief Finance Officer (or Deputy in ~~his~~ their absence) must personally authorise any contract which commits the Trust to expenditure from £10,000 up to £250,000 as determined by the scheme of delegation. The Chief Executive (or Chief Finance Officer in ~~his~~ their absence) must authorise all expenditure from £250,000 to £1,000,000. Any contract over £1,000,000 requires Board approval before Chief Executive authorization.

1.4 Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases~~, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan~~ must be approved by the Trust's Corporate Investment Group (CIG). ~~Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to CIG for review and recommendation to the Board.~~ These costs are whole life costs. All expenditure in excess of £1.0~~.5~~m requires approval of the Board.

1.5 In addition to the Trust delegated tendering limits, attention must be paid to the UK procurement regulations and any subsequent procurement legislation that become statutes following the UKs exit from the European Union in all cases advice should be sought from the Head of Procurement Head of Procurement to ensure compliance with appropriate thresholds.

2 COMPETITIVE TENDERING (Over £35,000)

2.1 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price. The standard method of procurement will be by competitive tender for goods or services expected to cost in excess of £35,000; this may be waived under the following circumstances:

- Where the requirements are ordered under existing contracts or where in the opinion of the ~~Finance Director~~Chief Finance Officer:

- there is only one supplier and no reasonably satisfactory alternative product/service;

- competition would be impractical, impossible or not beneficial;
- the requirement is to be ordered under existing contracts;
- the work for practical reasons must be of the same manufacture, for instance repairs/spare parts for existing equipment;
- where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

2.2 In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (£35,000 and under)

3.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £35,000 but is above £10,000. For quotations over £35,000, these must be undertaken by the Procurement Department.

3.2 Non-competitive quotations in writing may be obtained for the following purposes:

(a) where the supply of goods (or related goods) is of a special character and does not exceed £10,000;

or where in the opinion of the ~~Finance Director~~Chief Finance Officer:

(b) there being only one supplier and no reasonably satisfactory alternative product/service available;

(c) competition would be impractical, ~~impossible~~ or ~~not Beneficial;~~have no benefit to the Trust in terms of cost or time

(d) the requirement ~~is~~ to be ordered ~~under existing contracts;~~with the current provider, albeit outside the normal contract terms, for continuity reasons.

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment or brand recognition;

(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

(g) where there is an urgent time constraint to procure a product or service, that in all reasonable circumstances, the Trust would not have been able to foresee.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3.3 Officers should involve the Head of Procurement in choice of supplier, price negotiation and in the procurement process for all goods and services.

3.4 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the Head of Procurement should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

3.5 No single supplier or single annual order should be used for a period in excess of 12 months. The advice of Head of Procurement should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

4 TENDERING PROCEDURES

4.1 The basic procedures to be followed in relation to competitive tenders are set out below.

4.2 In all cases the tender that provides the best value for money must be accepted using a defined combination of cost and quality. Any proposal to waive this rule would need the approval of:

- goods/services in excess of £10,000 and up to UK Threshold of £112,515 excluding VAT~~111,750~~	Chief Finance Officer

Anything over UK Threshold needs initial advice from the Head of Procurement before commencement.

4.3 Officers with any doubts concerning the appropriateness of competitive tendering in particular circumstances must seek formal clarification from the Chief Finance Officer. The Trust will not be responsible for officers committing costs other than in accordance with the above procedures.

4.4 Tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

4.5 Every tender for building and engineering works, except any tender for maintenance work only, where "The efficient management of healthcare estates and facilities" guidance should be followed, shall embody or be in the terms of the current Edition of the Standard Form of Building Contract Local Authorities Edition with (or, where appropriate, without) quantities or the Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate or (when the contents of the works is primarily engineering) the General Conditions of Contracts recommended by the Institute of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institution of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These base documents should be modified and amplified to accord with current Departmental guidance forms of contract may be used after prior consultation with the Department.

4.6 Tenders submitted via e-tendering will be electronically date and time stamped.

4.7 Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

4.8 Alterations to tenders submitted via e-tendering will be electronically marked.

4.9 Tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

4.10 Technically late tenders (i.e. those uploaded in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

4.11 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon ~~his~~ their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

4.12 Necessary discussion with a tenderer of the contents of ~~his~~ their tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

4.13 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tenders will remain electronically unopened.

4.14 Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

4.15 Every contract for building and engineering works, except measured term contracts where Estmancode guidance should be followed, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

4.16 No goods, services or works other than works and services, executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Chief Finance Officer.

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Financial instructions –April 2025 - CORP/FIN 1 (B) v.13	CE/Finance	Matthew Bancroft	Existing Policy	April 2025

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework within which the Trust can properly conduct its financial affairs and transactions.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: April 2026

Checked by: Matthew Bancroft Date: April 2025

2609- H3 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Stephen Radford, Non-executive Director | 12:35

5 Minutes

REFERENCES

Only PDFs are attached

H3 - Chairs Log Assurance - Finance & Performance Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Subject:	**Finance & Performance Committee**	**Board Date: 1 September 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 Finance & Performance Committee meeting held on **28 July 2026**	

Matters of Concern (*Moderate, Limited,* or *Weak* Assurance)

The Committee received ***Moderate Assurance*** in the following areas:

Financial Performance - Month 3

- For month 3, the Trust reported a £6.4m year to date deficit, which is £3.9m adverse to plan due to Deficit Support Funding (DSF) now being received on different basis than originally budgeted.
- Award of DSF for Q1 has been confirmed and now received. To qualify for more DSF funding, further progress in de-risking the Reset plan must be demonstrated to NHSE.
- The underlying forecast deficit exit rate for 26/27 exit rate remains at £10.1m which is in line with the Medium-Term Plan.
- In the year to-date, Trust Improvement Delivery Plan (IDP) efficiency programme has delivered recurrent full year savings of £12.3m and a 70.8 WTE recurrent reduction in the funded establishment.
- Agency costs have reduced month on month and are now aligned to plan. Bank costs in month though lower than last month are still off target.
- Cash reduced to £8.1m and is adverse to plan by £19.4m mainly due to the payment profile of the year end capital creditors and timing of payment runs.
- The Committee assigned Moderate Assurance given that the Trust is only in Month 3. Progress will need to be made against the financial plan before a change in the level of assurance can be made.

Agency & Bank Optimisation Deep Dive

- The Committee received the requested deep dive into the Agency & Bank optimisation scheme within the Workforce & Organisational Design pillar of the Reset programme.
- Updates were provided for Medical, Nursing Bank & Allied Health Professionals, Sickness Absence and Rostering Effectiveness.
- It was noted that Agency usage overall in the Trust is experiencing a downward trend

Work Underway / Major actions commissions

Trust Reset Programme

- The Committee received an update on the overall programme and the 6 pillars within the programme and Red Amber Green (RAG) status associated with each. Detailed discussions took place on the Workforce & Organisational Design pillar which has a red RAG status.
- The Committee were told a remedial actions list is being developed to help to support savings delivery should a shortfall be identified.
- The £46.2m full-year forecast remains on plan, but the risk-adjusted forecast is £27.7m. Recurrent full-year effect delivered to date is £12.3m against £28.2m planned, and Whole Time Equivalent (WTE) change is behind plan.
- A NEON Health Solutions is being implemented through an initial six-week rapid engagement. The aim is to provide a single delivery-control view of schemes, milestones, benefits, WTE, risks, issues and impacts for the next Reset Board and future Finance and Performance Committee updates.
- The priority for Quarter 2 is to convert opportunities and designs into approved, implemented and saving projects.

when viewed over the past 12 months, however bank usage over the same time period has increased.

- Workstreams are focused on improving rostering, reporting, governance, and data quality
- Improvements have been made in grip and control, and reporting but further work remains to be performed to ensure that Reset targets for Bank and Agency are delivered. Moderate assurance was assigned.

Green Plan Delivery Report

- The Committee received the progress update on Green Plan delivery between February 2026 and July 2026.
- The Committee noted that resource limitations, competing priorities, and additional capacity constraints arising from the Trust's RESET programme would lead to delays to parts of the Green Plan, whilst areas supporting savings would be expedited.
- The Green programme remains aligned with national policy and the Trust's strategic objectives
- Moderate Assurance was assigned by the Committee given that satisfactory progress continues to be made and that arrangements are in place to support ongoing delivery of the Green Plan

Access Standards – June 2026

Emergency Care:

- ED 4 hours performance improved month on month to 71.3% but was 4.7% off plan.
- The performance is driven by underperformance at the Doncaster site.
- Action plans are in place to address this 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 62.9% against a target of 65.4%.
- Over 52 week waits - 2.7% of patients were waiting <52 weeks against the trajectory of 0.75%. An increase of 0.2% month on month.
- The most significant risk to >18 week & 52-week performance targets is Trauma and Orthopaedics speciality. Substantive improvements are required or both targets are likely to be missed by the Trust. These will be addressed if the proposed Trauma and Orthopaedic recovery plan obtains funding.

Cancer:

- The 31-day Cancer standards was 97.5% against plan of 95.5%. The Trust benchmarked well against other Trusts.
- The 28 Day Faster Diagnosis Standard was 76.3%, against a plan of 80.3%. A significant improvement month on month
- The 62-day referral to first treatment standard was 70.4% against the plan of 71.9%
- The Committee assigned Moderate Assurance

Substantial, Significant, Assurances	Decisions Made
Digital & Data Progress Report • The F&P Committee received an update on key digital projects and programmes • Electronic Patient Record (EPR) programme remains on track but remains with a RAG status of amber. • The Committee noted the positive progress being made across all deliverables within the Digital Enabling Plan. • A major restructuring of the Chief Information Officer services is planned as part of the Reset programme in 26/27, which may lead to some delays of the digital strategy for the Trust. • The Committee assigned significant assurance based on progress made to-date ***Board Assurance Framework Risk 4, and 5 plus Trust Risk Register*** • The F&P Committee received an update on BAF 4 (Estates and Care Environment) and BAF 5 (Finance). • The Committee noted the updates to the sources of assurance / gaps for BAF 4 particularly around funding and actions to address gaps in control. • Updates for BAF5 will be provided in the next iteration of the report. • The Committee assigned a significant level of assurance based on the report provided.	***Treasury Management Policy*** • The F&P Committee received the updated Treasury Management Policy for the Trust for review. After discussion, the revised Policy was approved by the Committee under delegated authority from the Board. ***Winter Plan 2026/27*** • The F&P Committee received the Winter Plan 2026/27 for review and approval, before its final approval by the Trust Board • The Plan involves the provision an additional 37 beds at Bassetlaw and 29 beds at Doncaster, plus extended opening hours for the Trauma Ambulatory Care Unit (TACU) at Doncaster for the period 01/01/27 to 31/03/27. This is at an incremental cost to the Trust of £4.01m. This amount is not included in the Trust budget and therefore would adversely affect the Trust's financial position and the expected outturn deficit of the Trust at the end of 2026/27. • The Committee noted that the proposal reflected previous years' experience and expected demand. • The F&P Committee asked for the paper to be updated for other available options and to clearly indicate the financial impact/reasoning for the recommended option • The Committee, subject to these changes recommended this to the Board for further review and final approval. ***Fire Safety Policy (CORP/HSFS 14 v.8)*** • The F&P Committee received the updated Fire Safety Policy for review. After the due consideration, the Policy was approved by the Committee and recommended to the Board for final review and approval ***Teleradiology Reporting Services Contract*** • The F&P Committee using the authority delegated from the Trust Board approved a direct award of the Teleradiology contract under the Provider Selection Regime via the NHS Supply Chain Managed Equipment and Clinical Service Solutions Framework. This involves the continuation of teleradiology reporting services with the existing provider. • The contract award had the full support of both procurement and clinical teams ***Trauma & Orthopaedic (T&O) Recovery Plan*** • The F&P Committee received the T&O Recovery plan for review. • The plan is intended to deliver the elimination 65 week waits by the end of February 2027, clear the remaining backlog and deliver the Medium-Term Plan referral to treatment trajectory from 2027/28. Once complete, the Trust will have a sustainable T&O service which meets the referral to treatment access standard of 92% recurrently

	from April 2029. • The Plan has been developed in conjunction with Operations, GIRFT Elective Team and Finance. • The Plan requires significant external funding to be put in place by the ICB for delivery. If this is not forthcoming the Trust will not be able to meet its Referral To Treatment (RTT) or treatment trajectory as defined in the Medium-Term Plan. • The plan is recommended to the Board for review and final approval.

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.

2609 - H4 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 12:40

5 Minutes

REFERENCES

Only PDFs are attached

H4 - Chair's Assurance Log - Quality Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Committee - Chair's Highlight Report to Trust Board

Subject:	**Quality Committee**	**Board Date: 1 September 2026**
Prepared By:	Jo Gander, Chair Quality Committee	
Approved By:	Quality Committee Members	
Presented By:	Jo Gander, Chair Quality Committee	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 6 August 2026	

Matters of Concern (*Moderate, Limited,* or *Weak* Assurance)	**Work / Major actions commissions**
None to report	Items brought to the Quality Committee for information; • Audit & Effectiveness Annual Report 2025/26, noting visibility of emerging/strengthening AI clinical governance and patient-safety oversight. • Patient Experience Annual Report 2025/26 • Safeguarding Annual Report 2025/26 • Urgent & Emergency Care Care Quality Commission Action Plan update • Infection prevention and Control Annual Report 2025/26 • Revised Mental Health Act Compliance Annual Report deferred to October due to technical challenges in producing required supporting data by Rotherham Doncaster and South Humber (RDaSH). • Care Accreditation Recognition for Excellence (CARE) Framework Outcomes noting the enhancement of the framework through the introduction of a new Accredited Plus award, recognising teams that demonstrate excellence beyond core standards through research, innovation and measurable improvement. Also, expansion to include outpatients and emergency departments, providing greater organisational oversight and opportunities for improvement across a broader range of services. • Maternity Care Bundle reporting now under development
Substantial, Significant, Assurances to Provide	**Decisions Made**
• Perinatal Quality & Safety report received giving significant assurance against the Perinatal Quality Oversight Measures (PQOM) Data & Maternity metrics, Progress to achieve NHS Resolution Maternity Incentive Scheme Year 8, Neonatal Nursing Workforce Updated Action Plan/ Progress update and neonatal Medical Workforce Updated Action Plan. BAPM business case and Safer Staffing reports to be reviewed by People Committee. **Significant Assurance** • Quality Priorities Workplan. **Significant Assurance**	QC as a committee of the Trust Board took assurance from the detail provided within the Perinatal Quality & Safety report and recorded in the Committee minutes to provide evidence for the Maternity Incentive Scheme the following; • The number of perinatal deaths. • The number of Maternity and newborn Safety Investigation (MNSI)/Early Notification Scheme (ENS) cases reported within required timescales. • Evidence that parental feedback is routinely sought, received and used to inform Perinatal Mortality Review Tool (PMRT) reviews • Assurance that families receive appropriate information in a timely manner and;

• Patient Safety report inc. Martha's Rule implementation received demonstrating established governance oversight, systematic review of patient safety incidents, clear learning responses and evidence that actions identified, monitored and escalated through appropriate governance routes. **Significant Assurance** • Quality of Care trends via review of IQPR metrics. **Significant Assurance** • Care Accreditation Recognition for Excellence (CARE) Framework Outcomes. **Significant Assurance** • Sharps Injury Deep Dive – referred to from Audit and Risk Committee. Improvements evidenced through Statistical Process Control (SPC) charted evidence providing assurance that concerns identified are being addressed. Further progress report to be presented to People's Committee moving forward. **Significant Assurance** • Learning from Deaths and Mortality Governance Quarter 4 Report– evidenced that robust mortality governance processes remain in place across the trust, with 100% of in-hospital deaths subject to medical examiner scrutiny and appropriate escalation through established pathways including coroner referral, Patient Safety Incident Response Framework (PSIRF) and Structured Judgement Review (SJR) processes. Noted the significant assurance over mortality governance while maintaining oversight of the elevated Summary Hospital-level Mortality Indicator (SHMI) and recurring learning themes. **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 recommended the updated BAF to the Board of Directors. **Significant Assurance**	• Assurance that meetings with parents following a perinatal death are routinely offered. • Confirmation that fetal growth charts and surveillance pathways comply with current Saving Babies Lives Care Bundle (SBLCB) v3.2 guidance with any risks mitigated. • The Maternal Care Bundle implementation plan has been reviewed and approved on behalf of the Trust Board. • The relevant British Association of perinatal medicine (BAPM) standards for Neonatal Nursing and medical workforce staffing have not yet been achieved, and the Committee has reviewed and approved the associated action plans and progress updates. • Noted that the Board Safety Champions continue to meet bi-monthly with the perinatal leadership team and any support required of the Trust Board has been identified and is being progressed. • No Maternity Operational Support System (MOSS) escalation triggers were received during Quarter 1. • The Committee has reviewed and discussed any exceptions, concerns and risks identified within this report and has agreed any matters requiring escalation to the Trust Board.

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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.

2609 - H5 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Stephen Radford, Non-executive Director | 12:45

5 minutes

REFERENCES

Only PDFs are attached

H5 - Chair's Assurance Log - Audit & Risk Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Audi & Risk Committee (ARC) - Chair's Highlight Report to Trust Board

Subject:	**Audit & Risk Committee**	**Board Date: 1 September 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 July 2026	

Matters of Concern (*Moderate, Limited,* or *Weak* **Assurance)**	**Work Underway / Major actions commissions**
a) Internal Audit i) Head of Internal Audit Opinion – Moderate. "The final opinion for 25/26 is a moderate opinion that there are areas for improvement in the areas of Governance, Risk Management, and control with some inconsistent application of controls puts the achievement of organisational objectives at risk. Overall, audit opinions from the approved audit plan were largely positive although 2 reviews receive limited assurance opinions relating to data quality and patient flow (with a focus on discharge). The Trust has responded positively to our recommendations with 96% of high & medium risk actions implemented on time. In forming my opinion am required to take account of third party and other sources of assurance. During the year the Trust has been managing a number of issues, in particular its response to 2 externally commissioned reviews undertaken by thevaluecircle – a well-led review and a culture review (The DBTH Way in Action) and the outcome of an unannounced CQC inspection of urgent and emergency care services at DRI. The service remained rated as requires improvement & a Section 29 A Warning notice was issued. External audit have raised a significant weakness in respect of the Trusts VFM arrangements in relation to how the body monitors and ensure appropriate standards, such as meeting legislative requirements. In forming my overall opinion, I have taken these issues into account. Whilst the assurance work completed through the	a) Internal Audit Mortality Planned work – Discussion was held regarding a change to the audit terms of reference from data quality to a governance focus, to add more value to the Trusts continued work on Mortality b) Internal Audit – Additional work requested to provide input into the Trusts arrangements for assurance on the Provider License requirements

internal audit plan produced largely positive findings, consideration of the wider sources of assurance & organisational context has impacted my overall assessment and contributed to the moderate assurance opinion". b) External Audit report – Value for Money – This followed up on previous work and confirmed a number of areas as satisfactorily concluded. However, the CQC S.29A Warning Notice in relation to the ED inspection has impacted on the "governance" element, with the conclusion that a significant weakness exists in the Trusts arrangements for Governance.	
***Substantial, Significant,* Assurances**	**Decisions Made**
a) Internal Audit: - i. Progress report including Audit Recommendations closure rate for high & medium risks -100% which remains very positive & evidence of continual improvement, albeit it is early in the year; ii. Data Security & Protection Toolkit – Low risk/high confidence – This reviewed the Trusts arrangements for data security & data protection in line with the standards required. 4 low risk recommendations were agreed. b) Local CounterFraud – Annual Report 25/26 and Quarter 2 26/27 update demonstrated significant assurance in the arrangements for fraud prevention, detection and investigation. The annual standards submission confirmed a Green self-assessment against national standards. c) External Audit Report – ISA 260 Audit Results Report – This confirmed a number of areas as positive: - i. Areas of Audit Focus (5) – No matters to report on any of the 5 identified risks; ii. Audit differences – EY did not identify any misstatements greater than the £9.75 threshold; Four reclassification misstatements were made; a number of corrections were made;	a) Standing Financial Instruction & Scheme of Reservation & Delegation – To recommend to the Board of Directors b) Risk Management Policy – ARC reviewed and approved the refreshed Risk Management Policy

iii. Control Observations – Control recommendations were followed up from last year (6) & reviewed for this year which resulted in confirmation that 3 have been actioned successfully, 2 new recommendations made, resulting in 5 for Audit Committee to follow up for 26/27. The focus of the recommendations was regarding improvements required to fixed asset accounting; plant, property and equipment recording; and details in the renumeration report complying with requirements; iv. VFM – See Section above; v. Annual report & Annual Governance Statement – There are no matters to report d) Single Tender Waivers and Losses & Compensations reports – These were agreed to provide significant assurance. Additional helpful benchmarking information from 360 Assurance gave additional insight, including a request to look a trends and themes. e) Risk Management, the Board Assurance Framework & Risk Management Annual Report – This report was given significant assurance following the recent positive Internal Audit report. The reports demonstrated ongoing evidenced improvements in the management, monitoring and mitigation of risks. f) Emergency Planning Resilience and Response (EPRR) Annual Report - ARC took significant assurance from the update in relation to the Trusts arrangements for EPRR and improvements made to resource allocation; training; documentation; business continuity; evaluation and communications.	

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2609 - I INFORMATION

12:50

2609 - I1 ANNUAL INFECTION, PREVENTION & CONTROL REPORT 2025/26

Information Item | Karen Jessop, Chief Nurse | 12:50

REFERENCES

Only PDFs are attached

I1 - Annual Infection Prevention & Control Report 2025-26.pdf

I1i - IPC Annual Report 2025-26.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Annual Infection Prevention and Control Report 2025/2026**			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Dr K Agwuh, Director of Infection Prevention and Control Miriam Boyack, Nurse Consultant and Deputy Director of Infection prevention and control Simon Brown, Deputy Chief Nurse			
Appendices:	N/A			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Proposed assurance Level (For assurance papers only)				
Assurance Rationale	The Trust has maintained robust Infection Prevention and Control governance, statutory compliance, effective surveillance systems, high environmental cleanliness standards and strong antimicrobial stewardship arrangements. Whilst some national infection trajectories were not achieved, these represent known and understood gaps with targeted improvement plans, clear accountability and ongoing oversight in place. Overall, controls are largely effective and provide confidence that infection risks are being appropriately managed and do not threaten the delivery of safe, high-quality care.			
Impacts on Strategic Risks (BAF 1-7)	BAF 1			

Executive Summary – Key messages and Issues

The annual report provides assurance regarding the effectiveness of Infection Prevention and Control (IPC) arrangements across Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) during the period April 2025 to March 2026. The report demonstrates that the Trust has maintained robust IPC governance arrangements, remains compliant with the requirements of the Health and Social Care Act 2008 (Code of Practice) and has continued to deliver a comprehensive programme of surveillance, prevention, education, assurance and improvement activity despite sustained operational pressures.

The year was characterised by mixed performance against national healthcare-associated infection (HCAI) trajectories. Positive achievements included sustained periods without MRSA bacteraemia, low surgical site infection rates, high environmental cleanliness standards, effective management of multi-resistant organisms with no evidence of transmission and significant progress in antimicrobial stewardship, including a 28% reduction in carbapenem use. The Trust also maintained strong hand hygiene compliance (95.9%), continued expansion of surveillance programmes and strengthened outbreak response arrangements.

Areas of challenge included performance against the national trajectories for Clostridioides difficile infection (89 cases against a threshold of 64) and Escherichia coli bacteraemia (110 cases against a threshold of 94). Blood culture contamination rates, whilst improving, remained above the national ambition of less than 3%. These areas continue to be subject to enhanced surveillance, multidisciplinary review and targeted quality improvement programmes. The report demonstrates a clear understanding of contributory factors and provides evidence that comprehensive mitigation plans are in place.
Significant assurance is provided that risks associated with infection prevention and control are appropriately identified, monitored and managed through established governance structures. Strong multidisciplinary oversight is evident through the Infection Prevention and Control Strategic Steering Group, Trust Wide Infection Group and Infection Control Operational Group, supported by comprehensive surveillance systems, environmental audits, antimicrobial stewardship programmes and quality improvement initiatives.

Key Areas of Assurance

- The Trust remains compliant with statutory IPC requirements and maintains effective governance arrangements.
- High standards of environmental cleanliness continue to be achieved, with PLACE cleanliness scores of 98.44% and patient care areas consistently achieving audit scores above 97%.
- Robust surveillance systems are in place across all key healthcare-associated infections, including expanded surgical site infection surveillance.
- No evidence of healthcare-associated transmission was identified for multi-resistant organisms, including CPE, VRE and Candida auris.
- Significant improvement has been achieved through antimicrobial stewardship programmes, quality improvement work and strengthened digital surveillance capabilities.

Key Risks and Improvement Priorities

- Reduction of Clostridioides difficile infections and Gram-negative bloodstream infections.
- Sustaining delivery against the MRSA zero-tolerance standard.
- Further reduction in blood culture contamination rates.
- Management of respiratory infection pressures, including the impact of estate constraints and ventilation risks.
- Strengthening workforce resilience within IPC services and improving staff vaccination uptake.
- Continued delivery of antimicrobial resistance and stewardship objectives.

Recommendations
The Board is asked to note that the Trust has maintained effective and mature Infection Prevention and Control arrangements throughout 2025/26 and provides evidence that systems, controls and governance arrangements are operating effectively to reduce infection risk and support the delivery of safe, high-quality care. While some national performance trajectories were not achieved, there is clear evidence of oversight, learning, and targeted improvement activity to address identified risks and sustain continued progress during 2026/27.

Healthier together – delivering exceptional care for all	
Patients	Safe and Effective Care
People	n/a
Partnerships	n/a
Pounds	n/a
Health Inequalities	n/a
Legal/ Regulation:	CQC Safe Care and Treatment, Health and Social Care Act
Partner ICB strategies	n/a
Assurance Route	
Previously considered by - including date:	Trust Wide Infection Control Group
Any outcomes/next steps / time scales	June 2026 Approved for QC

NHS

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust







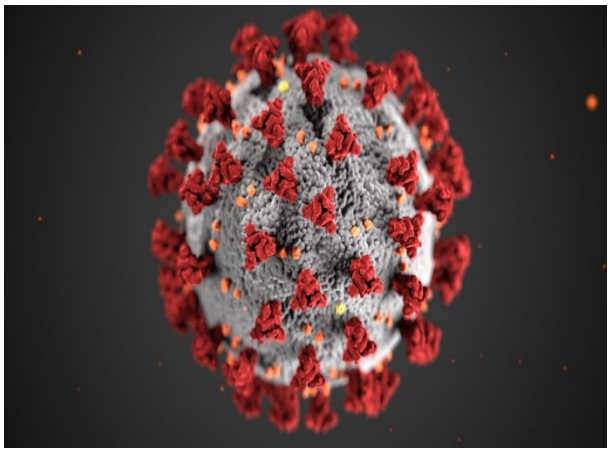
We care



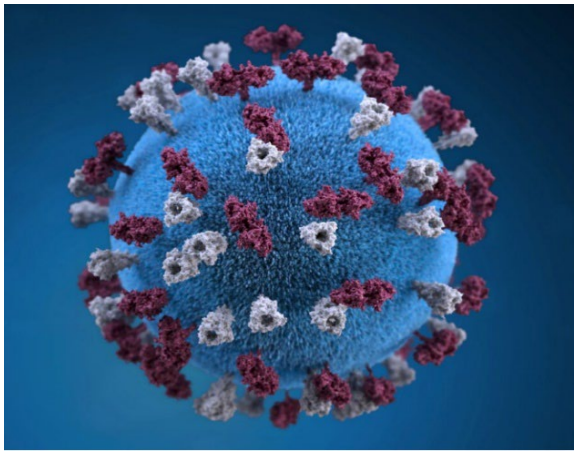
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Measles Virus (CDC)



Sars-Cov 2 (WHO)

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EXECUTIVE SUMMARY

This report outlines a summary of the key infection prevention and control initiatives and activities in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) during the year April 2025 to March 2026. Delivering the values – We Care, some of our achievements in the last twelve months, include:

We always put the patient first

- We continue to encourage the uptake of the COVID vaccination amongst our people and actively deliver Flu vaccination program in house for Healthcare workers in the Trust.
- We continue to support the use of point of care testing (in addition to confirmatory PCR tests) for diagnosis of COVID-19 and Influenza for all patients admitted with respiratory symptoms and for all patients if they developed respiratory symptoms during their admission between October and March.
- We provided 5113 POCT tests for COVID, and 5371 POCT for Flu A/B in 2025/26.

Everyone Counts – we treated each other with courtesy, honesty, respect and dignity

- Our Escherichia coli bloodstream infections increased by 17% in 2025/26. We reported 110 cases, out of 94 cases of E coli bloodstream infection threshold for healthcare associated *E coli* bloodstream infection.

Committed to quality and continuously improving patient experience

- We did not achieve our Clostridioides difficile trajectory, with 89 cases reported against a threshold of 64. Analysis identified two cases on one surgical ward with identical ribotype, indicating probable cross-infection wider. Targeted infection prevention and control measures were reinforced to minimise the risk of further spread.
- The Trust achieved 360 consecutive days without a MRSA bloodstream infection towards the end of the financial year and is aiming to build on this achievement during 2025/26.
- The Trust continues to participate in the Infection in Critical Care Quality Improvement – Blood Stream Infection (ICCQIP-BSI) surveillance programme.
- The Infection Prevention and Control Team has continued Surgical Site Infection surveillance across a range of specialties including Breast, Vascular, Gastro-intestinal surgery and Caesarean Section.

Always caring and compassionate

- Hand hygiene compliance remains high, with an average of 95.9% across IPC and ward-based observations.
- Ward environmental cleanliness standards have been maintained, with all patient care areas achieving scores above 97%.
- The Trust continues to participate in the national Point Prevalence Survey (PPS). The Trust HCAI rate has increased slightly to 4.8% in 2025 (from 4.5% in 2024) but remains below the national acute Trust average of 8.0%.

Responsible and accountable for our actions – taking pride in our work

- Blood culture contamination rates remain above the national ambition of <3%, with a Trust average of 4.0%; however, there has been marginal improvement from 4.1% in the previous year, and focused actions are in place to support further reduction.
- The Trust continues to update antimicrobial guidelines in line with NICE guidance, supporting effective management of sepsis and infections, strengthening antimicrobial stewardship, and addressing antimicrobial resistance.
- Compliance with water quality monitoring for *Legionella spp*. and *Pseudomonas aeruginosa* has improved across the Trust.

Encouraging, valuing our diverse staff, and rewarding ability

- IPC education continues to be developed and delivered through formal and informal teaching packages for staff across the Trust.
- Regular communication and learning resources remain in place to support infection prevention practice.
- The Trust is working collaboratively with UKHSA and Doncaster and Bassetlaw Place partners to respond to suspected and confirmed measles cases, supporting effective management and risk reduction."

Challenges

- Ongoing reinforcement of high standards in Infection Prevention and Control (IPC) practice remains a priority across the Trust.
- While the NHS Standard Contract for 2026/27 is awaited, the Trust is proactively working to its 2025/26 trajectories, with a continued focus on reducing Clostridioides difficile and Gram-negative bloodstream infections and building on performance achieved to date.
- Through the NHSE IPC Board Assurance Framework, the Trust continues to strengthen delivery of its antimicrobial resistance (AMR) agenda.
- Collaborative work with health economy partners remains key to reducing the incidence of Gram-negative bloodstream infections across the system.
- Sustaining delivery against the MRSA bacteraemia zero threshold remains an ongoing focus, alongside continued surveillance with UKHSA and ICB colleagues to better understand and respond to the emerging prevalence of PVL MRSA associated with intravenous drug use within the health economy.
- Further improvement in Trust-acquired MRSA colonisation rates is being supported through continued focus on hand hygiene compliance, including the application of behavioural science approaches.
- Continued emphasis on improving blood culture sampling practice, including no-touch technique, is required to support progress towards the <3% contamination ambition.
- There is a need to maintain oversight and management of dental chair water quality at Mexborough Hospital to ensure ongoing compliance.

- The current measles outbreak continues to present operational pressures for IPC teams across the region, requiring sustained multi-agency coordination and response.
- Work is ongoing to reduce the incidence of nosocomial COVID-19 and other respiratory viruses, recognising the additional challenge posed by estate constraints, including ventilation limitations within older ward areas.

INTRODUCTION

Purpose

This report provides an overview of infection prevention and control (IPC) activity undertaken by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) during the period April 2025 to March 2026. It is intended to inform patients, the public, staff, the Trust Board of Directors, Council of Governors, and system partners within South Yorkshire Integrated Care Board (Doncaster Place) and Nottingham and Nottinghamshire Integrated Care System (Bassetlaw Place).

The report also provides assurance that the Trust continues to meet the requirements of the Health and Social Care Act 2008 (Code of Practice on the Prevention and Control of Infections and Related Guidance), demonstrating compliance with standards relating to cleanliness, infection prevention, and control.

The Trust has a statutory responsibility to provide an annual report from the Director of Infection Prevention and Control (DIPC) to the Board of Directors. This report summarises the activity of the Infection Prevention and Control Team (IPCT) and outlines performance against nationally set thresholds, as defined within the NHS Standard Contract 2025/26. Prevention and control of healthcare-associated infection (HCAI) remains a strategic priority for the Trust. Avoidable infections can have a significant impact on patient outcomes, staff safety, and organisational resources, as well as contributing to antimicrobial resistance. Continued investment in IPC remains essential to sustaining improvement and delivering high-quality, safe care.

Key Points

- The Trust remains compliant with the Health and Social Care Act 2008, with ongoing assurance provided through established IPC governance arrangements.
- Four Trust-apportioned MRSA bacteraemia cases were reported during the year, against the national zero-tolerance standard.
- A total of 89 *Clostridioides difficile* cases were reported (70 HOHA and 19 COHA), which is above the threshold of 64 cases.
- Sixty MSSA bacteraemia cases were reported (45 HOHA and 15 COHA), a marginal increase compared with 2024/25.
- The Trust reported 110 *Escherichia coli* bacteraemia cases, above the threshold of 94, with 62 HOHA and 48 COHA cases.
- Between 1 April 2025 and 31 March 2026, there were 561 confirmed COVID-19 cases.
- The Trust managed 831 Influenza A cases, 42 Influenza B cases, and 159 Respiratory Syncytial Virus (RSV) cases.

- Three Norovirus outbreaks were recorded, affecting 43 patients and 25 staff.
- Forty-eight cases of vancomycin-resistant Enterococci (VRE) were identified (8 clinical isolates and 40 screening detections).
- Eleven cases of carbapenemase-producing Enterobacteriaceae (CPE) were detected (4 clinical and 7 screening), alongside a 22% increase in screening activity, reflecting strengthened surveillance.
- No cases of Mpox were reported during the year.
- All antimicrobial policies were reviewed and maintained as up to date.
- Hand hygiene compliance averaged 95.9%, slightly below the Trust target and previous year performance.
- The Trust continues to participate in the Surgical Site Infection (SSI) Surveillance Programme, with low numbers of deep SSI cases reported across sites.

Overall Assurance

The Trust has maintained robust IPC governance and remains compliance with statutory requirements. Whilst some performance metrics were not fully achieved, there is clear oversight of the underlying causes and targeted actions are in place to support improvement and reduce infection risk going forward.

Infection Prevention & Control Arrangements

During 2022/23, the proposed model for a Place-based Infection Prevention and Control (IPC) Team was formally agreed, enabling a collaborative approach to service delivery across organisational boundaries. This model was designed to extend IPC expertise beyond the acute setting and support the wider local population. Following approval, funding was secured and the IPC Team establishment was enhanced to support delivery of this model, which has continued to be embedded through 2024/25.

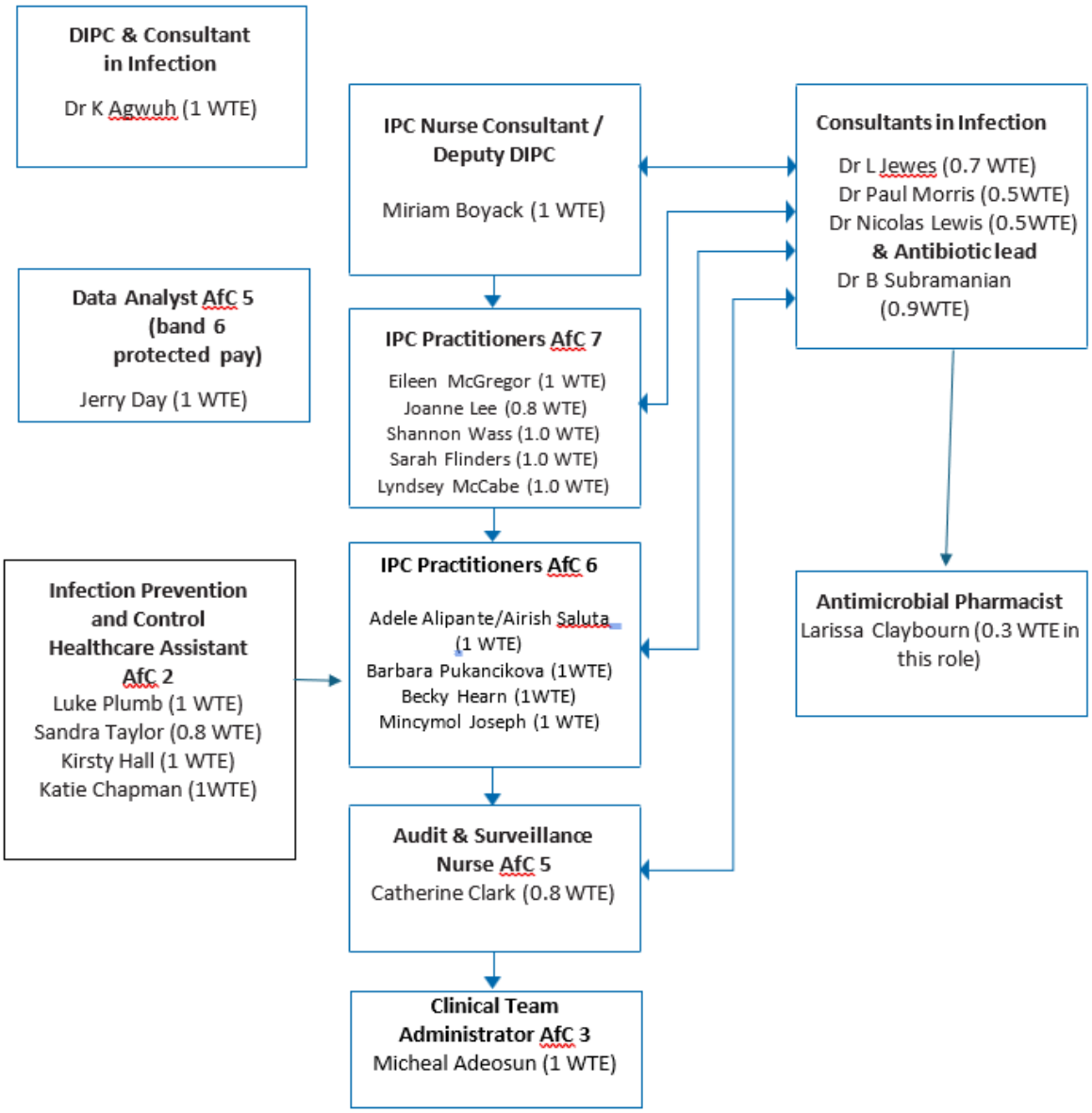
During 2025/26, the IPC service has continued to evolve to ensure it remains sustainable and aligned to current priorities. The team has maintained core functions and continued to provide oversight of key risks, demonstrating adaptability and resilience.

IPC Team	WTE	
Band 8b	1.0	Nurse Consultant & Deputy DIPC
Band 8a	1.0	Infection Prevention and Control Lead Nurse
Band 7	4.8	Infection Prevention and Control Practitioner
Band 6	4.0	Infection Prevention and Control Nurse Specialist

Band 5	0.8	Audit and Surveillance Nurse
Band 5	1.0	Data Analyst
Band 3	1.0	Infection Prevention and Control Administrative Assistant
Band 2	3.8	Infection Prevention and Control Assistant
Microbiology Team		
Consultant in Infection Dr K Agwuh	1.0	DIPC
Consultant in Infection Dr L Jewes	0.7	
Consultant in Infection Dr B Subramanian	0.9	Antimicrobial Lead
Consultant in Infectious Disease & GIM/Infectious Diseases Dr P Morris	0.5	
Consultant in Infectious Disease & GIM/Infectious Diseases Dr N Lewis	0.5	
Trust grade doctors in Infection Dr A Abdulghani & Dr F Abraham	2.0	Fixed term posts

The Consultants in Infection work closely with the IPC nursing team to deliver the infection prevention and control service across DBTH. In addition to supporting the Trust, they also provide specialist advice to Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH), strengthening partnership working across the wider health economy.

Infection Prevention and Control Team



Infection Prevention and Control Strategic Steering Group Meeting attendance 2025-2026

Title	Apr 17th	Jun 19th	Aug 21st	Oct 16th	Dec 18th	Feb 19th	% Attendance
Antimicrobial Pharmacist	×	✓	×	✓	×	✓	50%
Bassetlaw ICB	✓	✓	✓	✓	×	×	67%
CCDC UKHSA (Yorkshire and Humber)	×	×	✓	×	×	×	17%
CCDC UKHSA (North Notts)	×	×	✓	×	✓	×	33%
Consultant In Infection (Antimicrobial Lead)	✓	✓	✓	✓	×	✓	83%
Director of Infection Prevention and Control	✓	✓	×	✓	✓	✓	83%
Chief Nurse (Executive Lead for IPC)/ Deputy Chief Nurse (Representing Executive team) / Quality and Governance	✓	✓	✓	✓	✓	✓	100%
Doncaster ICB	✓	×	×	×	×	×	17%
Facilities Manager /Estates Manager	✓	✓	✓	✓	✓	✓	100%
Nurse Consultant Infection Prevention and Control	✓	✓	✓	✓	✓	✓	100%
Trust Decontamination Manager	×	✓	×	✓	×	×	33%
Occupational Health	✓	✓	✓	×	✓	×	67%
Medical Division	✓	✓	✓	✓	✓	✓	100%
Clinical Specialties Division	✓	✓	✓	✓	✓	✓	100%
Surgery Division	✓	✓	×	✓	✓	✓	83%
Children and Families Division	✓	✓	✓	×	✓	×	67%
Urgent and Emergency Care Division	✓	✓	✓	✓	✓	✓	100%

NON-ESSENTIAL ATTENDANCE: AP - apologies

The Trust has an established and effective IPC governance structure, providing clear oversight from strategic direction through to operational delivery, with regular monitoring, multidisciplinary engagement, and robust assurance processes in place.

The Infection Control Committee (ICCM) has evolved into a strengthened governance structure comprising the Infection Prevention and Control Strategic Steering Group (IPCSSG), and more recently the Trust Wide Infection Group (TWIG) and the Infection Control Operational Group (ICOG). Together, these groups provide a robust framework for IPC governance across the Trust.

The Trust Wide Infection Group (TWIG) meets bimonthly and is responsible for overseeing the implementation of national guidance, monitoring performance against IPC standards, and ensuring that policies remain up to date, are regularly reviewed, and subject to audit for compliance.

TWIG has broad multidisciplinary membership, including representatives from Occupational Health, Consultants in Infection, senior IPC practitioners, divisional nurses or deputies, pharmacy, Estates and Facilities, the Medical Director or deputy, and ICB representatives. Additional members are co-opted as required to support specific workstreams.

The Infection Control Operational Group (ICOG) provides the operational arm of IPC governance, maintaining oversight of delivery against key workstreams. ICOG meets on alternate months to TWIG, enabling continuous monitoring, escalation, and progression of IPC priorities.

1. **There are systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.**

Surveillance of Healthcare Associated Infection

Active surveillance remains a core component of the Infection Prevention and Control programme and underpins the Trust's ability to identify, respond to, and reduce healthcare-associated infections (HCAIs). Surveillance is undertaken in line with nationally defined standards, case definitions, and data collection protocols to ensure consistency, reliability, and comparability.

The Trust continues to meet all mandatory surveillance requirements and participates in a range of additional internal and external surveillance programmes. During 2025/26, this was strengthened further through the expansion of Surgical Site Infection surveillance to include Breast, Caesarean Section, Vascular, and Gastrointestinal surgery, improving oversight of infection risk across a broader range of specialties.

A key strength of the surveillance framework is the systematic feedback of data to clinical teams. Timely feedback supports clinical review, drives improvements in practice, and enables targeted action where variation or risk is identified. Findings are routinely reported through divisional and IPC governance structures, ensuring clear oversight and accountability.

Assurance:
The Trust has a robust and comprehensive surveillance system in place, providing timely intelligence, supporting continuous learning, and enabling targeted action to mitigate infection risk.

MRSA Bacteraemia

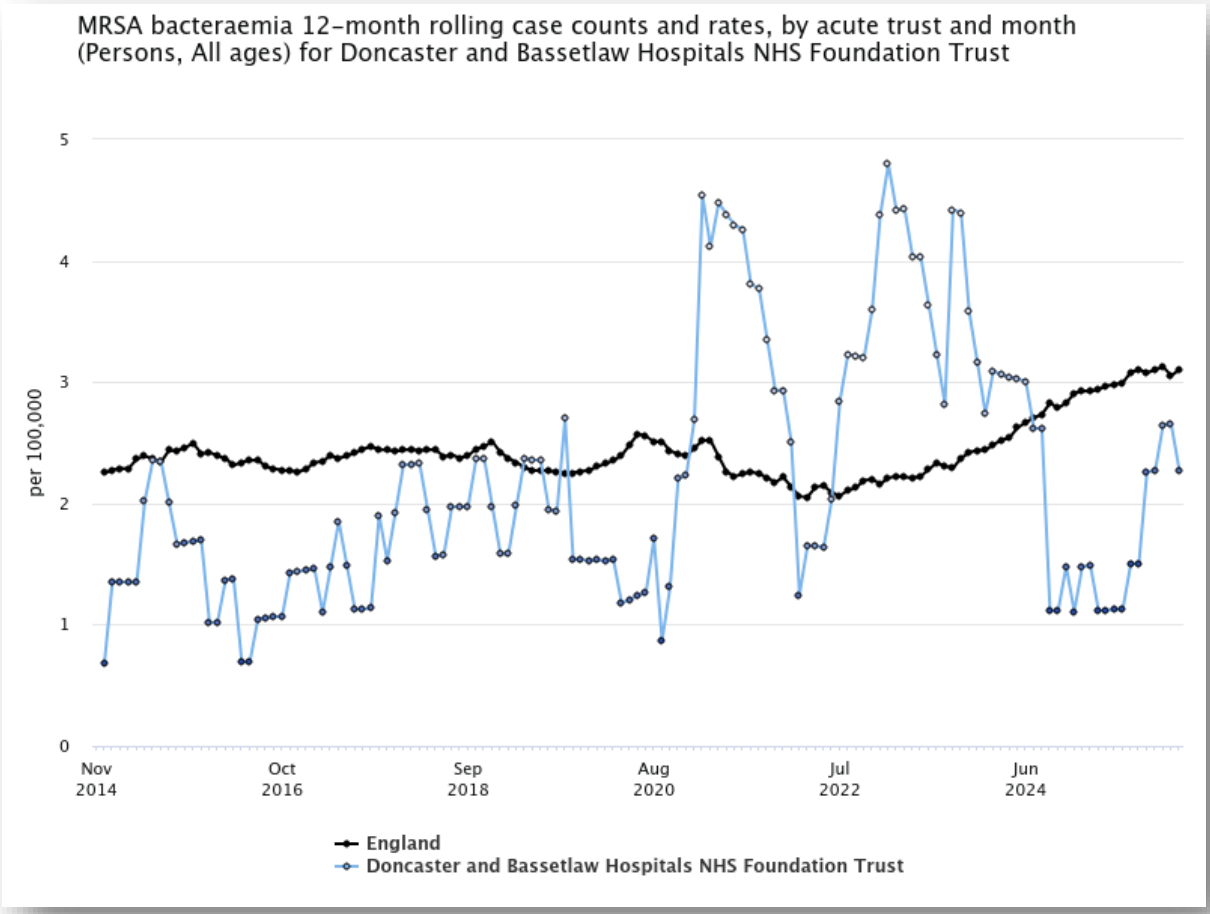
There remains a national expectation of zero tolerance for preventable MRSA bacteraemia. All cases are therefore subject to comprehensive Post Infection Review to identify contributory factors, support organisational learning, and inform targeted improvement action.

During 2025/26, four Trust-attributed MRSA bacteraemia cases were reported. Review identified opportunities to strengthen practice, including admission screening and venepuncture technique. Learning has been shared and improvement actions are being monitored through established governance arrangements.

Comparative UKHSA data shows that community-onset community-associated MRSA bacteraemia rates in Doncaster and Bassetlaw remain below the national average. Hospital-onset rates are also lower than the national benchmark, providing assurance of comparatively strong performance within the wider system context.

The Trust continues to maintain its commitment to the 'Zero Tolerance to MRSA Bacteraemia: Search and Destroy' approach, with sustained focus on early identification, effective management, and prevention of transmission.

Assurance:
While a small number of cases were reported, robust review processes, shared learning, and continued delivery of the 'Search and Destroy' approach provide assurance that appropriate controls are in place to minimise the risk of MRSA bacteraemia and support sustained improvement.



The graph above illustrates the 12-month rolling rate of MRSA bacteraemia per 100,000 population for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), benchmarked against the England average.

Nationally, MRSA bacteraemia rates have remained relatively stable over time, with a gradual increase observed from 2021 onwards, reflecting the restoration of healthcare activity and surveillance following the COVID-19 pandemic. In comparison, DBTH demonstrates expected variability, reflecting the low absolute number of cases and the proportional impact of individual cases on rolling rate calculations.

Historically, between 2014 and 2019, Trust performance was broadly aligned with, or better than, the national average. During the pandemic and early recovery phase (2020–2022), there were intermittent increases in rates, at times exceeding the national benchmark. These increases coincided with periods of sustained system pressure, changes in patient acuity and case mix, and disruption to standard care processes. Given the rolling methodology, isolated cases or small clusters during this period continued to influence reported rates for up to 12 months.

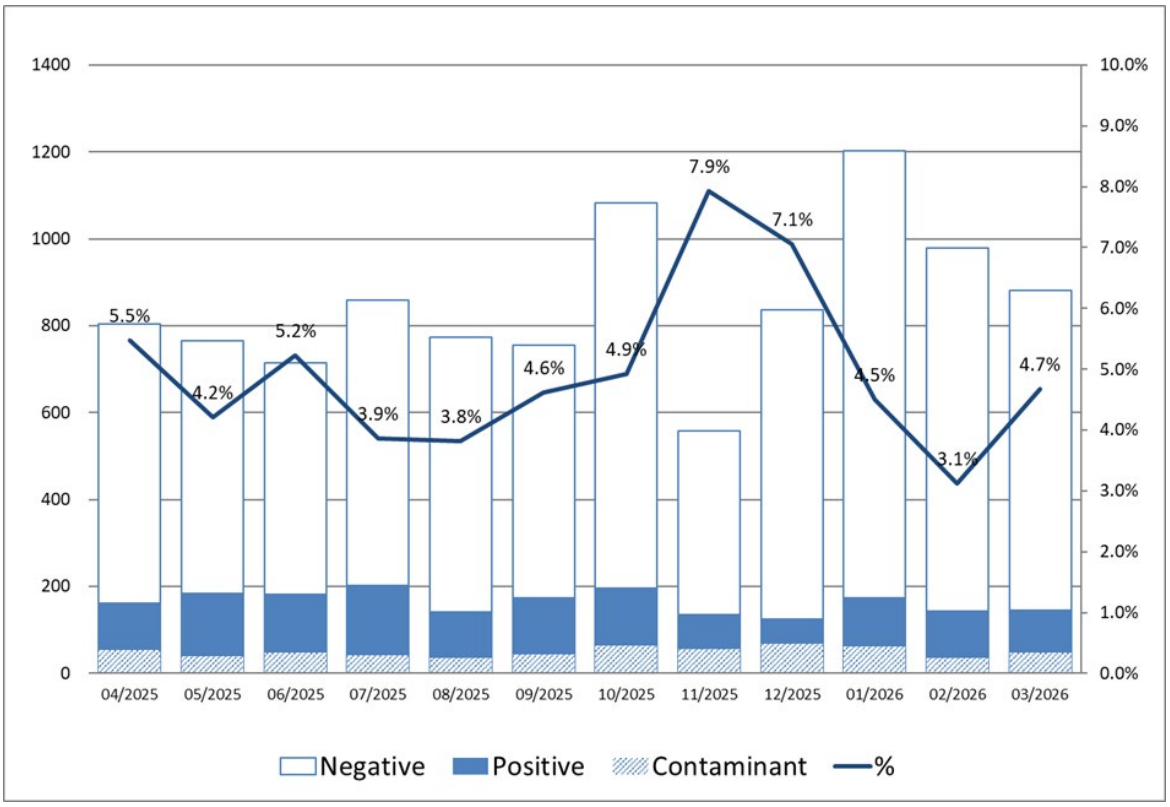
Since late 2022, there has been sustained improvement, with Trust rates now closely aligned to, and in the most recent period, among the lowest reported nationally. There is no evidence of sustained or systemic deterioration in MRSA performance when considered over the full surveillance period.

In 2025/26, the Trust reported a total of four MRSA bacteraemia cases. No cases were identified between April and August 2025, with subsequent cases reported in September (one case), November (two cases), and March (one case). As expected with low incidence events, each case had a proportionate impact on cumulative and rolling rates. All cases were subject to formal post-infection review in line with national requirements, with contributory factors identified, learning disseminated, and actions monitored through established IPC governance arrangements.

Overall, the pattern observed remains consistent with sporadic, isolated cases rather than sustained transmission within the organisation.

Assurance:
The Trust demonstrates sustained improvement in MRSA bacteraemia performance, with rates now comparable to or lower than national benchmarks. Robust surveillance, comprehensive case review processes, and strengthened governance oversight provide assurance that variation is understood and that effective controls are in place to minimise risk and support continued improvement.

Blood Culture Contamination



The Trust's average blood culture contamination rate for 2025/26 was 4.0%, above the national ambition of <3%, but demonstrating continued improvement from 4.1% in 2024/25 and 4.5% in 2023/24.

This should be viewed in the context of significantly increased diagnostic activity, with blood culture sampling more than doubling from 5,578 in 2021/22 to 12,194 in 2025/26. Despite

this, contamination rates have remained broadly stable and are now showing a gradual downward trend.

Monthly performance during 2025/26 showed some variation, including a short period of deterioration in November and December 2025 linked to operational and supply challenges affecting optimal skin antisepsis processes. Subsequent months demonstrated improvement, although sustained compliance with the <3% standard has not yet been achieved.

Focused improvement work remains in place, including education, observational practice, refresher training, and strengthened collaboration between Infection Prevention and Control, Antimicrobial Stewardship, and Sepsis teams.

Assurance:
There is clear evidence of improving trajectory despite increased diagnostic activity. The Trust has a comprehensive improvement programme in place, providing assurance that risks associated with blood culture contamination are understood and actively managed.

Clostridioides difficile infections

Clostridioides difficile infection (CDI) remains a key healthcare-associated infection risk, particularly affecting older and vulnerable patients and those exposed to antimicrobial therapy. While significant national progress has been made in reducing CDI incidence, the rate of improvement has stabilised in recent years, and a proportion of cases are influenced by factors beyond the direct control of the acute provider.

The 2025/26 reporting framework has been updated to include refined case definitions and attribution criteria, including earlier classification of hospital-onset cases, incorporation of prior healthcare exposure, and inclusion of patients managed within virtual ward pathways. Cases are categorised as hospital-onset healthcare-associated (HOHA) and community-onset healthcare-associated (COHA) for the purposes of acute Trust performance monitoring.

For 2025/26, the Trust's CDI trajectory was set at 64 cases, reduced from 69 in the previous year to reflect national direction. The Trust reported 89 cases (70 HOHA and 19 COHA), above this trajectory. The overall rate for DBTH was 25 per 100,000 bed days, compared to an England average of 21 per 100,000.

Encouragingly, community-onset healthcare-associated (COHA) rates were lower than the national average (4.8 per 100,000 bed days compared to 7.5), indicating comparatively strong performance in managing infection risk across the patient pathway.

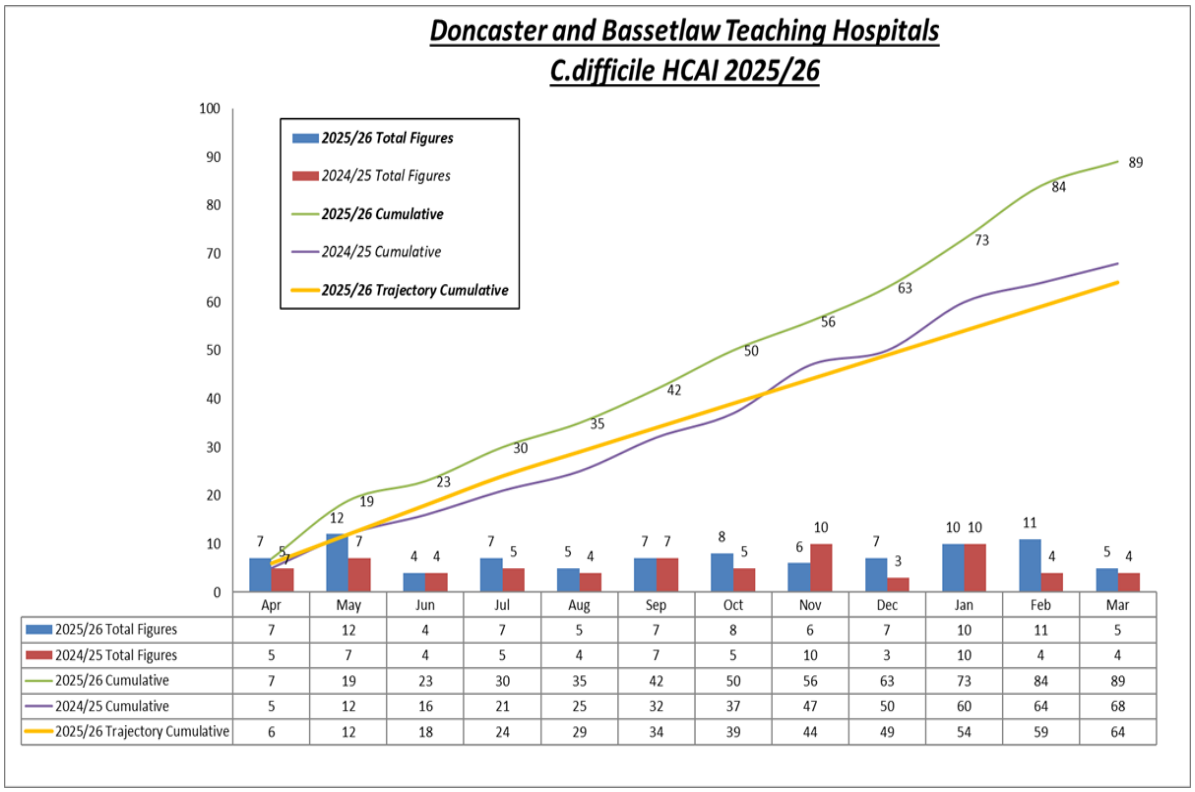
Case review has identified key contributory themes, including antimicrobial exposure, treatment complexity associated with recurrent infection, and prolonged use of proton pump inhibitors. Additional areas for improvement, not directly contributory to acquisition, include optimisation of stool chart completion, timeliness of isolation, and prompt sampling.

A range of targeted interventions have been implemented to mitigate risk and strengthen prevention, including:

- Point prevalence surveys to identify infection risks and antimicrobial use.
- Enhanced cleaning standards through RAG-rated environmental monitoring.
- Ongoing audit and compliance monitoring.
- Delivery of targeted CDI education programmes.
- Implementation of a standardised bay decontamination SOP.
- Quality improvement work focused on early identification of carriers and improved risk assessment for isolation.
- Regular multidisciplinary case review, including weekly senior clinical oversight

The Trust has also transitioned to the Patient Safety Incident Response Framework (PSIRF), strengthening its approach to learning from incidents and embedding continuous improvement in patient safety systems.

Assurance:
While the Trust has not achieved its CDI trajectory, there is clear understanding of the contributing factors and a comprehensive programme of targeted interventions in place. Governance oversight, strengthened surveillance, and alignment to PSIRF provide assurance that risks are being actively managed and improvement is being driven.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/26 Total Figures	7	12	4	7	5	7	8	6	7	10	11	5
2024/25 Total Figures	5	7	4	5	4	7	5	10	3	10	4	4
2025/26 Cumulative	7	19	23	30	35	42	50	56	63	73	84	89
2024/25 Cumulative	5	12	16	21	25	32	37	47	50	60	64	68
2025/26 Trajectory Cumulative	6	12	18	24	29	34	39	44	49	54	59	64

During 2025/26, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) experienced a sustained increase in Clostridioides difficile infection (CDI), with cumulative cases exceeding the agreed annual trajectory throughout the year. By March 2026, 89 cases had been reported against a trajectory of 64, representing a variance from plan and a deterioration compared with 2024/25, when performance was more closely aligned to trajectory.

Monthly case numbers remained consistently elevated, indicating ongoing background pressure rather than isolated outbreaks. Longer-term surveillance suggests that, while this increase reflects a broader national upward trend following the pandemic, the impact at DBTH has been more pronounced, with greater variability and periods above national benchmarks.

The pattern observed is consistent with a range of contributing factors, including increased patient acuity and frailty, antimicrobial exposure, and wider system pressures affecting patient flow. These factors are recognised and actively monitored through established governance processes.

Continuous oversight is maintained through routine case review, strengthened antimicrobial stewardship, and robust IPC governance. Targeted actions are in place to reduce avoidable risk, support improved practice, and work towards restoring performance in line with trajectory.

Assurance:
While CDI performance has not met trajectory, there is clear understanding of the drivers and sustained delivery of targeted interventions, providing assurance that risks are being actively managed and improvement remains a key organisational priority.

Ribotyping of Clostridioides difficile isolates supports identification of circulating strains, enables detection of potential cross-infection, and informs assessment of strains associated with more severe clinical outcomes.

In 2025/26, ribotyping demonstrated a diverse distribution of strains, with no single dominant ribotype. The most frequently identified strains (including RT014, RT015 and RT020) each accounted for a relatively small proportion of overall cases, with a wide range of other ribotypes collectively contributing to the remaining burden.

Importantly, there was no evidence of clustering by time or location, and epidemiological assessment did not identify person-to-person transmission or cross-infection. This pattern is consistent with endemic disease rather than sustained transmission events within the Trust.

All cases continue to be reviewed in line with national and Trust guidance, with ribotype data used to inform risk assessment and incident management where indicated. Ongoing surveillance, prompt isolation, antimicrobial stewardship, and effective environmental cleaning remain central to maintaining control.

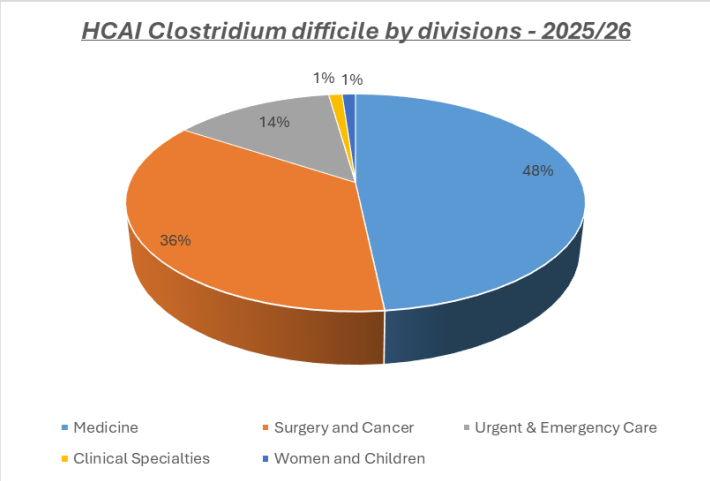
Assurance:
Ribotyping data provide assurance that CDI cases are not driven by sustained transmission, with current patterns consistent with endemic disease and supported by robust surveillance and control measures.

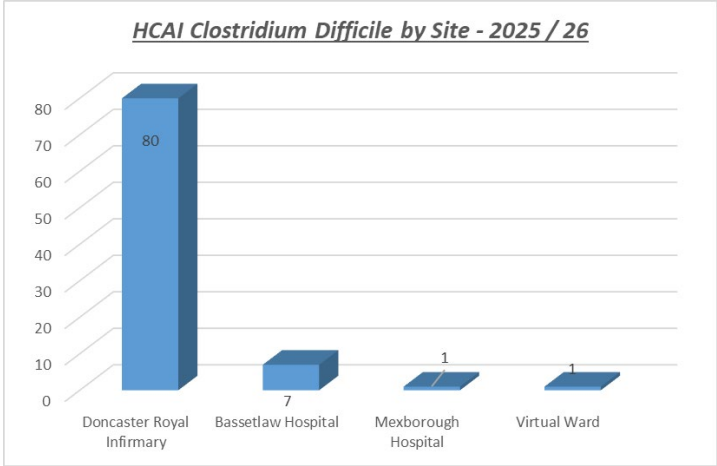
Analysis of Clostridioides difficile infection (CDI) cases in 2025/26 shows that activity is predominantly concentrated within Medicine (48%), followed by Surgery and Cancer (36%) and Urgent and Emergency Care (14%), with minimal cases in other specialties reflecting lower risk profiles.

By site, the majority of cases occurred at Doncaster Royal Infirmary (80 cases), with significantly fewer at Bassetlaw Hospital (7 cases) and isolated cases at Mexborough Hospital and within the

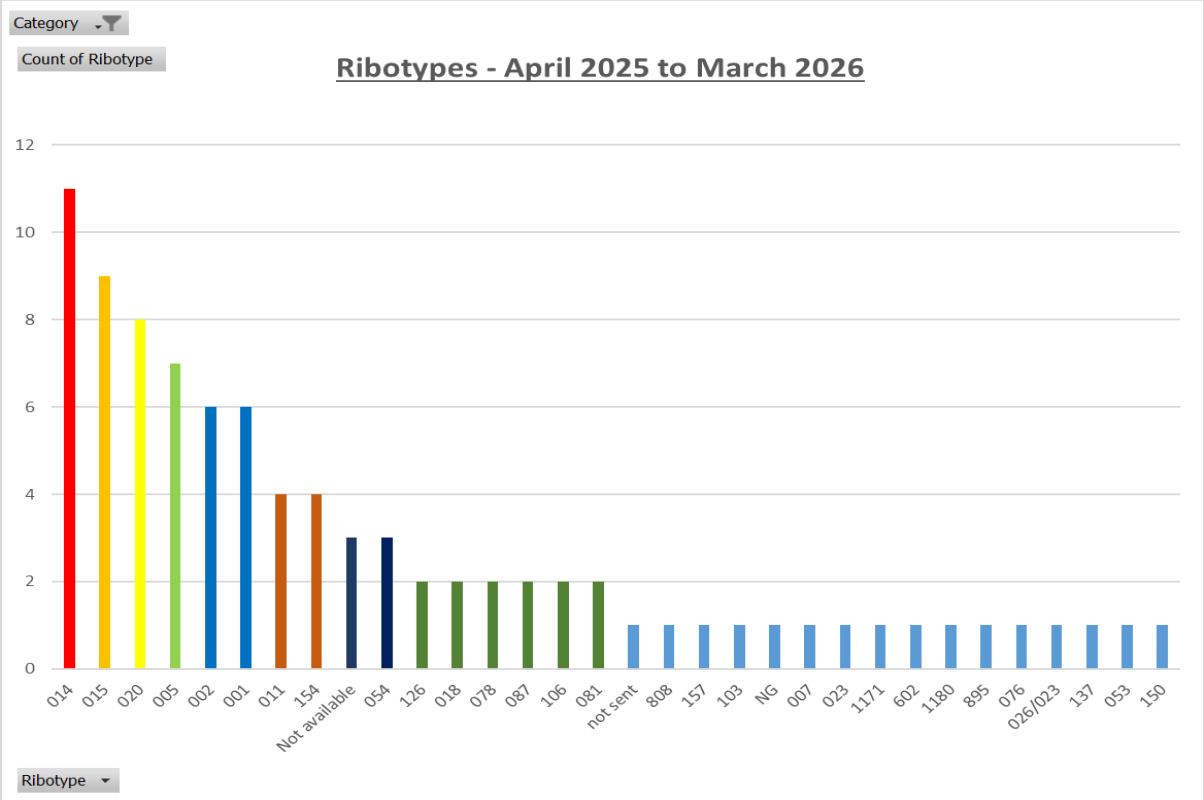
Virtual Ward. This distribution reflects the Trust's case mix, bed base, and the concentration of higher-risk, frail, and medically complex patients at Doncaster.

Overall, the pattern indicates that CDI is primarily associated with inpatient medical care and emergency admissions, rather than widespread across the Trust, and continues to inform targeted IPC, antimicrobial stewardship, environmental cleaning, and patient flow improvement initiatives within higher-risk areas

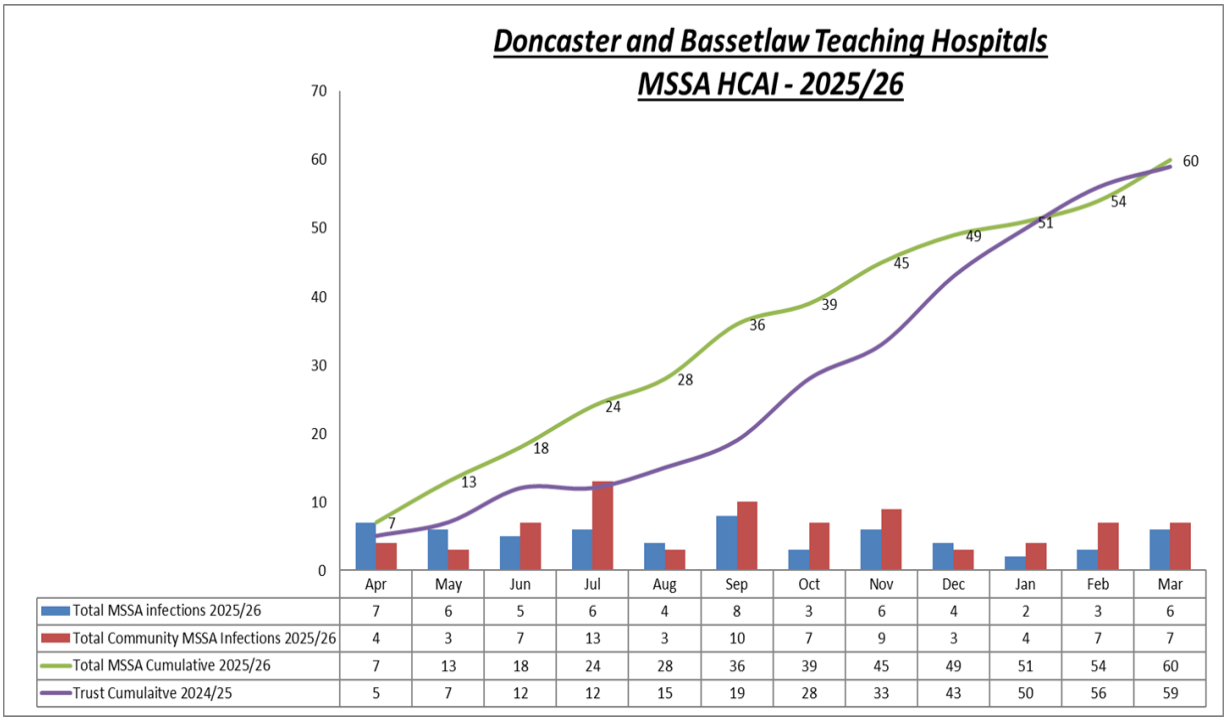




Ribotypes identified from samples submitted to reference laboratory



Methicillin sensitive Staphylococcus aureus bloodstream infection (MSSA BSI)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total MSSA infections 2025/26	7	6	5	6	4	8	3	6	4	2	3	6
Total Community MSSA Infections 2025/26	4	3	7	13	3	10	7	9	3	4	7	7
Total MSSA Cumulative 2025/26	7	13	18	24	28	36	39	45	49	51	54	60
Trust Cumulaitve 2024/25	5	7	12	12	15	19	28	33	43	50	56	59

Methicillin sensitive *Staphylococcus aureus* (MSSA) MSSA bacteremia remains part of the national mandatory surveillance programme, with hospital-onset cases attributed to acute Trusts.

In 2025/26, DBTH reported 60 MSSA cases, broadly in line with 2024/25 (59 cases), indicating a stable overall position. Monthly hospital-onset cases remained low and consistent, with no evidence of sustained transmission or outbreak activity. Community-onset cases continue to contribute a significant proportion of the overall burden, reflecting wider population prevalence.

Hospital-onset rates have shown a slight increase (15.5 per 100,000 bed days vs 14.9 in 2024/25), remaining above the England average, while community-onset rates have reduced (35.7 per 100,000), although still above national benchmarks.

Targeted IPC actions remain focused on early recognition, source control, optimisation of line and wound care, and adherence to aseptic technique, supported by close collaboration with antimicrobial stewardship.

Assurance:
MSSA bacteremia remains an important but controlled risk, with stable performance, no evidence of transmission, and targeted interventions in place to support continued improvement.

Gram-negative bloodstream infections surveillance

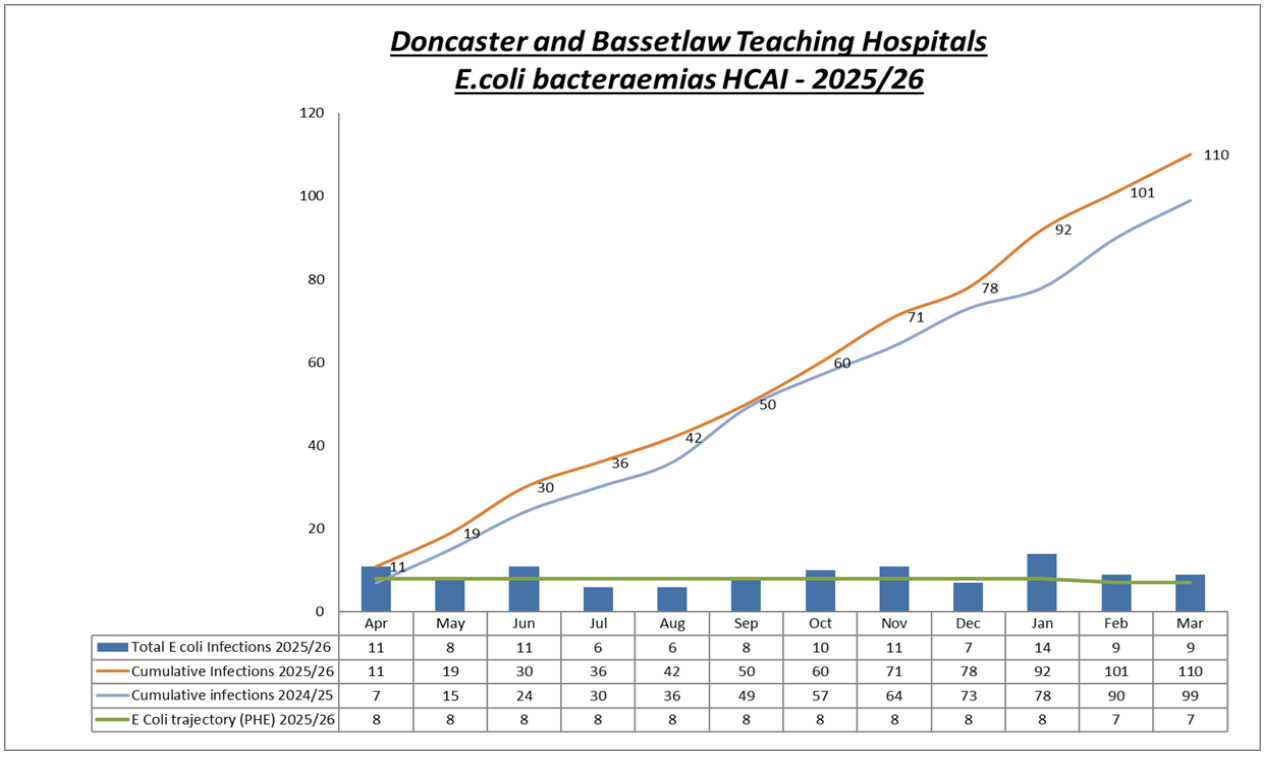
Public Heath England, in April 2017, introduced additional Gram-negative bloodstream infections surveillance. This was to enable NHS Trusts to report cases of bloodstream infections due to *Pseudomonas aeruginosa* and *Klebsiella spp,* on the Healthcare Associated Infections Data Capture System (HCAI DCS).

This was further expanded by HM government publication in January 2019, tackling antimicrobial resistance 2019-2024: the UK's five-year national action plan. This includes the aim to reduce the incidence of specified drug-resistant infections in humans in the UK, halve the number of healthcare associated Gram-negative blood stream infections, reduce UK antimicrobial use in humans by 15% and report on the percentage of prescriptions supported by use if a diagnostic test or decision support tool. This surveillance is expected to be in line with the existing *E. coli* bacteremia surveillance.

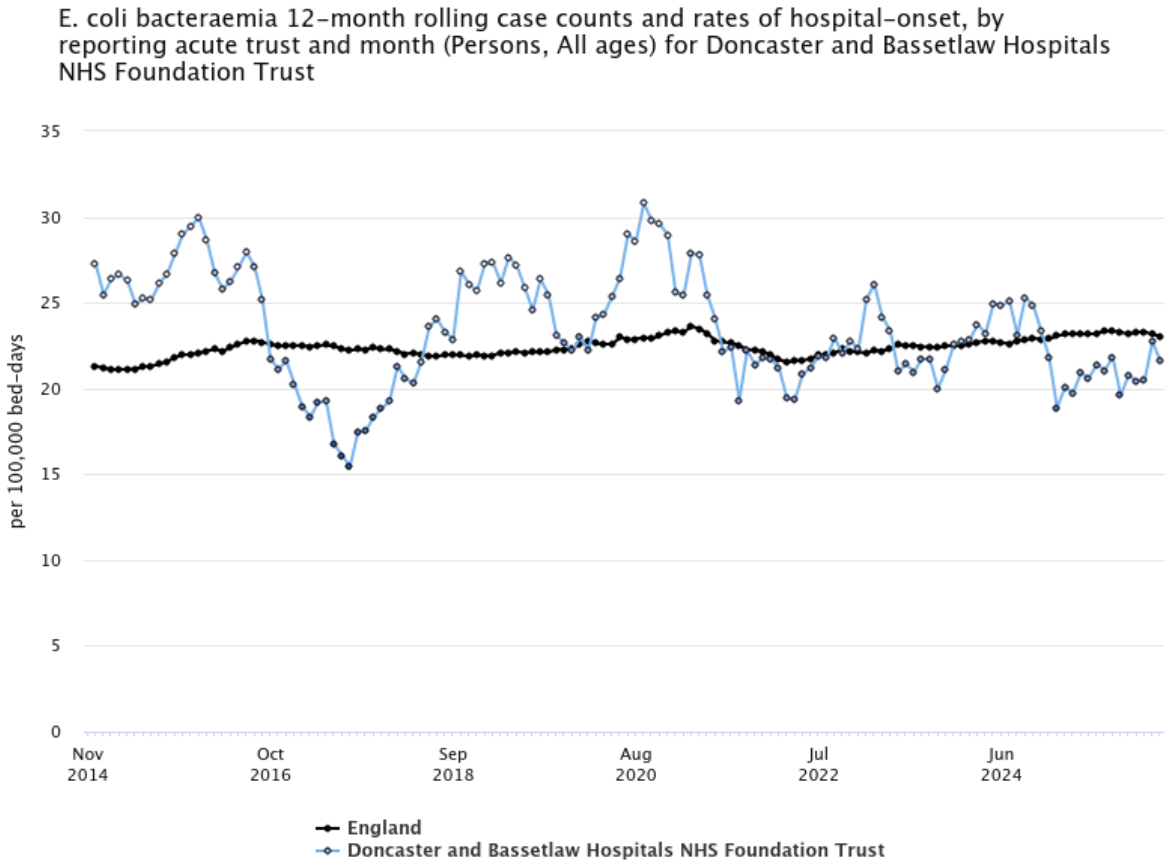
Assurance:

The Trust is fully engaged with national Gram-negative bloodstream infection surveillance and AMR priorities, with established processes in place to support monitoring, reporting, and targeted reduction of infection risk.

E. coli bloodstream infection (E. coli BSI)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total E coli Infections 2025/26	11	8	11	6	6	8	10	11	7	14	9	9
Cumulative Infections 2025/26	11	19	30	36	42	50	60	71	78	92	101	110
Cumulative infections 2024/25	7	15	24	30	36	49	57	64	73	78	90	99
E Coli trajectory (PHE) 2025/26	8	8	8	8	8	8	8	8	8	8	7	7



During 2025/26, DBTH recorded 110 *E. coli* bacteraemia cases, an increase from 99 in 2024/25, with activity remaining relatively stable month-to-month and a peak observed in January. The cumulative position exceeded both the previous year and planned trajectory from mid-year, indicating sustained background pressure rather than isolated spikes.

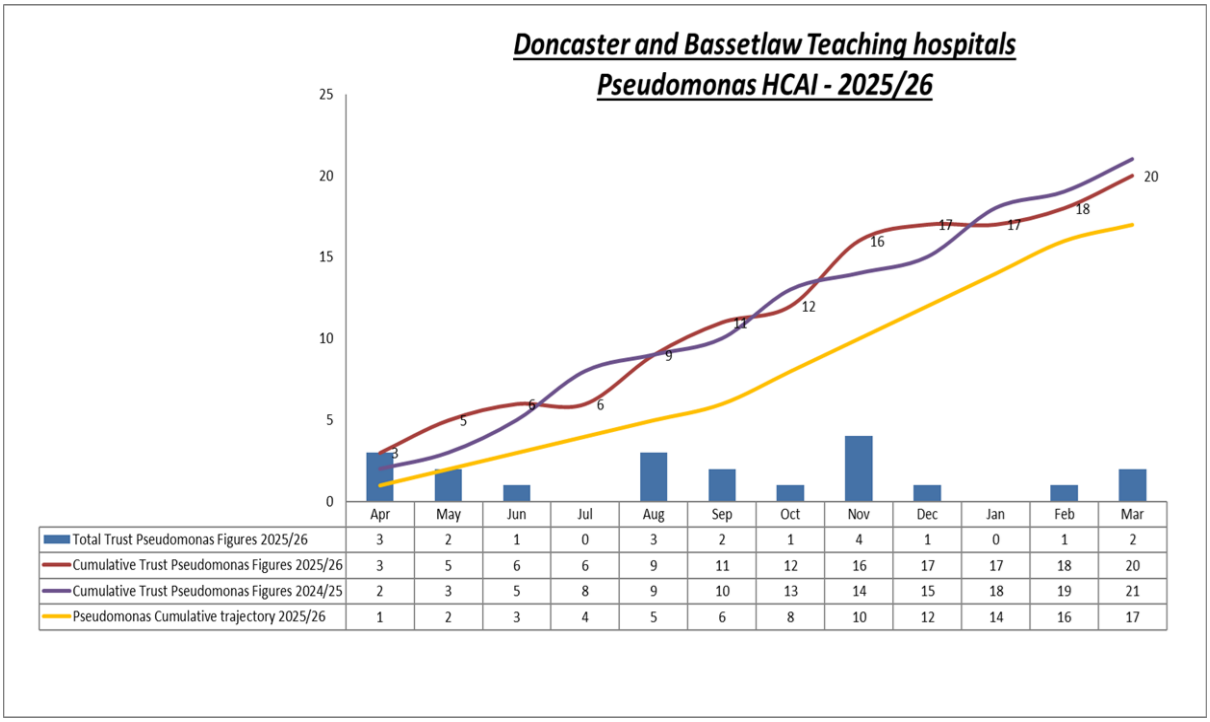
The 12-month rolling rate for hospital-onset cases remains broadly comparable to the England average, with no evidence of sustained divergence from national trends. Hospital-onset rates have shown a modest increase (21.6 per 100,000 bed days), although they remain below the national average, while the overall pattern reflects the multifactorial nature of *E. coli* infection, including patient complexity, emergency admission pathways, and urinary and intra-abdominal sources.

The majority of cases continue to occur in older patients (median age 76), with infections most commonly associated with urinary tract and hepato-biliary sources.

All cases are reviewed in line with national guidance, with control measures focused on catheter management, sepsis recognition and treatment, antimicrobial stewardship, and hydration. The Trust continues to work collaboratively with system partners across Doncaster and Bassetlaw to reduce incidence and deliver against national ambitions for Gram-negative bloodstream infections.

Assurance:
While activity has increased, performance remains aligned with national trends. Robust review processes and system-wide actions provide assurance that risks are understood and that sustained efforts are in place to reduce infection burden and support improvement in 2026/27.

Pseudomonas aeruginosa & Klebsiella spp



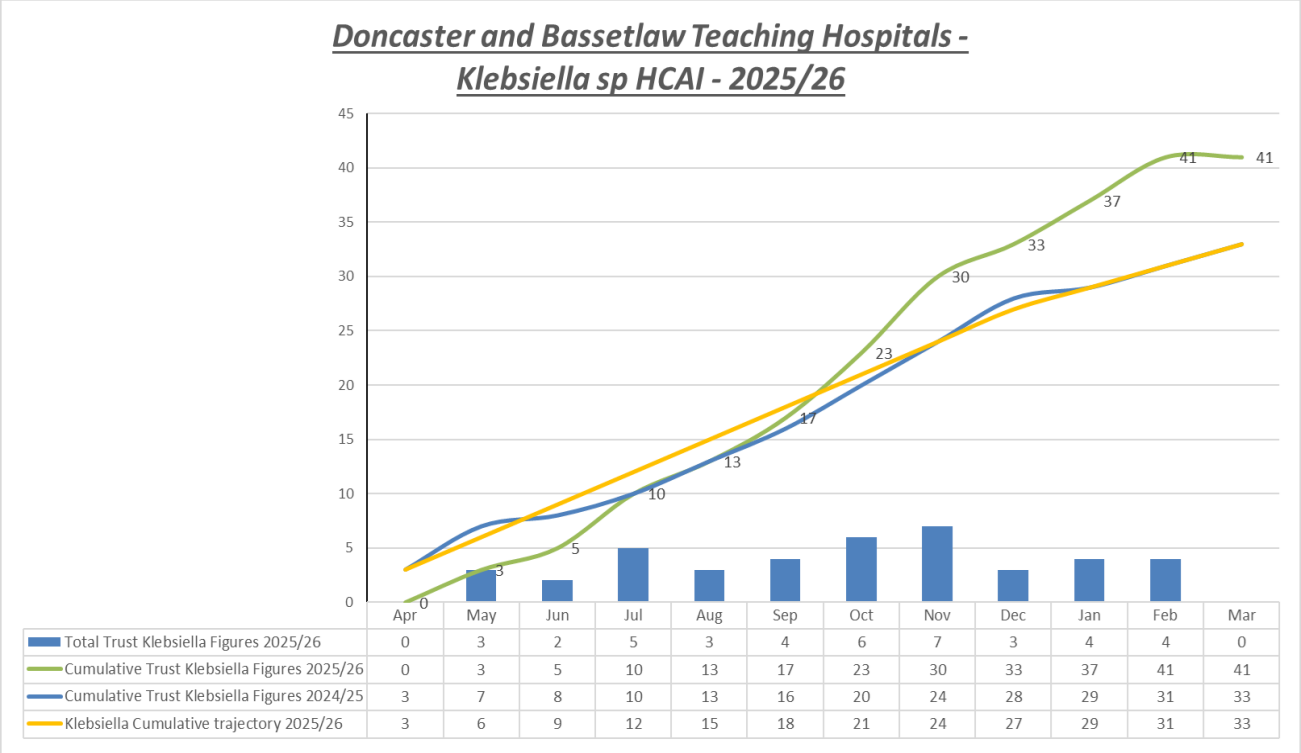
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Pseudomonas Figures 2025/26	3	2	1	0	3	2	1	4	1	0	1	2
Cumulative Trust Pseudomonas Figures 2025/26	3	5	6	6	9	11	12	16	17	17	18	20
Cumulative Trust Pseudomonas Figures 2024/25	2	3	5	8	9	10	13	14	15	18	19	21
Pseudomonas Cumulative trajectory 2025/26	1	2	3	4	5	6	8	10	12	14	16	17

Monthly activity remained low, with intermittent fluctuations and no evidence of sustained transmission or outbreak.

The cumulative total was comparable to 2024/25 and remained broadly aligned to expected trajectory, with the overall pattern reflecting steady accrual rather than any significant increase.

All cases were reviewed by the Infection Prevention and Control (IPC) team, with no common source identified. Control measures focused on reinforcing standard precautions, optimising device care (including urinary catheters and invasive lines), and maintaining assurance over water safety and environmental cleaning where required.

Assurance:
Activity remains stable and consistent with expected patterns, with no evidence of transmission or system failure. Robust surveillance and targeted controls provide assurance that risks associated with Pseudomonas aeruginosa are being effectively managed.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Klebsiella Figures 2025/26	0	3	2	5	3	4	6	7	3	4	4	0
Cumulative Trust Klebsiella Figures 2025/26	0	3	5	10	13	17	23	30	33	37	41	41
Cumulative Trust Klebsiella Figures 2024/25	3	7	8	10	13	16	20	24	28	29	31	33
Klebsiella Cumulative trajectory 2025/26	3	6	9	12	15	18	21	24	27	29	31	33

During 2025/26, DBTH recorded 41 *Klebsiella spp.* healthcare-associated infections, exceeding the previous year's trajectory from mid-year onwards and reflecting steady accumulation rather than a sharp increase.

All cases were reviewed, with no evidence of sustained transmission or a common source. The observed pattern is consistent with underlying patient complexity and device use within the inpatient population.

Targeted IPC measures, including prompt isolation, adherence to standard and transmission-based precautions, and close collaboration with clinical teams and antimicrobial stewardship, have been maintained. Learning from case review continues to inform improvement priorities.

Cases occurring more than two days (for *Pseudomonas aeruginosa and Klebsiella spp*) after admission are shown by ward and Divisions in Appendix 3

Assurance:
Activity remains under close surveillance with no evidence of outbreak or system failure. Established controls and targeted actions provide assurance that Klebsiella risk is being actively managed.

Surgical Site Infection Surveillance:

The Trust continues to participate in the UKHSA SSI surveillance programme, enabling benchmarking against national performance. Surveillance processes include clinical review, patient follow-up and post-discharge monitoring, with regular reporting through established

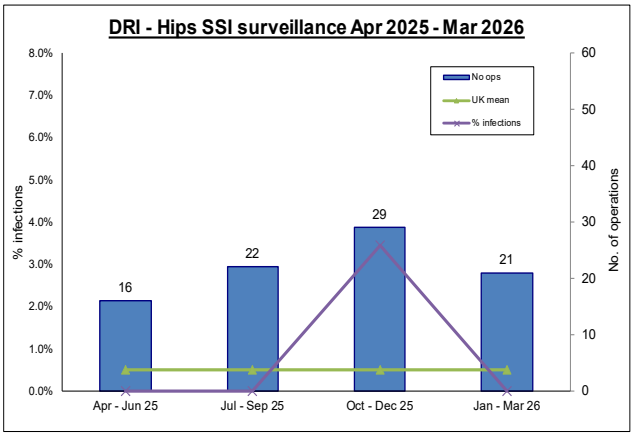
governance structures.

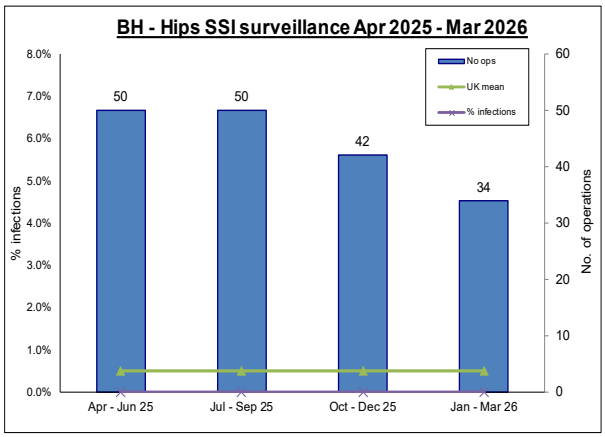
Orthopaedic SSI rates for hip and knee procedures remained low overall, with no evidence of sustained increase or clustering. Knee SSI rates were 0% at Doncaster and approximately 0.5% at Bassetlaw, broadly aligned with national benchmarks. Hip SSI performance was favourable at Bassetlaw (0%), with a single case at Doncaster resulting in a rate above the national average but not indicative of a wider trend.

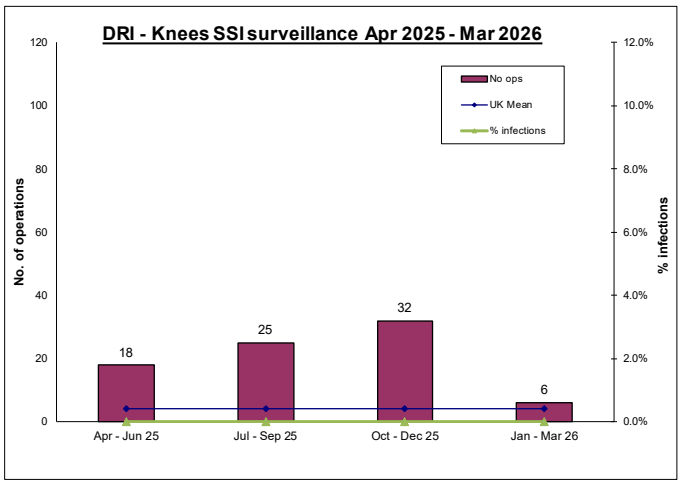
Episodes of patient-reported concerns did not translate into confirmed infections and are considered reflective of enhanced surveillance and follow-up processes rather than increased infection risk.

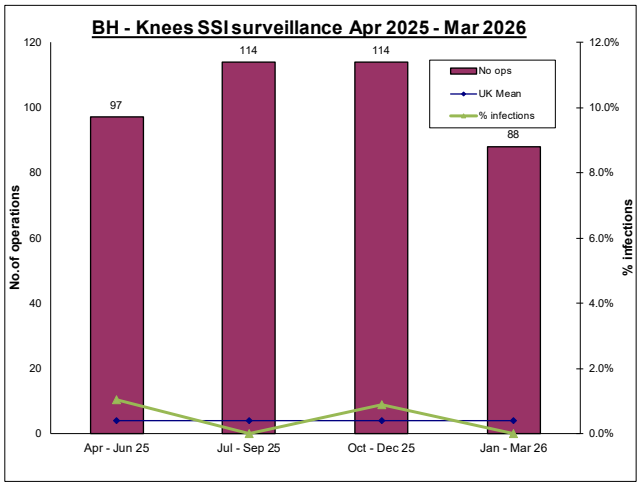
Assurance:

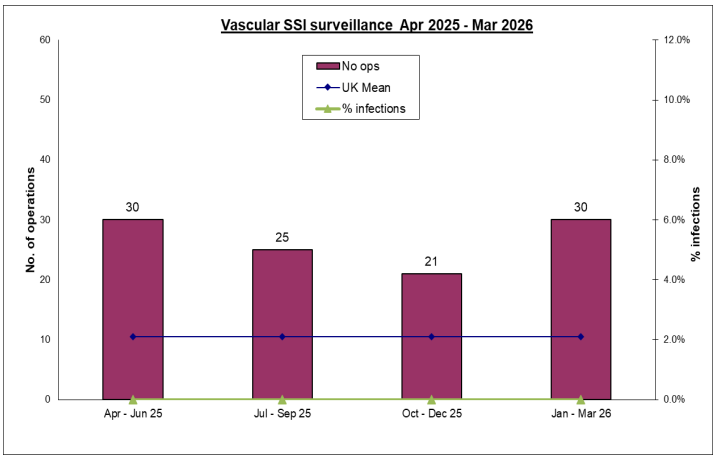
SSI surveillance demonstrates low infection rates and no evidence of systemic issues. Robust monitoring and benchmarking provide assurance that surgical infection risk is well controlled across the Trust.

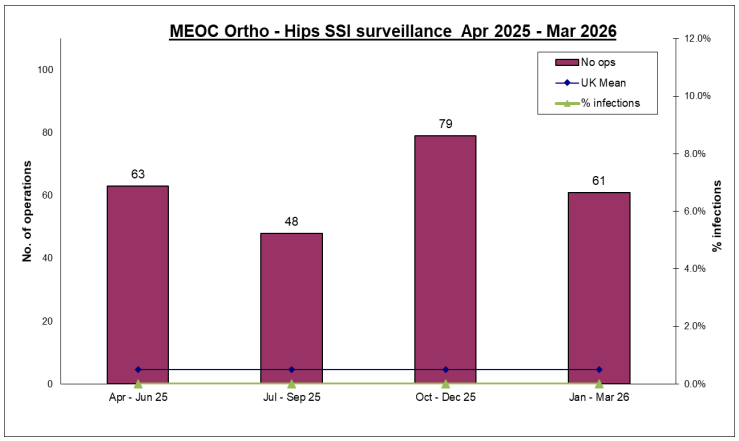


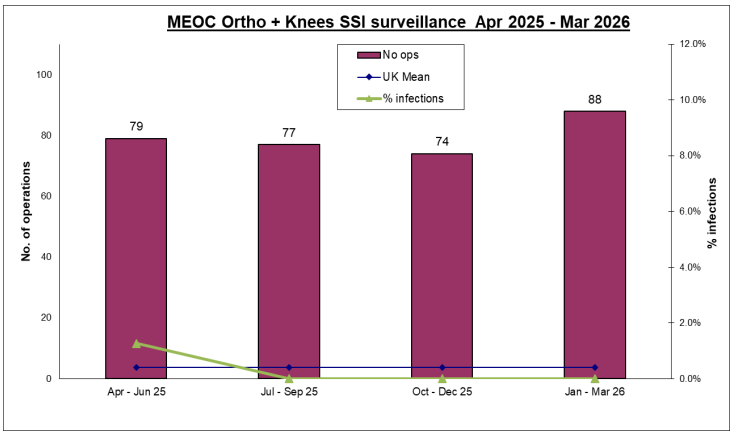


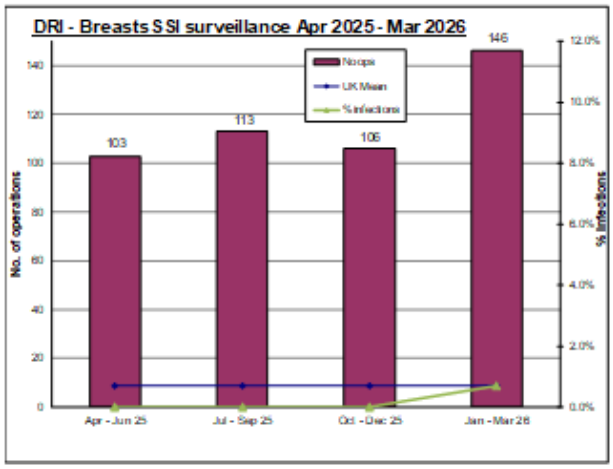

DRI - Knees SSI surveillance Apr 2025 - Mar 2026
No ops
UK Mean
% infections
No. of operations
% infections
18
25
32
6
Apr - Jun 25
Jul - Sep 25
Oct - Dec 25
Jan - Mar 26

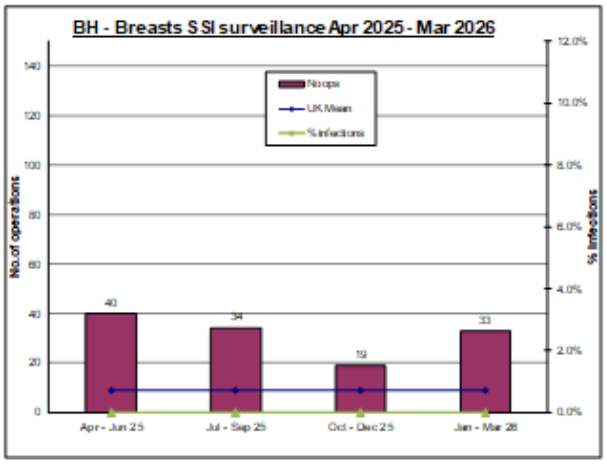

BH - Knees SSI surveillance Apr 2025 - Mar 2026
No ops
UK Mean
% infections
No.of operations
% infections
97
114
114
88
Apr - Jun 25
Jul - Sep 25
Oct - Dec 25
Jan - Mar 26

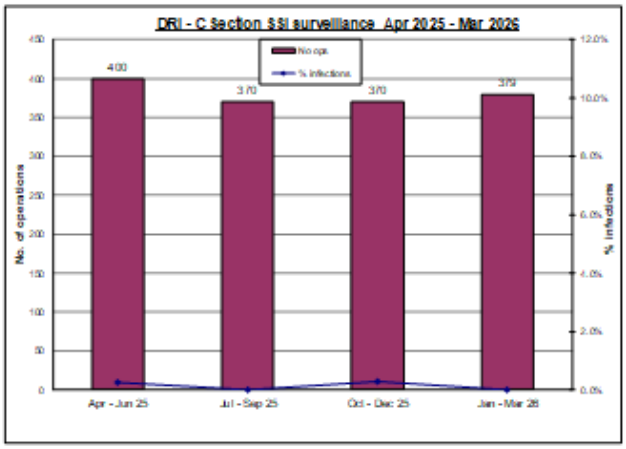

Vascular SSI surveillance Apr 2025 - Mar 2026
No ops
UK Mean
% infections
No. of operations
% infections
30
25
21
30
Apr - Jun 25
Jul - Sep 25
Oct - Dec 25
Jan - Mar 26

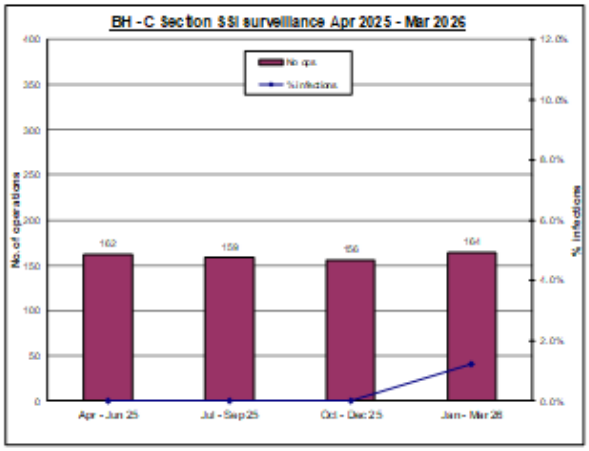

MEOC Ortho - Hips SSI surveillance Apr 2025 - Mar 2026
No ops
UK Mean
% infections
No. of operations
% infections
63
48
79
61
Apr - Jun 25
Jul - Sep 25
Oct - Dec 25
Jan - Mar 26


MEOC Ortho + Knees SSI surveillance Apr 2025 - Mar 2026
No ops
UK Mean
% infections
No. of operations
% infections
79
77
74
88
Apr - Jun 25
Jul - Sep 25
Oct - Dec 25
Jan - Mar 26









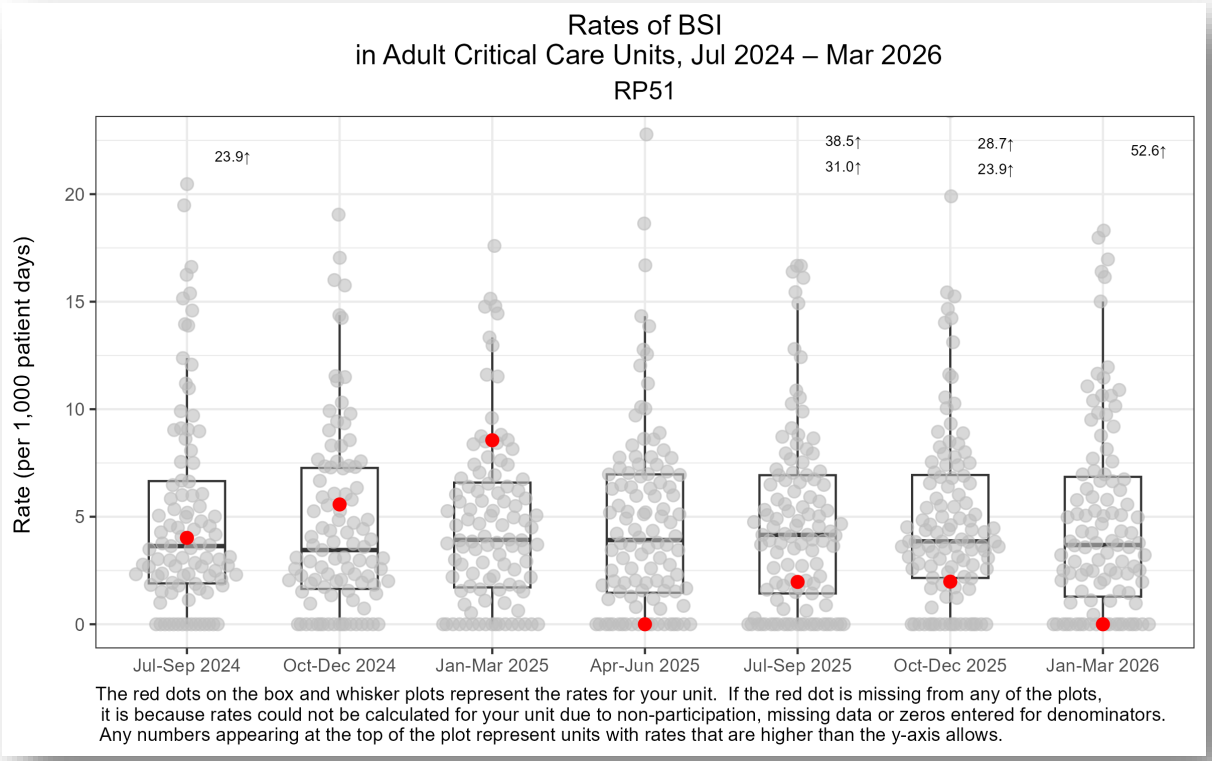
Infection in Critical Care Quality Improvement Programme (ICCQIP):

The Trust joined the Infection in Critical Care Quality Improvement Programme, which carries out ICU bloodstream infection surveillance in England. The graph below shows the progress made by our Adult critical care unit at the Doncaster Royal Infirmary in reducing our ICU-associated bloodstream infection and catheter associated bloodstream infection respectively. We will be extending the surveillance and any learning to the Bassetlaw Hospital Intensive care unit.

Central Venous Line Infection in Critical Care, referred to as Catheter related blood stream infections (CRBSI), are monitored and reported via the UKHSA. This is mandatory surveillance for all critical care units in England.

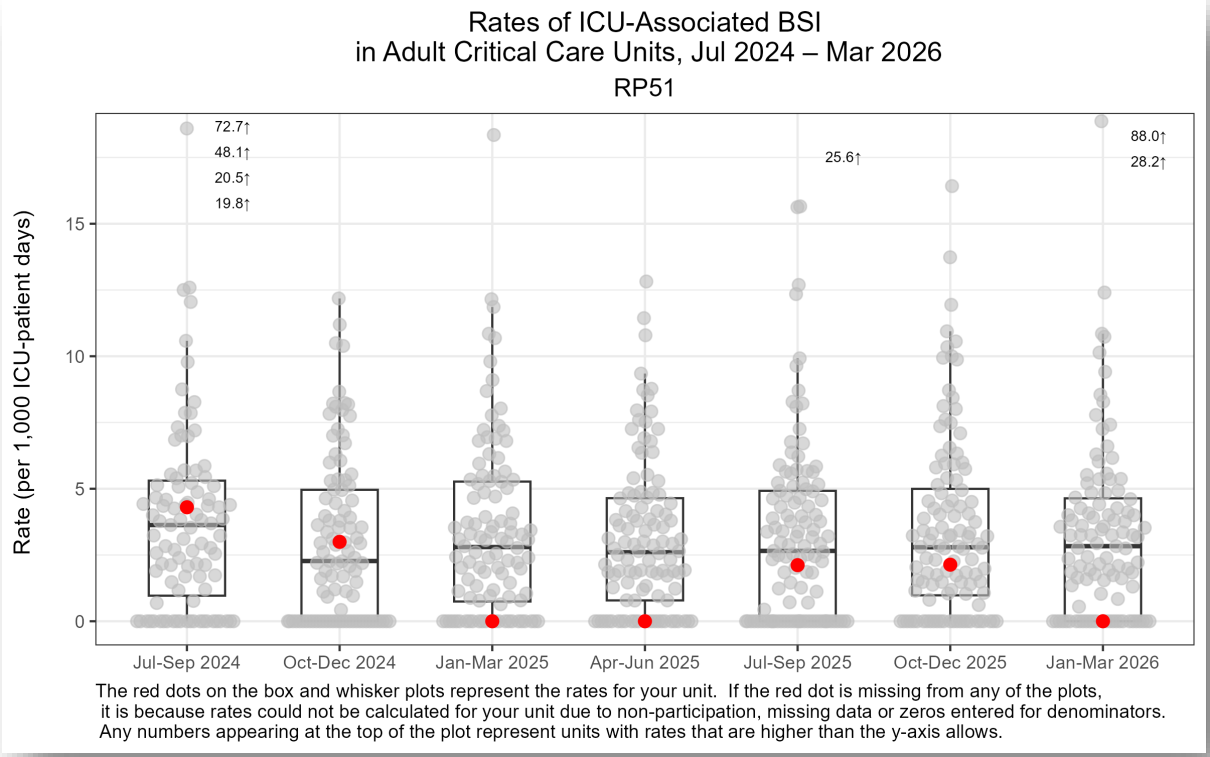
The infection rate peaked during the COVID pandemic and has remained higher than baseline nationally as well as at DBTH. This is likely due to higher morbidity in the case mix in critical care, in hospital and in the population generally.

Below are data obtained for Trust participation in the ICCQIP for 2025/2026:

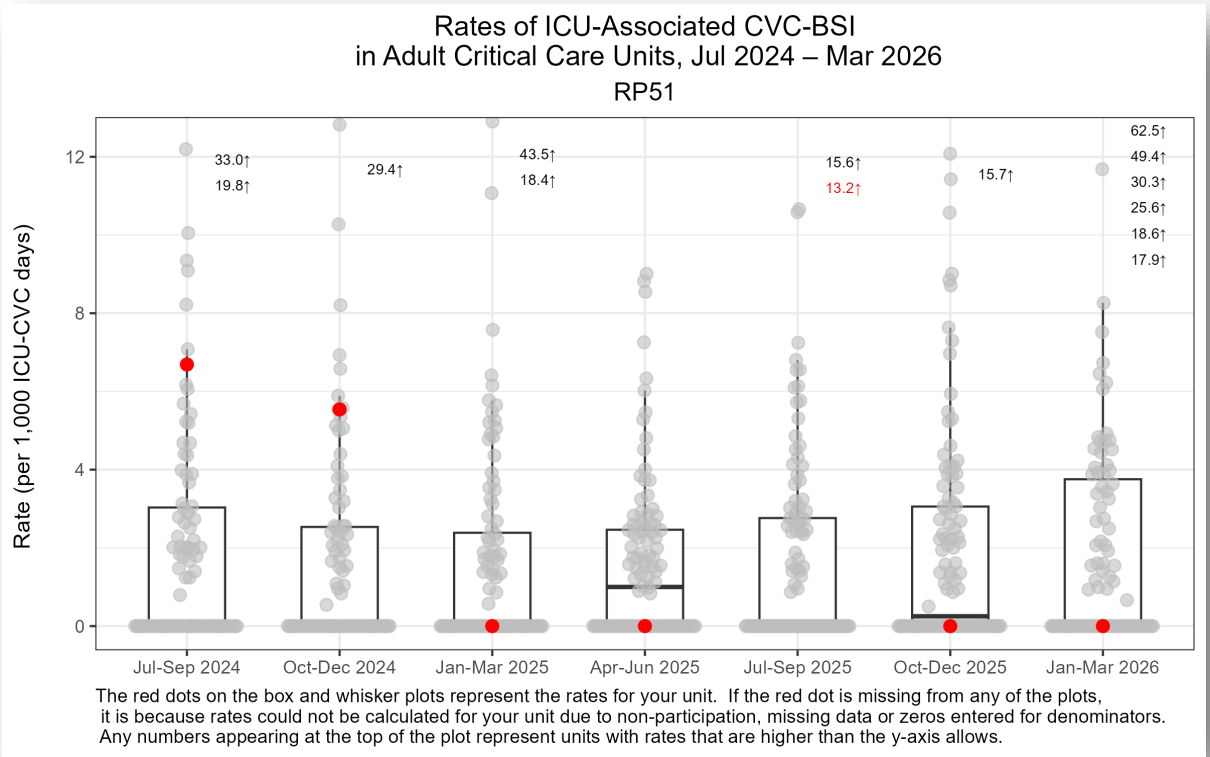


The rate of BSI in Adult Critical Care Units showed overall good improvement, with a spike in Jan-Mar 2025 probably due to number of cases outside of the ICU and not CVC-related or ICU-associated BSI for the same periods.

Analysis of Adult Critical Care BSI rates from April 2024 to December 2025 shows that the Trust's performance remained broadly in line with national comparator units throughout the period, with no evidence of sustained outlier status. Rates were within the interquartile range in most quarters, with lower-to-mid range performance in 2024, followed by a temporary increase in January–March 2025 that remained within national variation. This was followed by a marked improvement in April–September 2025 and only a modest rise in the final quarter of 2025. Against a backdrop of wide national variation, including extreme outliers in peer units, the Trust has avoided repeated high-end rates, providing assurance that critical care IPC controls, surveillance, and response arrangements are effective, with appropriate capacity to identify, respond to and recover from short-term increases in infection risk.



The Trust Department of Critical Care (DCC) unit through 2025/26 has shown improvement in our BSI rates (especially in Jan – Mar 2025), and relatively stable performance otherwise a couple of higher-than-average quarters.



Surveillance of ICU-associated central venous catheter–related bloodstream infection (CVC-BSI) rates across adult critical care units from April 2024 to December 2025 demonstrates overall stability at system level, with median rates generally remaining below 3 per 1,000 ICU-CVC days. Variation between units persists, with intermittent high outliers observed in each reporting period, indicating episodic elevations rather than a sustained deterioration in performance. Rates for DBTH (shown in red) were within the peer distribution in most quarters where data were available, although there were periods where rates could not be calculated due to zero denominators or incomplete data submission. No sustained upward trend is evident over the reporting period. These data support continued focus on CVC insertion and maintenance bundles, ongoing assurance around line necessity and prompt removal, and improvement in data completeness to ensure robust benchmarking. CVC-BSI prevention remains a key IPC priority, with targeted review of any elevated episodes through local governance and learning processes.

Influenza virus infection

Influenza season this year saw a significant number of cases, with Flu A and B, when compared to 2024/25 where we recorded 428 cases. Most cases were seen between October 2025 and February 2026.

	POCT - NUMBER OF TESTS AND POSITIVES							
	FLU POCT	COVID POCT	RSV	FLU A+	FLU B+	COVID+	RSV+	TOTAL POS PER MONTH
Apr-25	541	567	19	22	14	24	1	61
May-25	12	12	32	1	0	1	0	2
Jun-25	0	1	11	0	0	0	0	0
Jul-25	0	0	13	0	0	0	0	0
Aug-25	1	0	16	0	0	0	0	0
Sep-25	0	1	29	0	0	1	3	4
Oct-25	756	773	17	37	3	68	1	109
Nov-25	857	783	9	168	4	29	1	202
Dec-25	1172	965	20	259	4	20	2	285
Jan-26	841	832	19	59	2	14	1	76
Feb-26	617	613	24	7	0	14	0	21
Mar-26	574	566	16	6	1	9	0	16
TOTAL	5371	5113	225	559	28	180	9	

	PCR - NUMBER OF TESTS AND POSITIVE					
	COVID/FLU/RSV PCR	FLU A+	FLU B+	COVID+	RSV+	TOTAL POS PER MONTH
Apr-25	292	23	3	22	9	57
May-25	370	2	2	15	4	23
Jun-25	303	0	2	14	0	16
Jul-25	229	3	0	5	0	8
Aug-25	239	0	0	28	0	28
Sep-25	418	2	0	92	4	98
Oct-25	480	12	4	80	6	102
Nov-25	455	48	1	49	13	111
Dec-25	586	116	1	30	48	195
Jan-26	454	54	0	17	45	116
Feb-26	327	11	1	12	16	40
Mar-26	307	1	0	17	5	23
TOTAL	4460	272	14	381	150	

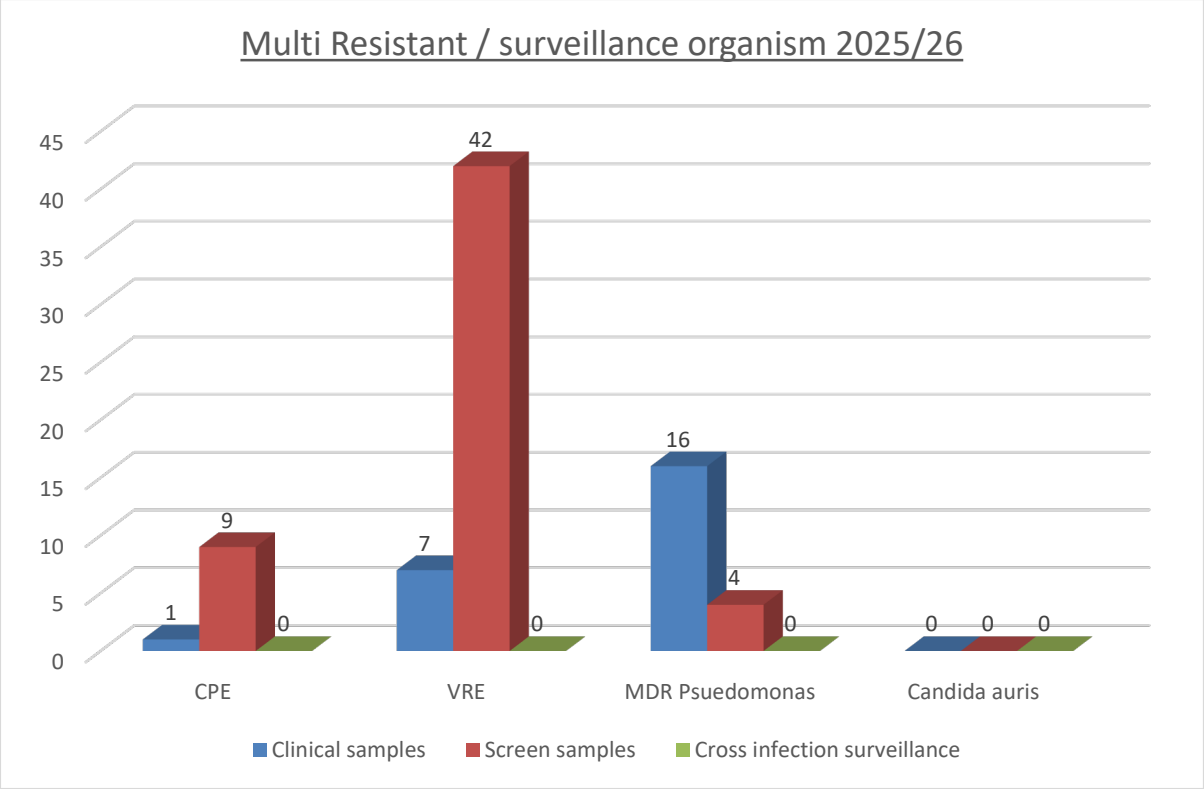
During 2025/26, the Trust utilised a combined approach of near-patient point-of-care testing (POCT) and laboratory PCR to support timely diagnosis and effective infection prevention and control (IPC) for respiratory viruses. Testing activity increased appropriately during the winter period, with POCT enabling rapid clinical decision-making and early isolation, while PCR provided confirmatory testing and enhanced detection, particularly for RSV.

This dual approach supported resilience in testing capacity, timely IPC interventions, and effective management of seasonal surges, with no evidence of delays impacting patient safety.

The Trust continued to manage operational challenges associated with significant seasonal variation in demand, requiring sustained workforce, equipment, and supply chain capacity. While POCT supported rapid decision-making, its lower sensitivity for RSV necessitated continued reliance on PCR for confirmation and surveillance. Balancing appropriate use of POCT and PCR, maintaining staff competency, and ensuring robust governance of an expanding POCT service remained key priorities.

Assurance:
The combined POCT and PCR testing strategy has provided a resilient and effective diagnostic model, supporting timely IPC action and patient safety, with ongoing oversight to address operational challenges and optimise testing pathways.

Multi-resistant organisms & Carbapenemase-Producing Organisms



During 2025/26, surveillance of key multi-resistant organisms at Doncaster and Bassetlaw Teaching Hospitals demonstrates that activity was predominantly identified through proactive screening rather than clinical infection. There was no evidence of cross-infection or outbreaks during the reporting period, indicating effective infection prevention and control (IPC) measures.

Organism-specific findings

Carbapenemase-producing Enterobacterales (CPE)
A total of 10 detections was identified, with 9 identified through screening and 1 clinical isolate. This profile is consistent with effective admission and risk-based screening processes, with timely IPC intervention preventing onward transmission.

Assurance: There is significant assurance that CPE risks are being effectively mitigated through early detection, prompt isolation, and robust IPC management, with no evidence of transmission.

Vancomycin-resistant Enterococci (VRE)
A total of 49 detections were recorded, predominantly from screening samples (42 cases), with 7 clinical isolates. No cross-infection episodes were identified. Findings are consistent with colonisation in higher-risk patient cohorts rather than healthcare-associated transmission.

Assurance: There is significant assurance that VRE cases reflect expected colonisation patterns in high-risk groups, with IPC controls effectively preventing healthcare-associated spread.

Multi-drug resistant Pseudomonas

Twenty cases were identified, including 16 clinical isolates and 4 screening detections. Cases were sporadic, with no epidemiological linkage or evidence of transmission.

Assurance: There is significant assurance that cases are isolated and non-transmissible, with no indication of clustering or systemic IPC gaps.

Candida auris

No cases were identified from either clinical or screening samples during the reporting period.

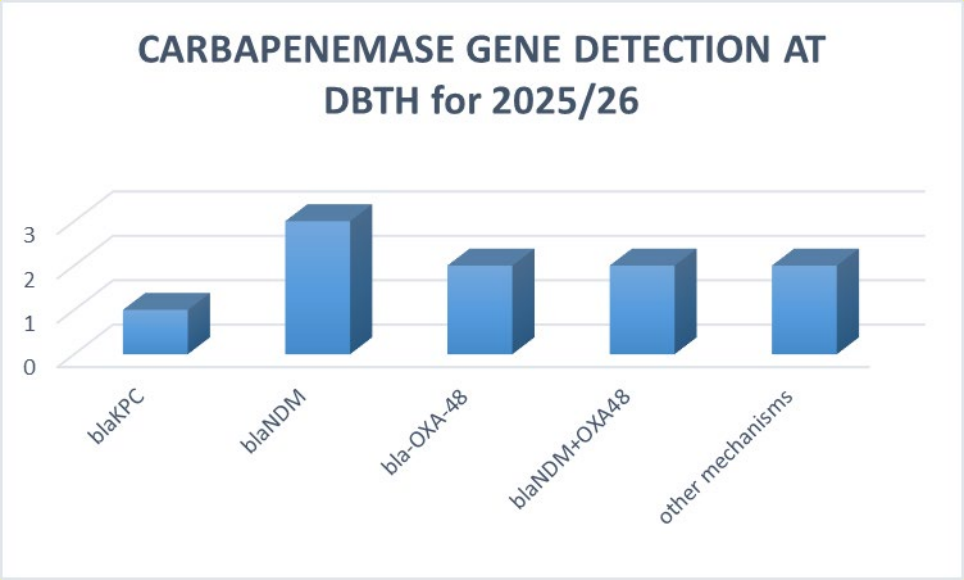
Assurance: There is significant assurance that there has been no emergence or detection of Candida auris within the Trust.

Overall Position and Forward Look

Overall, surveillance data demonstrates effective IPC systems for early detection, isolation, and management of multi-resistant organisms, with containment achieved and no confirmed transmission events.

Overall Assurance Statement

The Trust can provide significant assurance that systems and controls for the surveillance and management of multi-resistant organisms are effective, with robust processes in place to detect, contain, and mitigate risk, and no evidence of healthcare-associated transmission during 2025/26.



Carbapenemase-producing Enterobacterales (CPE) are a group of organisms with significant resistance to multiple antimicrobials, including carbapenems (e.g. meropenem and imipenem), with some isolates demonstrating resistance to all currently available treatment options. Whilst many of these organisms may exist as part of normal gut flora, they present a substantial risk within healthcare settings due to their capacity for rapid transmission and association with poorer clinical outcomes.

In September 2020, Public Health England (now UKHSA) established a national framework for the containment of CPE. This sets clear expectations for active screening, robust surveillance systems, early laboratory detection of key carbapenemase mechanisms (including KPC, OXA-48-like, NDM and VIM), implementation of standard and transmission-based precautions, antimicrobial stewardship, and effective outbreak management with defined organisational oversight.

Surveillance Findings

During 2025/26, Doncaster and Bassetlaw Teaching Hospitals identified a small number of carbapenemase gene detections, consistent with ongoing vigilance through targeted screening and diagnostic pathways. Detected mechanisms included:

- blaNDM (most frequently identified)
- blaOXA-48
- combined blaNDM/blaOXA-48
- blaKPC
- other carbapenemase variants (low frequency)

The distribution of detected mechanisms was characterised by low numbers and sporadic occurrence, with no clustering identified.

Assurance: There is significant assurance that surveillance systems are effective in identifying a range of carbapenemase mechanisms at an early stage, enabling timely intervention and risk mitigation.

IPC Management and Transmission Risk

The majority of detections were identified through established screening pathways and were managed promptly by the Infection Prevention and Control (IPC) team. All cases were subject to:

- Individual risk assessment.
- Isolation or cohorting where appropriate.
- Implementation of transmission-based precautions.
- Ongoing review in line with national guidance.

There was no evidence of cross-transmission or outbreaks associated with CPE during the reporting period.

Assurance: There is significant assurance that IPC controls are consistently applied and effective in preventing transmission, with no confirmed healthcare-associated spread identified.

Benchmarking and Epidemiological Context

The observed pattern of CPE detection is consistent with background epidemiology seen across the NHS, reflecting sporadic importation and colonisation rather than sustained transmission within the organisation.

Assurance: There is significant assurance that the Trust's CPE profile aligns with expected national patterns and does not indicate increased organisational risk.

Forward Look and Priorities (2026/27)

To sustain and strengthen current performance, the following priorities will be maintained:

- Continued targeted screening of high-risk patient groups
- Rapid laboratory identification and reporting of carbapenemase mechanisms
- Sustained compliance with IPC precautions
- Ongoing enhancement of antimicrobial stewardship programmes
- Multidisciplinary oversight and surveillance triangulation to identify emerging risks early

Overall Assurance Statement

The Trust can provide significant assurance that systems for the detection, surveillance, and management of carbapenemase-producing organisms are effective. Robust screening, timely laboratory identification, and consistent IPC interventions have ensured early containment, with no evidence of transmission or outbreaks during 2025/26.

Point Prevalence Survey

National Point Prevalence Survey (PPS) of Healthcare-Associated Infections

There are now nine years of comparative data available to support benchmarking and trend analysis, incorporating national Point Prevalence Surveys (PPS) undertaken in 2016 and 2024, alongside locally delivered surveys between 2018 and 2023, and most recently in 2025. This longitudinal dataset provides a robust evidential basis to assess improvement and identify areas of ongoing risk.

The Infection Prevention and Control (IPC) Team undertook a Trust-wide PPS in November 2025 across inpatient wards over a two-week period. A total of 495 patients were surveyed, aged between 16 and 100 years, with a gender distribution of 54.3% female and 45.7% male.

HCAI Findings

A total of 24 patients (4.8%) were identified as having a healthcare-associated infection (HCAI), comprising:

- 8 Pneumonia.
- 5 Urinary Tract Infections.
- 2 Gastrointestinal infections.
- 5 Skin/soft tissue, wound or deep tissue infections.

- 1 Laboratory-confirmed bacteraemia.
- 3 Other infections.

The overall HCAI prevalence rate of 4.8% represents a slight increase from 4.5% in the previous year. However, this remains below the most recently available national benchmark of 6.6% (2016 PPS). Updated national comparator data from the 2024 PPS is awaited to enable refreshed benchmarking.

Assurance: There is moderate assurance that the Trust's HCAI prevalence remains below established national benchmarks, although the year-on-year increase indicates the need for continued vigilance and targeted improvement.

Interpretation and Benchmarking

The observed increase in prevalence is modest and should be interpreted within the context of:

- Improved case ascertainment through enhanced surveillance.
- Ongoing acuity and complexity of inpatient cohorts.
- Seasonal and respiratory infection pressures influencing pneumonia rates.

Whilst current performance remains favourable against historical national data, the absence of updated national comparators limits full benchmarking assurance.

Assurance: There is moderate assurance in benchmarking position, with confirmation pending publication of the latest national PPS dataset.

Forward Focus and Priorities (2026/27)

To sustain and improve performance, the following priorities will be progressed:

- Strengthen targeted interventions for high-prevalence infection types (particularly pneumonia and UTIs).
- Continue to embed consistent surveillance and case validation processes.
- Maintain focus on fundamental IPC practices, including hand hygiene, device management, and environmental standards.
- Align improvement actions with antimicrobial stewardship programmes.
- Undertake comparative analysis against 2024 national PPS data once available.

Overall Assurance Statement

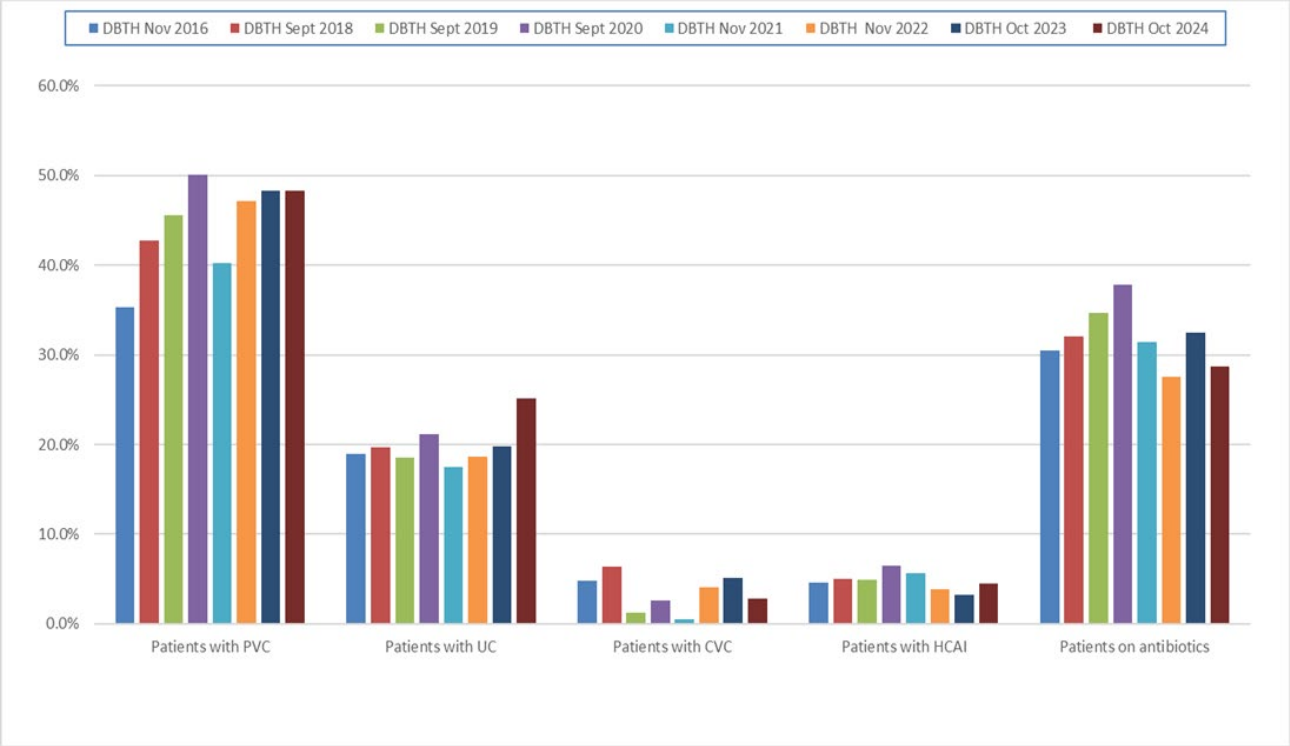
The Trust can provide moderate assurance that systems for the surveillance and management of healthcare-associated infections are effective. HCAI prevalence remains below national benchmarks; however, the observed increase compared to the previous year and pending national comparator data require continued scrutiny and targeted improvement focus.

Year on year HCAI prevalence in DBTH from 2016 to 2025

Measure	DBTH Nov 2025		DBTH Oct 2024		DBTH Sep 2023		DBTH Nov 2022		DBTH Nov 2021		DBTH Sept 2020		DBTH Sept 2019		DBTH Sept 2018		DBTH Nov 2016		National Nov-16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Patients surveyed	495		572		779		414		423		415		404		458		476		48312	
Patients with PVC	232	46.9%	276	48.3%	376	48.3%	195	47.1%	170	40.2%	208	50.1%	184	45.5%	196	42.8%	168	35.3%	20675	42.8%
Patients with UC	96	19.4%	144	25.2%	154	19.8%	77	18.6%	74	17.5%	88	21.2%	75	18.6%	90	19.7%	90	18.9%	9724	20.1%
Patients with CVC	12	2.4%	16	2.8%	40	5.1%	17	4.1%	2	0.5%	11	2.7%	5	1.2%	29	6.3%	23	4.8%	3183	6.6%
Patients with HCAI	24	4.8%	26	4.5%	25	3.2%	16	3.9%	24	5.7%	27	6.5%	20	5.0%	23	5.0%	22	4.6%	3174	6.6%
Patients on antibiotics	148	29.9%	164	28.7%	253	32.5%	114	27.5%	133	31.4%	157	37.8%	140	34.7%	147	32.1%	145	30.5%	17884	37.0%

	DBTH Nov 2016	DBTH Sept 2018	DBTH Sept 2019	DBTH Sept 2020	DBTH Nov 2021	DBTH Nov 2022	DBTH Oct 2023	DBTH Oct 2024	DBTH Nov 2025
Patients with PVC	35.3%	42.8%	45.5%	50.1%	40.2%	47.1%	48.3%	48.3%	46.9%
Patients with UC	18.9%	19.7%	18.6%	21.2%	17.5%	18.6%	19.8%	25.2%	19.4%
Patients with CVC	4.8%	6.3%	1.2%	2.7%	0.5%	4.1%	5.1%	2.8%	2.4%
Patients with HCAI	4.6%	5.0%	5.0%	6.5%	5.7%	3.9%	3.2%	4.5%	4.8%
Patients on antibiotics	30.5%	32.1%	34.7%	37.8%	31.4%	27.5%	32.5%	28.7%	29.9%

Year on year comparison of main elements of Point Prevalence Survey



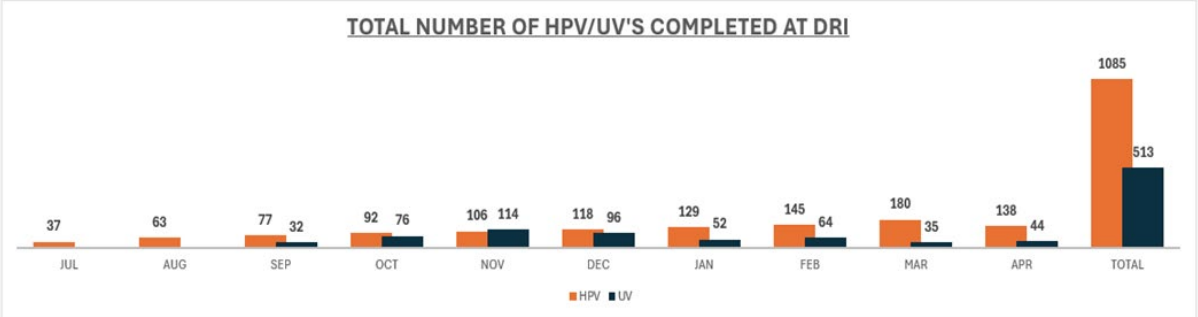
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

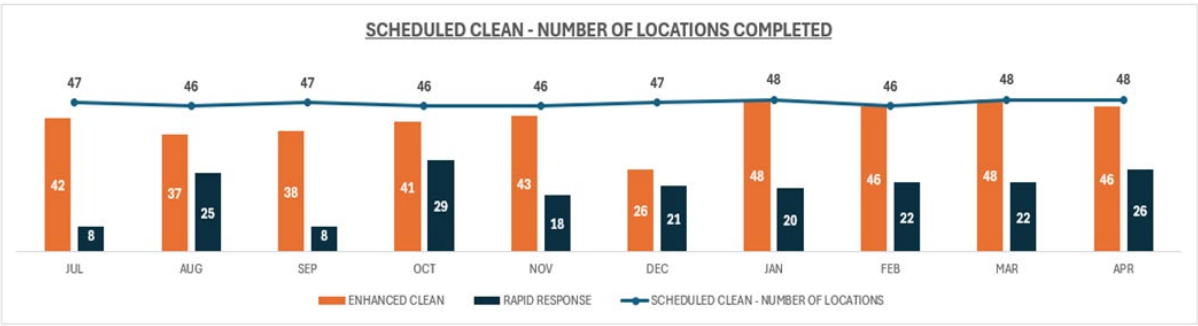
Rapid Response Cleaning & Elements Cleaning Team

The Elements Team, established as part of the National Standards of Healthcare Cleanliness roll out, has been delivering a structured programme of cleaning tasks across functional areas. These tasks address gaps identified between daily scheduled cleaning and the requirements set out in the 2025 standards.

The Rapid Response Team provides support up to 22:00, enabling rapid turnaround of bedspaces and terminal cleans to maintain patient flow and maximise capacity. The team also supports the Deep Clean Team, deploys HPV disinfecting devices, and delivers targeted interventions when required — for example, following the CQC visit which highlighted issues with patient equipment in ED.

A summary of the team's outputs is summarised below.





National Standards of Healthcare Cleanliness

The Trust remains fully committed to achieving and sustaining compliance with the National Standards of Healthcare Cleanliness. A coordinated delivery model is in place, with Facilities Assistants across wards and departments working alongside the Elements, Rapid Response, and Deep Clean teams to provide a comprehensive, risk-based approach to environmental cleanliness.

This model combines routine, enhanced, and reactive cleaning functions, ensuring that both scheduled requirements and identified gaps are effectively addressed through structured processes and robust oversight arrangements.

Assurance: There is significant assurance that an integrated and systematic approach to healthcare cleanliness is embedded, with clearly defined roles supporting delivery of national standards.

Enhanced Cleaning Delivery (Elements and Specialist Teams)

The Elements Team, established as part of the national standards implementation, delivers a structured programme of targeted cleaning across functional areas. This work specifically addresses gaps between routine daily cleaning schedules and the enhanced requirements introduced within the 2025 standards, with a focus on high-touch surfaces, patient equipment, and higher-risk clinical environments.

The Rapid Response Team provides extended support up to 22:00, enabling:

- Timely turnaround of bedspaces and terminal cleans.
- Maintenance of patient flow and bed capacity.
- Responsive deployment to areas of emerging risk.

In addition, the team:

- Supports the Deep Clean Team in delivering intensive cleaning programmes.
- Deploys hydrogen peroxide vapour (HPV) disinfection where indicated.
- Undertakes targeted interventions in response to audit findings and external inspection feedback (e.g. Emergency Department equipment cleaning).

Assurance: There is significant assurance that enhanced and responsive cleaning capacity is effectively deployed, enabling rapid mitigation of environmental risks and supporting both IPC and operational flow.

Audit, Oversight and Performance Monitoring

Enhanced governance arrangements are in place to ensure delivery of cleanliness standards is consistently monitored and validated. Newly established Facilities roles provide dedicated capacity to:

- Undertake and validate cleanliness audits.
- Accompany matrons on joint inspections.
- Complete cleaning efficacy checks.
- Produce and display star rating posters, promoting transparency and local ownership.

Key activity during 2025/26 includes:

- 1,804 audits completed across the highest-risk functional areas.
- 3,000 audits annually across all wards and departments.
- Monthly performance reporting via PRM meetings to provide structured assurance
- Development of dashboards and management information to support trend analysis, operational oversight, and targeted improvement.

This comprehensive audit framework supports early identification of risks and enables timely corrective action at ward and departmental level.

Assurance: There is significant assurance that a robust audit and reporting infrastructure is in place, providing effective oversight of cleanliness standards and driving continuous improvement.

Overall Position

The combined approach of planned, enhanced, and reactive cleaning, supported by a strong audit and governance framework, ensures the Trust is well-positioned to maintain safe, clean care environments aligned to national standards.

Overall Assurance Statement

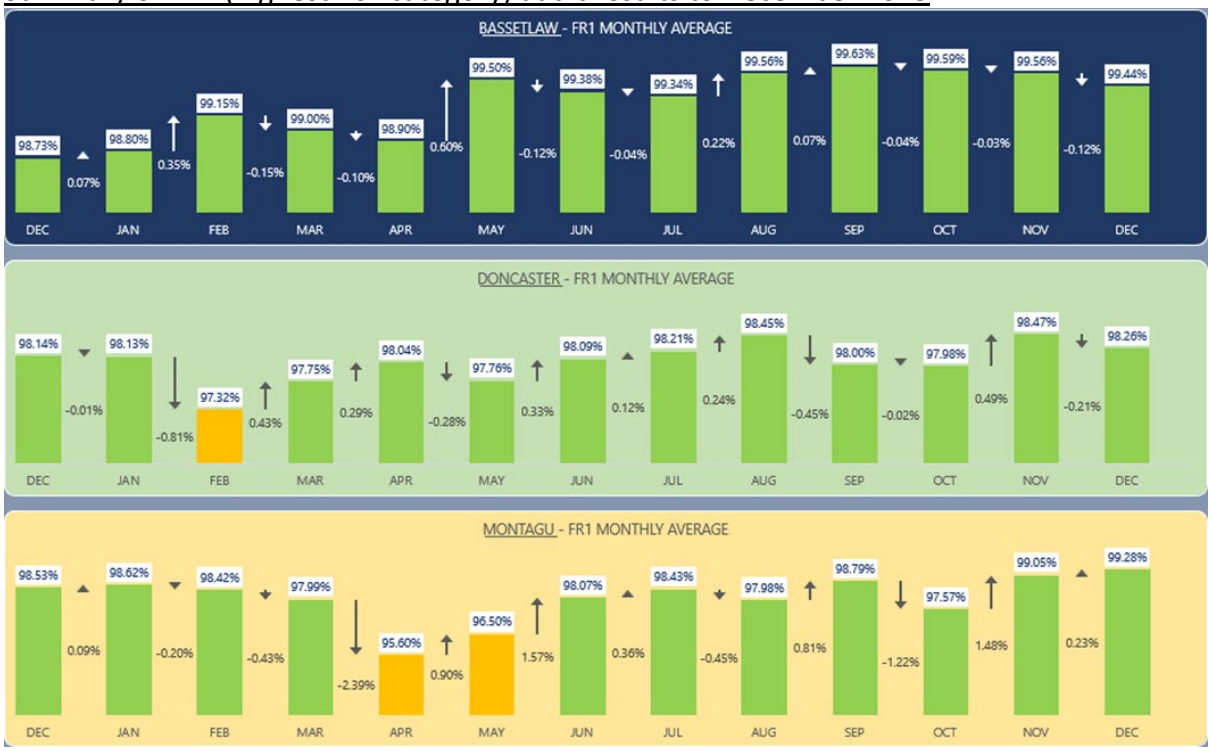
The Trust can provide significant assurance that systems and processes to deliver and monitor healthcare cleanliness are effective. Enhanced cleaning delivery, responsive

operational capacity, and strengthened audit arrangements are collectively ensuring sustained compliance with the National Standards of Healthcare Cleanliness and supporting infection prevention, patient safety, and operational flow.

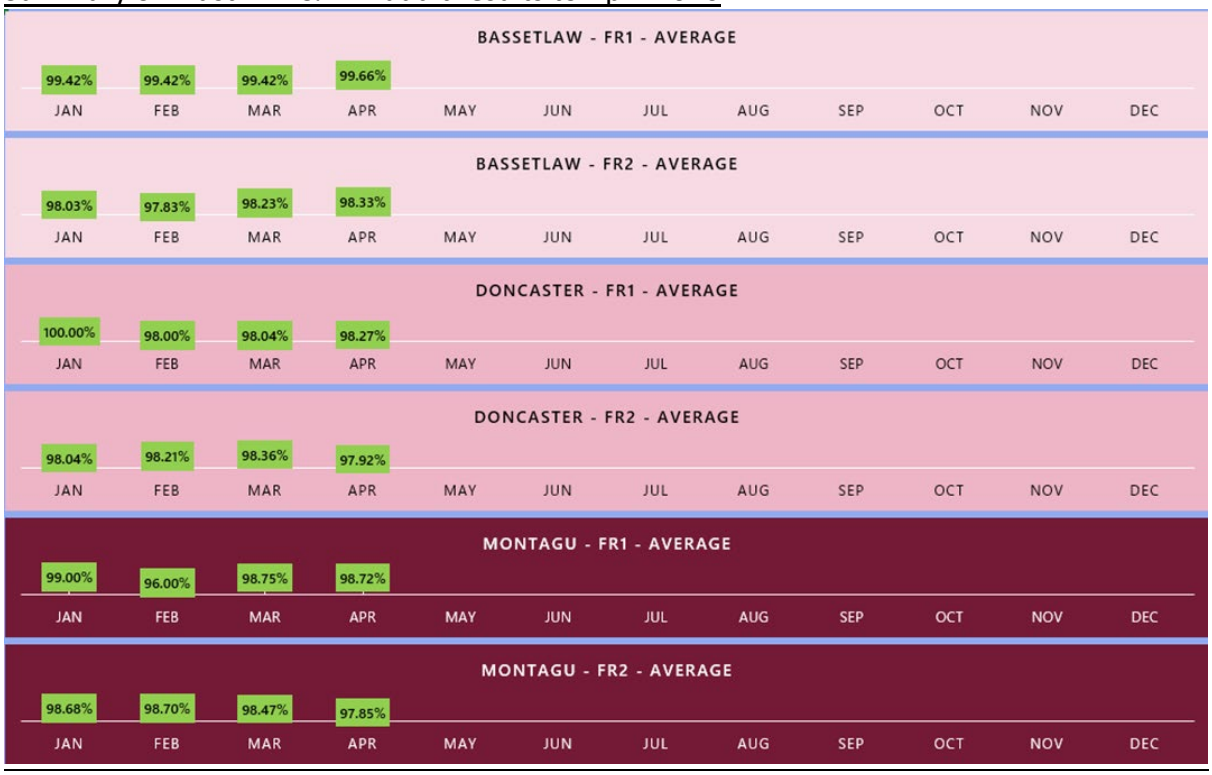
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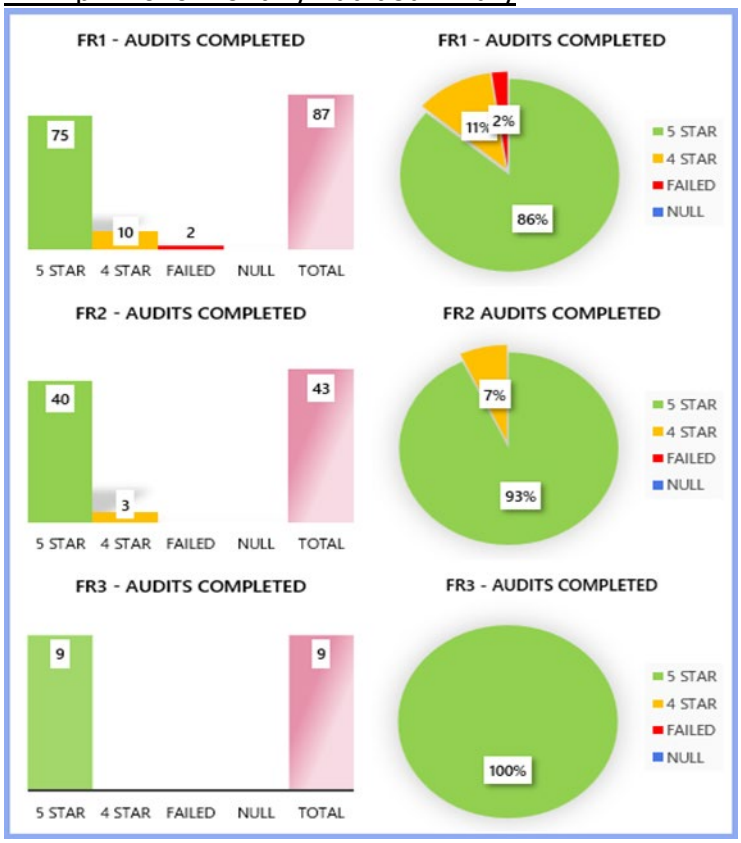
Summary of FR1 (highest risk category) audit results to December 2025



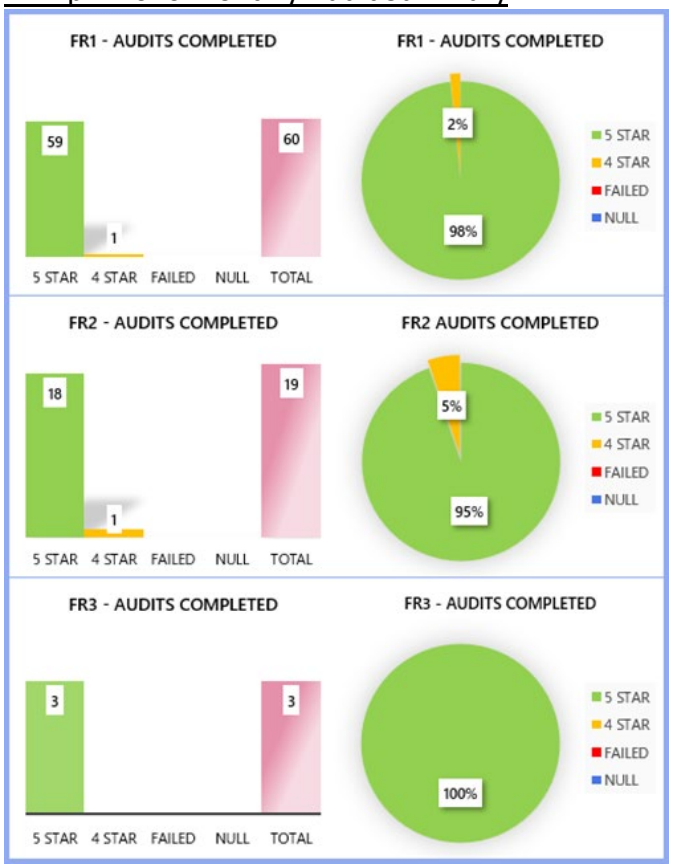
Summary of Trust FR1 & FR2 audit results to April 2026



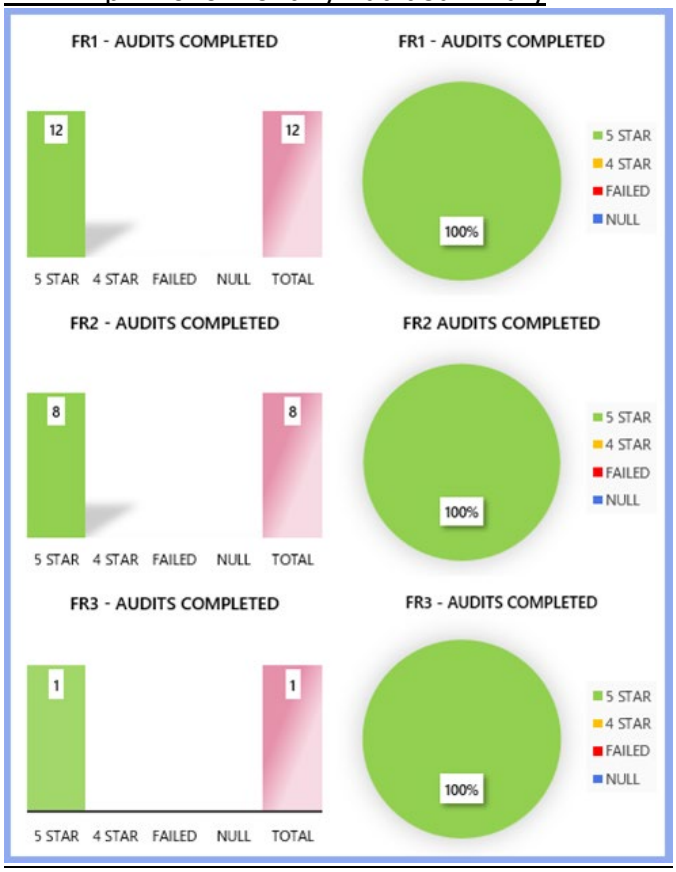
DRI April 2026 Monthly Audit Summary



BH April 2026 Monthly Audit Summary



MMH April 2026 Monthly Audit Summary



PLACE Inspections

The Facilities Management Team in conjunction with Corporate Nursing led the Patient Led Assessment of the Care Environment (PLACE) data collection exercise in October 2025, with all three main Trust sites assessed across a range of domains, including cleanliness.

The PLACE process provides an independent, patient-focused assessment of the environment, offering valuable external validation of internal cleanliness standards and overall patient experience.

Assurance: There is significant assurance that independent patient-led assessment processes are embedded and provide robust external validation of environmental standards across the Trust.

Cleanliness Performance

Facilities teams continue to deliver consistently high standards of cleanliness, reflected in both internal audit outcomes and PLACE inspection results. The Trust achieved an overall organisational cleanliness score of 98.44%, demonstrating sustained high performance across all sites.

This performance aligns with:

- Strong internal audit results.
- Effective delivery of routine, enhanced, and reactive cleaning models.
- Visible ownership of standards at ward and departmental level.

Assurance: There is significant assurance that cleanliness standards are consistently achieved across the organisation, with performance validated through both internal and independent assessment processes.

Continuous Improvement and Transparency

The PLACE findings complement the Trust's wider cleanliness assurance framework, including:

- Ongoing audit activity and star rating visibility at ward level.
- Targeted deployment of Elements, Rapid Response, and Deep Clean teams.
- Use of performance data and dashboards to drive improvement.

The graphic summaries (below) provide detailed breakdowns of performance across domains and sites, supporting transparency and local accountability.

Assurance: There is significant assurance that PLACE outcomes are effectively triangulated with internal audit data to support continuous improvement and sustained compliance with national standards.

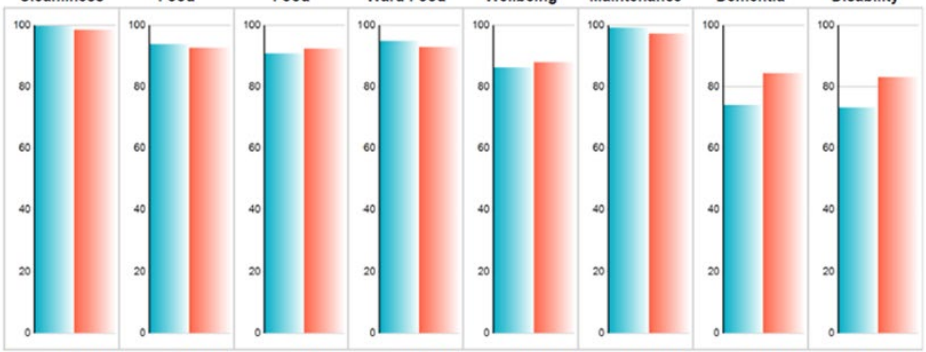
Overall Position

PLACE results reinforce the strength of the Trust's cleanliness systems and confirm that high standards are consistently delivered across clinical environments.

Overall Assurance Statement

The Trust can provide significant assurance that environmental cleanliness standards are effective, consistently achieved, and independently validated, contributing to safe, high-quality patient care environments.

BASSETLAW DISTRICT GENERAL HOSPITAL- Collection: 2025

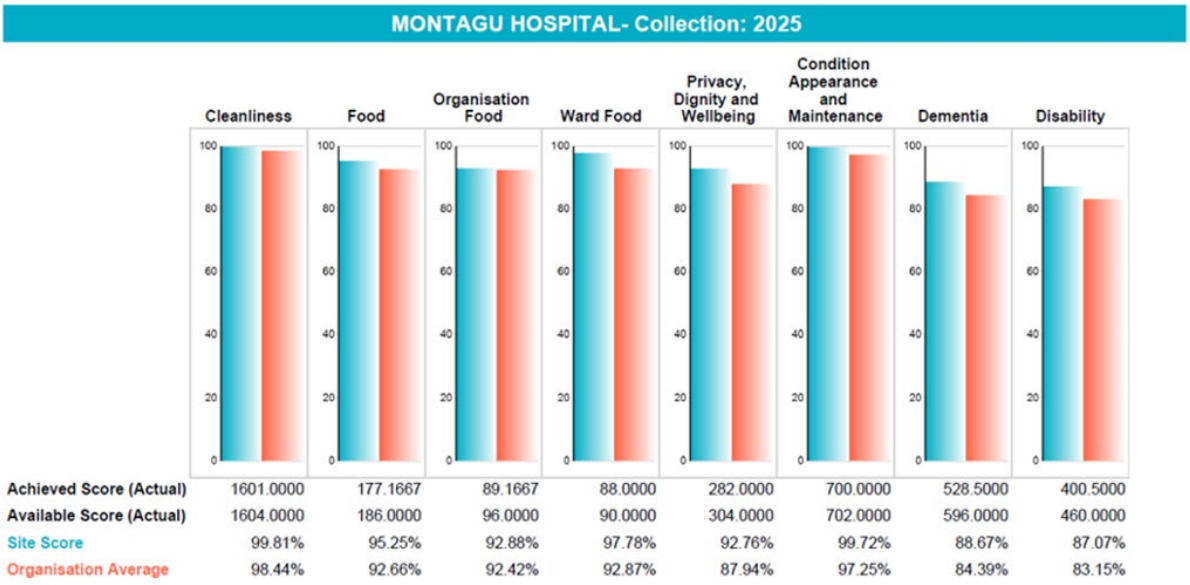


	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2991.0000	347.1667	87.1667	260.0000	498.6667	1342.0000	710.5000	518.5000
Available Score (Actual)	2998.0000	370.0000	96.0000	274.0000	578.0000	1352.0000	960.0000	708.0000
Site Score	99.77%	93.83%	90.80%	94.89%	86.27%	99.26%	74.01%	73.23%
Organisation Average	98.44%	92.66%	92.42%	92.87%	87.94%	97.25%	84.39%	83.15%

DONCASTER ROYAL INFIRMARY- Collection: 2025



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	4116.0000	431.1667	89.1667	342.0000	722.6667	1781.0000	1216.5000	850.5000
Available Score (Actual)	4202.0000	468.0000	96.0000	372.0000	820.0000	1846.0000	1394.0000	990.0000
Site Score	97.95%	92.13%	92.88%	91.94%	88.13%	96.48%	87.27%	85.91%
Organisation Average	98.44%	92.66%	92.42%	92.87%	87.94%	97.25%	84.39%	83.15%



Deep Clean Update 2025-26

The Deep Clean Programme has progressed well against the planned annual schedule, supported through effective collaboration between the Infection Prevention and Control (IPC) Team, Head of Patient Flow, and Deputy Chief Nurse. This multidisciplinary approach has ensured that deep cleaning activity is aligned to both infection risk and operational priorities.

Where access to planned clinical areas has been constrained due to activity and capacity pressures, the team has demonstrated a flexible and proactive approach, redirecting activity to alternative environments. This has included theatres, communal spaces, preventative treatments, and functional areas across other Trust sites, ensuring overall programme momentum has been maintained.

Assurance: There is significant assurance that the Deep Clean Programme is being delivered in a flexible and responsive manner, maintaining progress despite operational pressures.

Operational Delivery and Impact

Despite an increase in some healthcare-associated infections (HCAIs) during 2025/26, the Deep Clean Team has continued to deliver timely decontamination of affected areas prior to patient reoccupation, ensuring that patient safety is prioritised without adversely impacting patient flow. This reflects:

- Strong alignment between IPC and operational teams
- Effective prioritisation of high-risk environments
- Responsiveness to emerging infection risks

Assurance: There is moderate assurance that deep cleaning interventions are timely and effective, supporting infection prevention while maintaining operational flow.

Monitoring, Oversight and Data Intelligence

A comprehensive Deep Clean Dashboard has been developed to provide enhanced oversight of disinfecting activity. This includes tracking of:

- Cleaning schedules and completion status.
- Location and deployment of resources.
- Types of disinfection undertaken (eg. standard, enhanced, HPV where applicable).
- Utilisation trends and activity levels.

This improved visibility supports data-driven decision-making, enabling targeted deployment of resources and strengthened operational oversight.

Assurance: There is significant assurance that monitoring and governance arrangements for deep cleaning are robust, with improved data visibility supporting proactive management and continuous improvement.

Overall Position

The Deep Clean Programme is delivering a planned yet flexible approach to environmental decontamination, ensuring that infection risks are mitigated effectively while maintaining service continuity.

Overall Assurance Statement

The Trust can provide moderate assurance that deep cleaning arrangements are effective, responsive, and well-governed. The programme is maintaining delivery against plan, adapting to operational pressures, and ensuring timely decontamination to support infection prevention and patient safety.

Tracking Details include Location, Date & Reason for Disinfectant Deployment

WARD	SITE	DATE	ROOM/BAY NO.	REASON FOR REQUEST
Ward 25	DRI	01/04/2026	Bed 18	Colostrum-Difficile (C.DIFF)
AMU	BDGH	02/04/2026	Room 15	Previous C.DIFF, GDH
Ward26	DRI	02/04/2026	19	E COLI 157
AMU	BDGH	02/04/2026	Single room 15	Colostrum-Difficile (C.DIFF)
Ward26	DRI	02/04/2026	18	Esbl
Amu	DRI	02/04/2026	26	Previous C.DIFF, GDH
AMU	BDGH	02/04/2026	Side room 2wc	Covid-19
AMU	BDGH	02/04/2026	Side room 2	Covid-19
Ward 19	DRI	02/04/2026	Bed 19	MRSA/MSSA/PVL
Ward21	DRI	02/04/2026	18	Covid-19
Ward25	DRI	02/04/2026	5	MRSA/MSSA/PVL
A one	DRI	03/04/2026	10	Colostrum-Difficile (C.DIFF)
Ward15	DRI	03/04/2026	43	Colostrum-Difficile (C.DIFF)
Ward20	DRI	03/04/2026	8	Colostrum-Difficile (C.DIFF)
Ward 32	DRI	03/04/2026	2	Colostrum-Difficile (C.DIFF)
Amu	DRI	03/04/2026	15	Colostrum-Difficile (C.DIFF)
Ward 24	DRI	03/04/2026	19	Previous C.DIFF, GDH
Ward 1	DRI	03/04/2026	Bed 1	Previous C.DIFF, GDH
Ward 18	DRI	03/04/2026	Bed 25	Colostrum-Difficile (C.DIFF)
28	DRI	03/04/2026	Bed 6	Previous C.DIFF, GDH
Amu	DRI	03/04/2026	Bed 13	Colostrum-Difficile (C.DIFF)
Amu	DRI	03/04/2026	Bed 14	Colostrum-Difficile (C.DIFF)
A+E	DRI	05/04/2026	Cubicle 9	Colostrum-Difficile (C.DIFF)
AMU	BDGH	05/04/2026	Single bed 15 WC	Meningitis
AMU	BDGH	05/04/2026	Single Bed 15	Meningitis
Ward 9	DRI	06/04/2026	Room 10	Colostrum-Difficile (C.DIFF)
Ward 28	DRI	06/04/2026	Bed 6	VRE
28	DRI	06/04/2026	17	(Diarrhoea NON Positive GDH/CDI
AMU	BDGH	06/04/2026	Side room 1	Loose stool
AMU	BDGH	06/04/2026	Side room 1	Loos stool
Theatre	DRI	07/04/2026	Theatre 1	Tb
Fau	DRI	07/04/2026	6	E COLI 157
Kingfisher	DRI	07/04/2026	Bed 21	Previous C.DIFF, GDH
Ward 28	DRI	07/04/2026	6 (isolation room) and en-suite	Schedule
odular ward/ winter pressur	DRI	07/04/2026	Bed 5	Vre
C 1	BDGH	07/04/2026	Side room c wc	Covid-19
C 1	BDGH	07/04/2026	Side room c	Covid-19
Ward 27	DRI	07/04/2026	Bed 15	MRSA/MSSA/PVL
Amu	DRI	08/04/2026	Bed 44	Colostrum-Difficile (C.DIFF)



Water Safety Group

Water hygiene sampling for Pseudomonas aeruginosa and Legionella species is undertaken proactively to monitor and assure water quality across Trust premises. In addition, reactive sampling is implemented where potential failures in water safety controls are identified, providing an additional layer of assurance.

Routine sampling is conducted on a monthly basis across all three main sites, incorporating:

- Repeat testing of any previously failed outlets.
- Planned sampling of identified outlets in line with risk-based schedules.

The sampling methodology has been further strengthened during 2025/26, with enhanced follow-up of results exceeding 1,000 CFU/L, including:

- Sampling of the next downstream outlet.
- Additional upstream sampling to identify potential sources.

The overall sampling strategy is jointly agreed between the Infection Prevention and Control (IPC) Team and Estates through the Water Safety Group (WSG), which meets quarterly to review performance and actions.

Assurance: There is significant assurance that a robust and collaborative water safety framework is in place, with proactive and reactive monitoring supporting effective risk management.

Compliance with National Guidance

The Trust's approach aligns with HTM 04-01: Safe Water in Healthcare Premises, which recommends six-monthly sampling of outlets in augmented care areas for Pseudomonas aeruginosa. This element of the programme is delivered through a contracted third-party water quality provider, providing independent assurance alongside internal monitoring.

Assurance: There is significant assurance that water sampling arrangements are compliant with national guidance and supported by independent validation.

Pseudomonas Aeruginosa Results

During 2025/26:

- 1,031 samples were taken (a slight reduction of 20 samples compared to the previous year).
- The majority of results were clear.
- 77 positive samples were identified.

All positive results were subject to prompt investigation and appropriate remedial action to address and resolve identified issues.

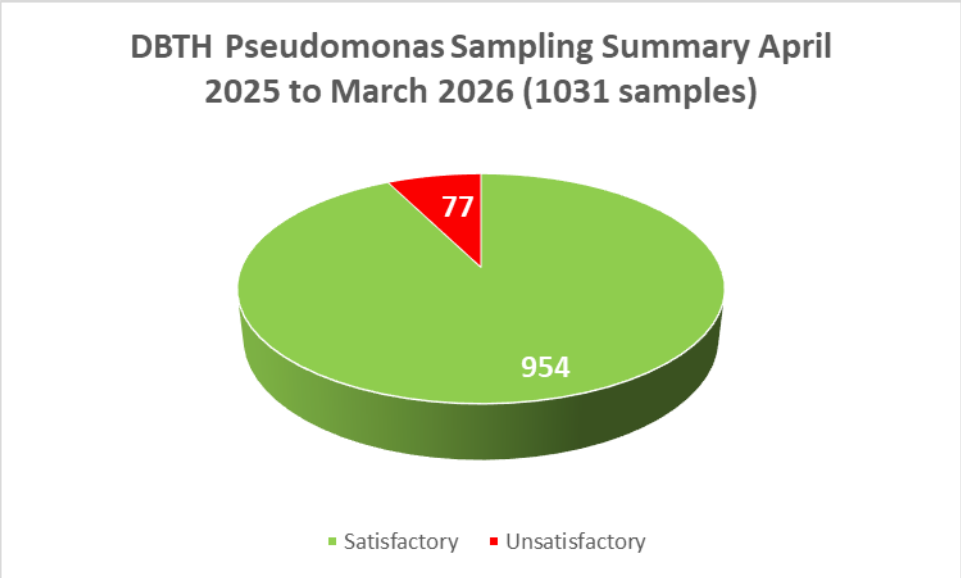
Assurance: There is significant assurance that detection rates remain low, results are effectively managed, and appropriate corrective actions are taken in a timely manner to mitigate risk.

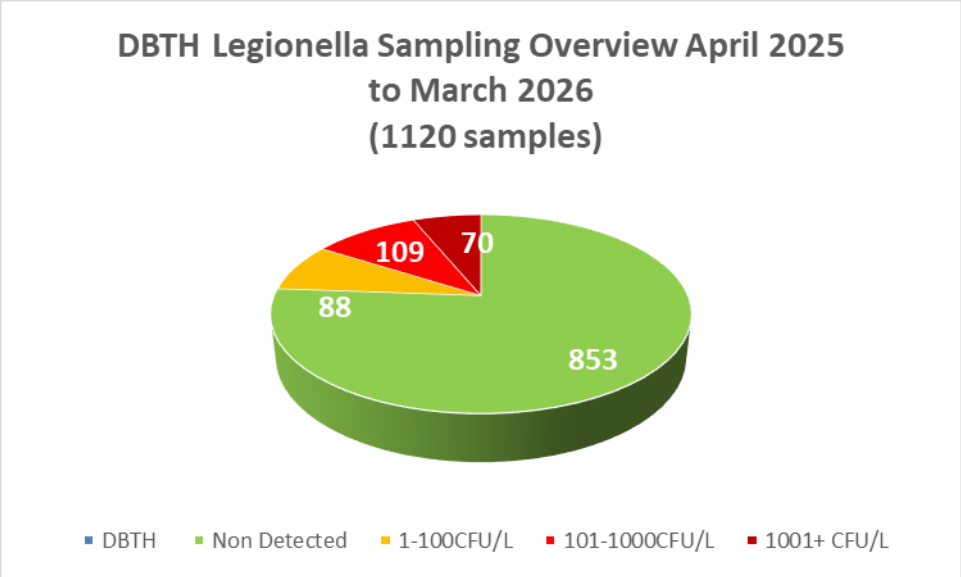
Overall Position

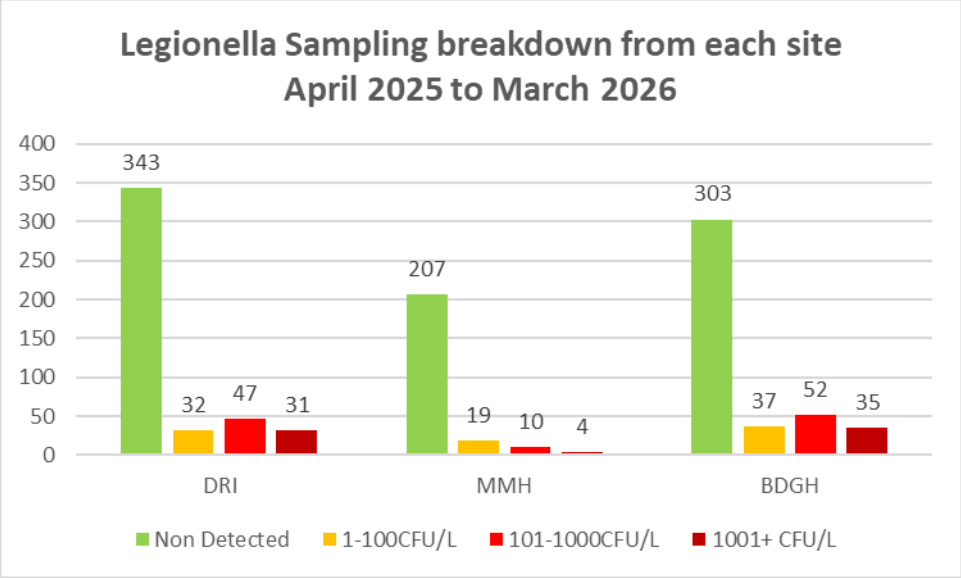
The Trust maintains a proactive, risk-based water hygiene programme, with strengthened sampling methodology, clear governance through the Water Safety Group, and effective partnership between Estates and IPC.

Overall Assurance Statement

The Trust can provide significant assurance that water safety arrangements are robust, compliant with national standards, and effective in monitoring and mitigating risks associated with waterborne pathogens, including Pseudomonas aeruginosa and Legionella species.







Ventilation

Poor ventilation remains a recognised challenge across parts of the Trust's estate and continues to be actively managed through a structured governance framework. Oversight is provided by the Ventilation Safety Group, which meets on a six-monthly basis to review performance, risks, and assurance reports relating to both critical and non-critical ventilation systems.

Assurance: There is significant assurance that governance arrangements are in place to identify, monitor, and manage ventilation risks across the estate.

Capital Investment and Targeted Improvement

In the context of constrained capital funding, the Trust has prioritised investment in ventilation systems where improvements will deliver the greatest clinical impact. During 2025/26, the Ventilation Safety Group approved investment to replace main supply and extract fans within the East Ward Block and Women's & Children's Hospital, targeting areas of highest clinical risk, including:

- Critical Care.
- Respiratory services.

These areas are classified as critical ventilation zones under Health Technical Memorandum (HTM) guidance.

Progress to date includes:

- East Ward Block: 1 supply fan and 2 extract fans replaced; 3 extract fans remain outstanding.
- Women's & Children's Hospital: 1 supply fan and 2 extract fans replaced; 3 extract fans remain outstanding.
- Completion expected: Early Summer 2026.

Assurance: There is significant assurance that capital investment is appropriately prioritised towards high-risk clinical areas, with measurable progress against planned improvement works.

Risk Mitigation and Contingency Measures

To support risk mitigation, the Ventilation Safety Group has agreed to retain and centrally store air scrubber units procured during the COVID-19 pandemic. These are held by the Estates team and can be deployed rapidly, under the direction of the Infection Prevention and Control (IPC) team, where local ventilation risks are identified.

Assurance: There is significant assurance that contingency measures are in place to mitigate short-term ventilation risks and support IPC requirements when needed.

Planned Preventative Maintenance (PPM) Performance

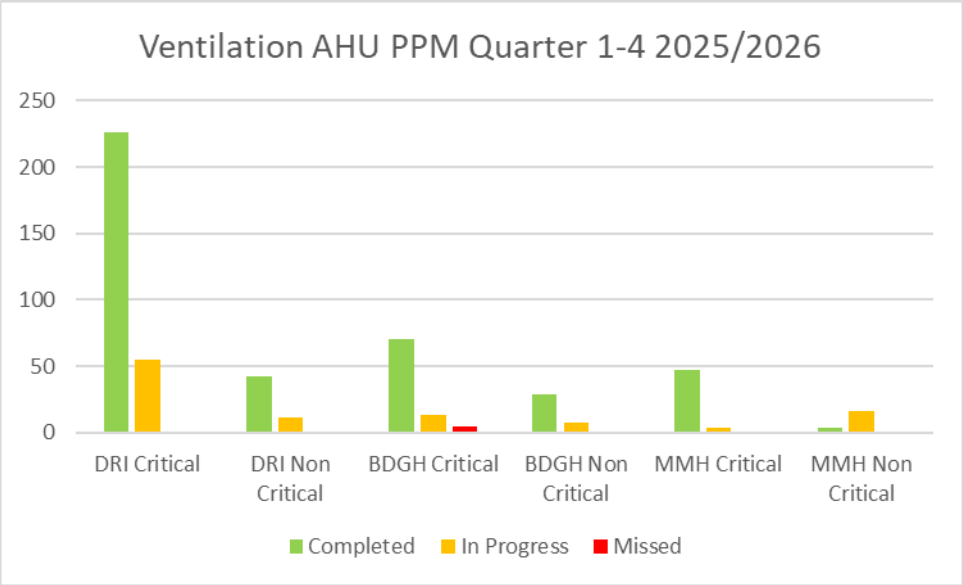
PPM performance for ventilation systems during 2025/26 was:

- **78.19% completion** for critical ventilation systems.
- **71.59% completion** for non-critical ventilation systems.

Whilst full compliance remains a challenge, largely due to workforce capacity constraints (as identified in the Estates Review), robust management processes are in place to mitigate associated risks. These include:

- Identification of missed PPM activity through Estates KPI meetings.
- Independent follow-up and completion of outstanding tasks.
- Prioritisation based on system criticality and patient risk.

Assurance: There is moderate assurance that PPM processes are effective in identifying and addressing gaps; however, performance below full compliance indicates a continued risk requiring sustained management focus.



2025-26	CRITICAL	Completed	NON CRITICAL	Completed
DRI	281	80.43%	53	79.25%
BDGH	88	79.55%	37	78.38%
MMH	63	74.60%	7	57.14%

3. Provide suitable accurate information on infections to service users and their visitors.

Patient Information

General patient information is available on the Trust's website. This includes up-to-date details about hospital services and is reviewed and updated regularly throughout the year.

A range of patient information leaflets is also available. These provide clear explanations about different organisms, what they are, and the measures that may be put in place during a patient's stay in hospital. The leaflets also outline what these measures mean for patients and their families.

4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

Performance Dashboard

During the reporting period, the Trust intranet continued to provide access to key Infection Prevention and Control (IPC) clinical indicators. These were presented through visual "performance dials", enabling managers and clinical teams to undertake high-level assessments of performance against core IPC metrics. Users could access more detailed information through interactive functionality, supporting divisional oversight and performance review.

However, usability challenges have been identified. Access to information requires navigation through multiple steps within the HIVE system, reducing accessibility compared to the previous intranet platform. In addition, the current infrastructure requires significant time and specialist input to update, which is not sustainable within existing IPC team resources. As a result, the system has not fully kept pace with evolving organisational requirements.

Assurance: There is moderate assurance that IPC performance data is available; however, limitations in system usability and sustainability reduce overall effectiveness.

Development of Real-Time IPC Visibility

In parallel, the Trust's transition to Nervecentre has provided an opportunity to enhance the accessibility and timeliness of IPC information. The IPC Team has worked collaboratively with the Digital Transformation Team to develop an IPC profile within the system.
This enables:

- Real-time entry of IPC information.
- Immediate visibility of data via handheld devices and desktop systems in clinical areas.
- Improved access to patient-level IPC status at the point of care.

Whilst this represents a significant improvement in the timeliness and visibility of IPC information, current functionality is limited to a real-time snapshot of inpatients with infectious organisms and does not yet provide a cumulative or longitudinal view across the reporting period.

Assurance: There is significant assurance that real-time patient-level IPC information is improving, although functionality remains limited in supporting trend analysis and reporting.

System Investment and Future Direction

Historically, financial constraints have limited the Trust's ability to invest in a comprehensive IPC information system.

During 2025/26, Doncaster and Bassetlaw Teaching Hospitals (DBTH) has worked in partnership with the Digital Transformation Team, Project Management Team, and Baxter to procure the ICNet system, designed to support IPC data management, surveillance, and reporting requirements.

Implementation of ICNet is scheduled to commence in early 2026 and is expected to:

- Provide an integrated platform for IPC surveillance and reporting.
- Enable longitudinal data analysis and performance monitoring.
- Improve efficiency and sustainability of IPC data management.

Assurance: There is significant assurance that the procurement of ICNet represents a significant step toward establishing a sustainable, integrated IPC information system aligned to organisational needs.

Overall Position

The Trust is transitioning from legacy and limited-function systems toward a more integrated digital solution for IPC management.

Overall Assurance Statement

The Trust can provide moderate assurance that IPC information systems are currently effective, with real-time visibility improving through Nervecentre. The planned implementation of ICNet provides clear trajectory to high assurance, enabling robust, sustainable, and comprehensive IPC data management and surveillance going forward.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

COVID-19 and Other Acute Respiratory Infections

During 2025/26, Doncaster and Bassetlaw Teaching Hospitals continued to manage cases of SARS-CoV-2 (COVID-19) and other acute respiratory infections. Overall case numbers remained significantly lower than in previous years. In line with national guidance and the National Infection Prevention and Control Manual (NIPCM), COVID-19 continues to be managed alongside other respiratory infections, using standardised definitions for healthcare-associated infection (identified from day 5 of admission, with day of admission defined as day 0).

The Trust has maintained a proactive and responsive approach, ensuring patients with suspected or confirmed infection are identified promptly through point-of-care testing and clinical assessment, enabling timely treatment and reducing the risk of onward transmission.

Assurance: There is significant assurance that respiratory infections, including COVID-19, are being managed effectively within established national frameworks, with robust processes in place for early identification and risk mitigation.

Key Infection Prevention and Control (IPC) Measures

The Infection Prevention and Control Team (IPCT) continues to support the organisation through a comprehensive range of IPC interventions:

Personal Protective Equipment (PPE)

Mask use is risk-assessed and required when caring for patients with suspected or confirmed respiratory infection. National guidance is also followed to support mask use for

staff attending work with mild respiratory symptoms. Following risk assessment, universal masking has not been implemented, as existing IPC controls have been effective in mitigating transmission risk.

Early Identification and Testing

Point-of-care testing for COVID-19, influenza, and RSV remains embedded within clinical pathways between October and March, enabling rapid diagnosis (typically within 10 minutes) and timely clinical decision-making. PCR testing has remained available throughout the year.

Clinical Collaboration

Close multidisciplinary working between clinical teams, Consultants in Infection, and the IPCT supports effective clinical management and consistent IPC practice.

System-Wide Partnership Working

The Trust continues to provide IPC advice across the wider Doncaster health and care system, including care homes, supported living settings, and community providers, ensuring a coordinated and consistent approach to infection prevention.

Outbreak Prevention and Control

Rapid response arrangements are in place for suspected or confirmed outbreaks, with timely implementation of control measures to minimise transmission in both acute and community settings.

Assurance: There is significant assurance that comprehensive IPC measures are consistently applied, supporting prevention, early detection, and control of respiratory infections.

Patient Management and Cohorting

Early identification remains central to reducing transmission risk. Patients presenting with respiratory symptoms are tested promptly, enabling:

- Timely isolation or cohorting during the infectious period.
- Segregation to minimise exposure to non-infected patients.
- Rapid clinical decision-making and initiation of appropriate treatment.

The IPCT continues to provide expert input into daily operational and flow meetings, supporting safe patient placement and capacity management.

Assurance: There is significant assurance that patient pathways effectively minimise transmission risk while supporting operational flow.

Workforce Capacity and Service Provision

A full seven-day IPCT service has not been sustainable during 2025/26 due to workforce challenges, including vacancies and maternity leave. However, out-of-hours IPC support has

been maintained through local arrangements, including on-call Consultants in Infection and senior IPC nursing leadership.
Assurance: There is moderate assurance that specialist IPC advice remains accessible; however, workforce constraints present a resilience risk that requires ongoing management.

Preparedness and PPE (EPRR)
Fit testing for FFP3 masks remains a requirement under Emergency Preparedness, Resilience and Response (EPRR) standards. Progress during the year includes:

- Targeted fit testing in response to emerging risks (e.g. measles cases).
- Integration of fit testing into new staff induction programmes.
- Approval of a business case to establish a dedicated fit testing team, with recruitment expected in 2026.

The Trust has also maintained preparedness for High Consequence Infectious Diseases (HCIDs), including procurement of appropriate PPE. Further training in specialist donning and doffing procedures is required to strengthen resilience.

Assurance: There is moderate assurance that PPE preparedness is improving, with clear plans in place to strengthen resilience.

Outbreak Management and Learning

The Trust has maintained a robust and responsive approach to outbreak management, with the IPCT undertaking:

- Immediate on-site review of suspected outbreaks.
- Rapid implementation of control measures.
- Proactive auditing of IPC practices and PPE compliance.
- Identification of learning themes to inform continuous improvement.

Key themes identified include:

- Transmission from unidentified or asymptomatic cases.
- Environmental factors, including ventilation and ward layout.
- Impact of high activity levels and unrestricted visiting.

Learning from outbreak reviews continues to inform improvements in early identification, environmental controls, and adherence to IPC practices.

Assurance: There is significant assurance that outbreak management arrangements are effective, with learning systematically applied to reduce future risk.

Norovirus Outbreaks

During 2025/26, community-acquired Norovirus cases resulted in three confirmed outbreaks within the Trust. The IPCT responded promptly in each case, undertaking rapid assessment of affected areas and implementing control measures to limit transmission.

Ongoing proactive audit activity, including PPE and IPC practice reviews, has been undertaken both during and outside outbreak periods to strengthen assurance.

Contributory themes included:

- Transmission from unidentified sources.
- Environmental factors such as ventilation and ward conditions.
- Operational pressures, including unrestricted visiting.

Assurance: There is significant assurance that outbreaks are identified and managed promptly, although environmental and operational factors continue to influence transmission risk.

Overall Position

The Trust has sustained a robust and adaptive approach to managing respiratory infections, integrating national guidance, rapid diagnostics, effective cohorting, and strong IPC governance.

Overall Assurance Statement

The Trust can provide moderate assurance that respiratory infections, including COVID-19, are effectively managed. While strong systems are in place for prevention, detection, and control, workforce capacity challenges and environmental factors (including ventilation) require continued focus to further strengthen resilience and reduce transmission risk.

Antimicrobial Management

During 2025/26, the Trust delivered a wide-ranging Antimicrobial Stewardship (AMS) programme aligned with national and local AMR priorities, local IPC objectives, and the DIPC assurance framework. The programme addressed the quality, safety, effectiveness and appropriateness of antimicrobial prescribing across adult and paediatric services, with a strong emphasis on governance, audit, diagnostic stewardship and targeted quality improvement activity.

This report provides a summary of the activities undertaken this year.

1. AMS team and service
2. National AMR targets
3. AMS 5-year strategy for DBTH
4. AWaRe Antibiotic usage
5. Monitoring carbapenem prescribing
6. Antibiotic audits and feedback
7. Improving the blood culture pathway
8. AMU AMS initiatives
9. Penicillin allergy de-labelling (PADL)
10. Introducing extended beta lactam infusions in critical care
11. Specialty ward rounds and MDTs
12. Paediatric AMS activities
13. Stewardship in Surgery – LEAP project
14. Orthopaedic AMS
15. Restricting fluoroquinolone use
16. Reducing MSSA bacteraemia in renal dialysis patients
17. Antimicrobial guidelines
18. Virtual wards for complex antibiotic regimens/monitoring
19. AMS Educational activities
20. Participation in regional AMS committees
21. Priorities for 2026/2027

1. AMS Team and Service Model

AMS activity is delivered through a multidisciplinary Infection team comprising Consultants in Infection, Antimicrobial Stewardship Nurse, Antimicrobial Pharmacists, Clinical Fellows in Microbiology, and close collaboration with Infection Prevention and Control (IPC), Sepsis and specialty teams. Core activity includes:

- Daily clinical advice and urgent prescribing support.
- Bacteraemia and complex infection reviews.
- Routine ICU and specialty-based AMS ward rounds and MDTs.
- Trust wide surveillance, audit and real time feedback.
- Reporting through TWIG, Drugs & Therapeutics Committee, and specialty governance meetings.
- This integrated model provides assurance across both prescribing quality and IPC risk.

2. National AMR Targets

Trust performance continues to be benchmarked against NHSE antimicrobial stewardship targets:

- Overall antibiotic consumption remains above the 2019 baseline (+15.9%), highlighting sustained system wide prescribing pressures. National AMS target is to reduce overall antibiotic use by 5% vs 2019.
- Access antibiotic use from July – September 2025 was 57%, below the ≥70% national ambition.
- Watch and Reserve antibiotic use has increased compared to the 2017 baseline (+20%). National target is 10% reduction in Watch and Reserve antibiotic use vs 2017.
- Carbapenem use. Nationally shared NHSE data indicated a 20% rise in carbapenem use for October 2024 – Sept 2025 compared with the previous year. However, independent analysis using Rx-Info rolling 12-month data showed a smaller increase of 13.6% for the same period.
- Despite these challenges, there has been significant improvement in carbapenem stewardship, with a 28% reduction in carbapenem use over the most recent rolling 12-month period, representing the strongest improvement among South Yorkshire Trusts.

This has been highlighted in various forums, such as TWIG, clinical governance meetings, resident doctor teaching sessions and at World Antibiotic Awareness Week 2025.

The AMS team aims to continue to address these priorities in the upcoming financial year.

3. AMS 5-Strategy for DBTH

Our Trust 5-year strategy for AMS has been developed to reflect local and national AMR requirements. In the past year, we have been working more collaboratively with the Sepsis Action Group to align our aims and deliver on the key priorities. See outline below:

DBTH ANTIMICROBIAL STEWARDSHIP (AMS) 5 YEAR STRATEGY JUNE 2025

OUR VISION
To optimise the use of antimicrobials across Doncaster and Bassetlaw Teaching Hospitals.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

OUR MISSION
Improve antimicrobial prescribing, diagnostic testing and optimise antimicrobial review process.

STRATEGIC PRIORITIES

- Trust wide engagement with antimicrobial stewardship
- Consistent and complete documentation of antimicrobial allergies
- Combatting antimicrobial resistance
  Antimicrobial choice is consistent with guidelines or directed therapy
- Quality review of antimicrobial therapy within 72 hours
- Collaboration between AMS team and Sepsis Action Group workstreams

HOW WE'LL ACHIEVE THEM

- Increase AMS workforce
  Strengthen lines of communication with Governance structures
  Improve workforce education and awareness
- Optimise process for review and documentation of allergies
- Reducing consumption of Watch and Reserve antibiotics.
  Guidelines are current and accessible
  Timely and rational microbiological sampling and review of results
- IV to oral switch
  Documented review of antimicrobials
- Inclusion of AMS in existing Sepsis Action Group structures

ACTIONS

- Business case for increased AMS workforce
- Inclusion of AMS in mandatory Sepsis updated at Clinical Governance
- KPI/Surveillance activities agreed with schedule for presentation to Divisions
- Reviewed and agreed lines of communication
- Consistent AMS and Divisional representation at Sepsis Action Group
- Review update of AMS ward round recommendations
- Review and update education program and resources
- Engage with clinical educators
- QII and feedback at ward level

- Development of penicillin allergy de-labelling protocol
- Data collected annually and reviewed by AMS work stream
- Review of literature/ national/regional recommendations and procedures
- Review of current process for allergy documentation and review, including as part of medicines reconciliation in context of current workforce capacity
- Review service improvement opportunities (inc. delabeling and challenge)

- Updates to The Hive
- Antibiotic/infection rounds
- Early infection team involvement
- Guidelines built into sepsis screening tool
- First line antibiotics included on Sepsis guideline posters
- Allocate pharmacy/micro/ clinician responsibility to guidelines
- Add guidelines due to expire to Sepsis meeting and clinical governance updates
- Microbiological sampling poster
- Blood culture guidance updates and posters
- Blood culture pathway improvement group
- Benchmark use of Watch and Reserve antibiotics against comparable Trusts

- IVOS policy
- Baseline data collection for IVOS in antibiotic audits
- Antibiotic/infection rounds
- Explore possibility of flag on Wellsky

- AMS representation at Sepsis Action Group meetings
- AMS to update key themes and contamination rates to Divisions
- Collaboration across all strategic and operational priorities

SUCCESS LOOKS LIKE

- Consistent Divisional representation at Sepsis Action Group meeting
- AMS agenda, monitoring and escalations communicated effectively across Trust
- Improved uptake of AMS ward round recommendations
- Clinical staff aware of agreed responsibilities regarding AMS
- Engagement from Divisions for sustained improvements to meet targets
- Team has capacity to meet service demands

- Updated process for documentation of allergies implemented
- Agreed target for complete allergy documentation met
- Reduction in 'spurious' penicillin allergy documentation
- Reduction in second line antimicrobials being used
- Implementation of PADL protocol

- Guidelines are current and accessible – evidence through spreadsheet / audit
- Increase in directed therapy
- Reduction in HAI rates (CDI, SAB and GNBSI

- Reduction in watch and reserve antimicrobials
- Documented 48 hour review
- Increase in proportion of antimicrobials stopped within 72h
- Reduction in HAI rates (CDI, SAB and GNBSI)

Consistent collaboration across strategic and operational priorities to meet AMS and Sepsis Action Group visions.

4. AWaRe Antibiotic Usage

Antimicrobial Stewardship – AWaRe Antibiotic Usage.

Monthly Performance Report (12 month rolling up to March 2026).

a. As part of routine monitoring of antimicrobial prescribing and in line with national antimicrobial stewardship targets, the following information summarises the Trust's performance across four key AWaRe related antibiotic usage indicators, benchmarked against the South Yorkshire region.

   Data are derived from Treatment Information and presented as rolling 12 month figures up to March 2026

b. National Targets

   The following national targets underpin this analysis:

   - Proportion of AWaRe antibiotics
     Aim to increase Access antibiotic use to ≥70% of total antibiotic consumption.

   - Total antibiotic usage (DDDs per 1,000 admissions):
     Aim to achieve a ≥5% reduction compared with the 2019 baseline.

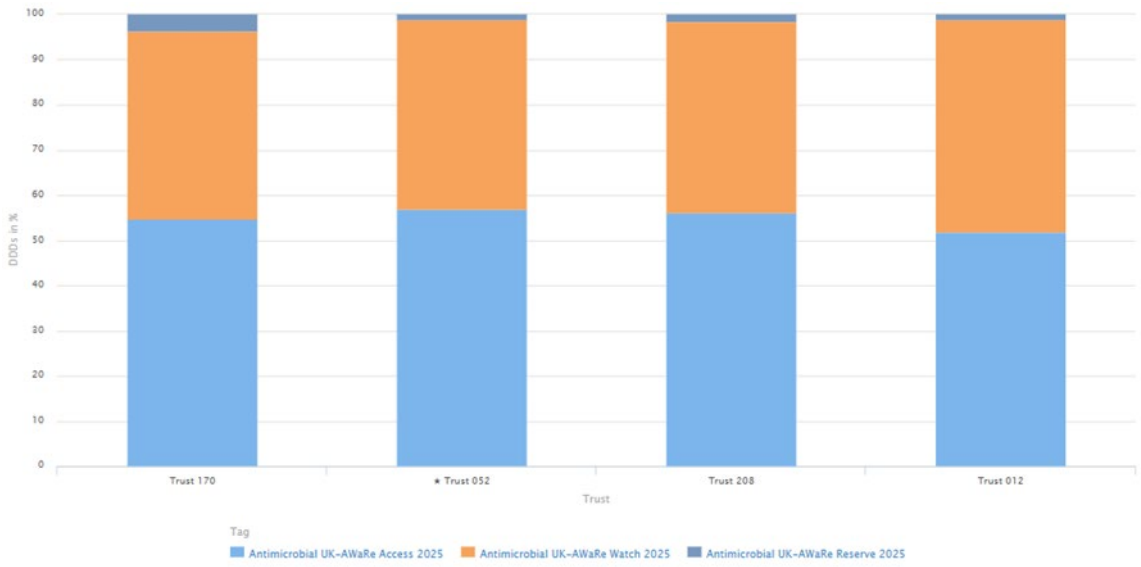
   - Total Watch & Reserve antibiotic usage (DDDs per 1,000 admissions):
     Aim to achieve a ≥10% reduction compared with the 2017 baseline.

   These targets are reflected within the performance assessment of each indicator below.

c. Key Performance Indicators

(i) AWaRe Distribution – Proportion of Defined Daily Doses (DDDs) 12 Month rolling period up to March 2026.

This indicator assesses the proportion of total antibiotic consumption attributed to Access, Watch and Reserve antibiotics, measured against the national ambition for ≥70% Access usage.



Trust	STH (170)	DBTH (052)	RGH (208)	BH (012)
Reserve	4%	1%	2%	1%
Watch	41%	42%	42%	47%
Access	55%	57%	56%	52%

Table 1: Proportion of DDDs used for Access, Watch and Reserve categories – similar.

NHS Trust in SY region

For the 12-month rolling period up to March 2026, the Trust's AWaRe profile remains comparable with other NHS Trusts across the South Yorkshire region. Antibiotic use is distributed as 57% Access, 42% Watch and 1% Reserve. While this demonstrates controlled use of Reserve agents, further work is required to increase Access antibiotic prescribing towards the national ambition of 70%.

(ii) Total Antibiotic Use DDDs per 1,000 admissions – 12-month rolling up to March 2026 Comparison with 2019 baseline National target: ≥5% reduction.

Trust	Total AB (DDDs/1000 adm) 2019	Total AB (DDDs/1000adm) 12mth to Mar-26	% difference in total AB vs 2019 (DDDs/1000adm)
RGH (208)	7316	7297	-0.3
DBTH (052)	5480	6007	9.6
STH (170)	4829	5334	10.5
BH (012)	5663	4940	-12.8

Compared with the 2019 baseline, total antibiotic consumption in the Trust continues to show an overall increase of approximately 9.6%. This indicates that, despite stewardship efforts, total antibiotic usage remains above baseline levels. Ongoing and enhanced antimicrobial stewardship interventions will be required to reverse this trend and move towards the national target of a 5% reduction.

(iii) Total Watch and Reserve Antibiotic Use DDDs per 1000 admissions – 12-month rolling up to March 2026 comparison with 2017 baseline.

National target: ≥10% reduction

Trust	Total WaRe (DDDs/1000adm) 2017	Total WaRe (DDDs/1000adm) 12mth to Mar-26	% difference in WaRe vs 2017 (DDDs/1000adm)
RGH (208)	3616	3129	-13.5
DBTH (052)	2552	2491	-2.4
STH (170)	2123	2369	11.6
BH (012)	2550	2328	-8.7

When compared with the 2017 baseline, the Trust demonstrates a modest reduction in Watch and Reserve usage of 2.4% over the 12-month period to March 2026. Although this reflects early progress, further targeted action is needed to achieve the national ambition of a 10% reduction in broader spectrum antibiotic use.

(iv) Carbapenem Use DDDs per 1,000 admissions – 12-month rolling April 2025 – March 2026 vs April 2024 – March 2025.

Trust	Carbapenem DDD/adm rolling 12mth to Mar-25	Carbapenem DDD/adm rolling 12mth to Mar-26	Carbapenem trend vs prev year (12mth rolling)
RGH (208)	46.65	52.10	11.7
DBTH (052)	27.03	19.35	-28.4
STH (170)	76.56	76.28	-0.4
BH (012)	36.55	31.29	-14.4

Carbapenem consumption for April 2025 to March 2026, compared with the preceding 12 months, shows a 28% reduction. This represents the strongest performance among South Yorkshire NHS Trusts.

5. Monitoring Carbapenem Prescribing

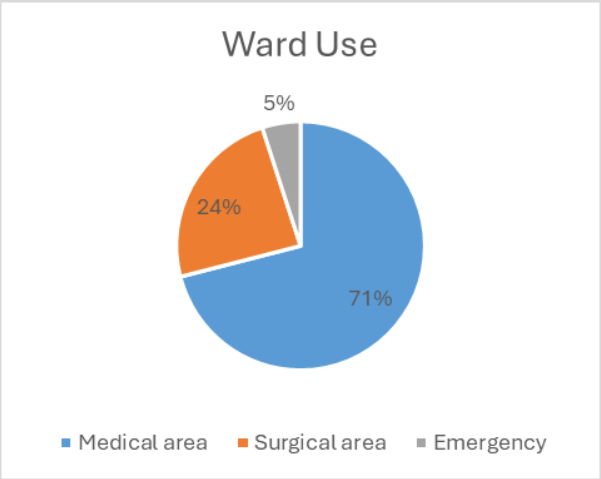
We aim to demonstrate strengthened oversight and assurance of broad-spectrum antibiotic prescribing, with a particular focus on carbapenems, in response to concerns regarding increased carbapenem use at DBTH compared with the 2019 baseline.

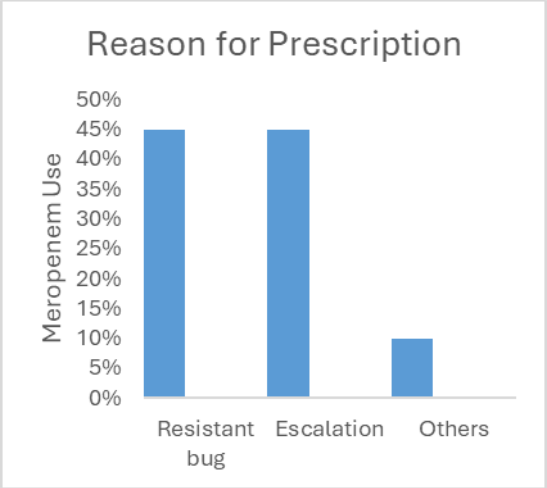
To address this, several initiatives have been introduced. These include patient level monitoring and targeted audits assessing indication, duration, and appropriateness of therapy, alongside education and awareness initiatives relating to Watch and Reserve antibiotics. Educational activity has included posters and structured teaching sessions for prescribers.

Meropenem and other carbapenems are already classified as restricted antibiotics at DBTH and require prior Microbiology approval before initiation.

Since February 2026, we have implemented real time surveillance of meropenem prescribing twice weekly (Mondays and Thursdays). Preliminary review demonstrates that the majority of carbapenem use is appropriately discussed with Microbiology and is principally driven by confirmed or suspected multidrug resistant organisms or justified antibiotic escalation in clinically deteriorating patients. A small proportion of prescriptions particularly within the Respiratory Unit were done without seeking advice from Microbiology. See audit findings below:

- In the first quarter, 30 patients were reviewed, 10 were hematology patients, who have been excluded from this data (because it was prescribed as per the guidelines).
- Of the 20 remaining patients, 71% were prescribed on medical wards, 24% on surgical wards, and 5% in ED.
- 45% had resistant gram-negative organisms isolated from blood culture, wound swabs or urine (E. coli and Klebsiella pneumoniae were the most prominent), 45% prescribed as escalation after other antibiotics had been given, 10% for other reasons (including sensitivities and allergy status).
- 23% had no samples sent for microscopy, culture and sensitivity, and 23% of the patients were started on Meropenem without consulting the infection team.





As a result of this AMS initiative:

- 45% of Meropenem prescriptions were either discontinued or switched to other antibiotics.
- Implemented removal of ward stock of Meropenem (with the exception of Haematology, where immediate access is required).
- Promoted ward pharmacist oversight.

This project is still ongoing and aims to reduce the prescribing of Meropenem in the Trust.

6. Antibiotic Audits and Feedback

We have developed a standardised antibiotic ward round data collection tool used by the AMS and IPC teams to provide real time data and feedback to clinical teams against key AMS performance indicators. These include appropriate documentation of antibiotic indication, guideline compliant choice or evidence of Microbiology discussion, completion of a 48-hour review, and a documented antibiotic plan including duration or stop date.

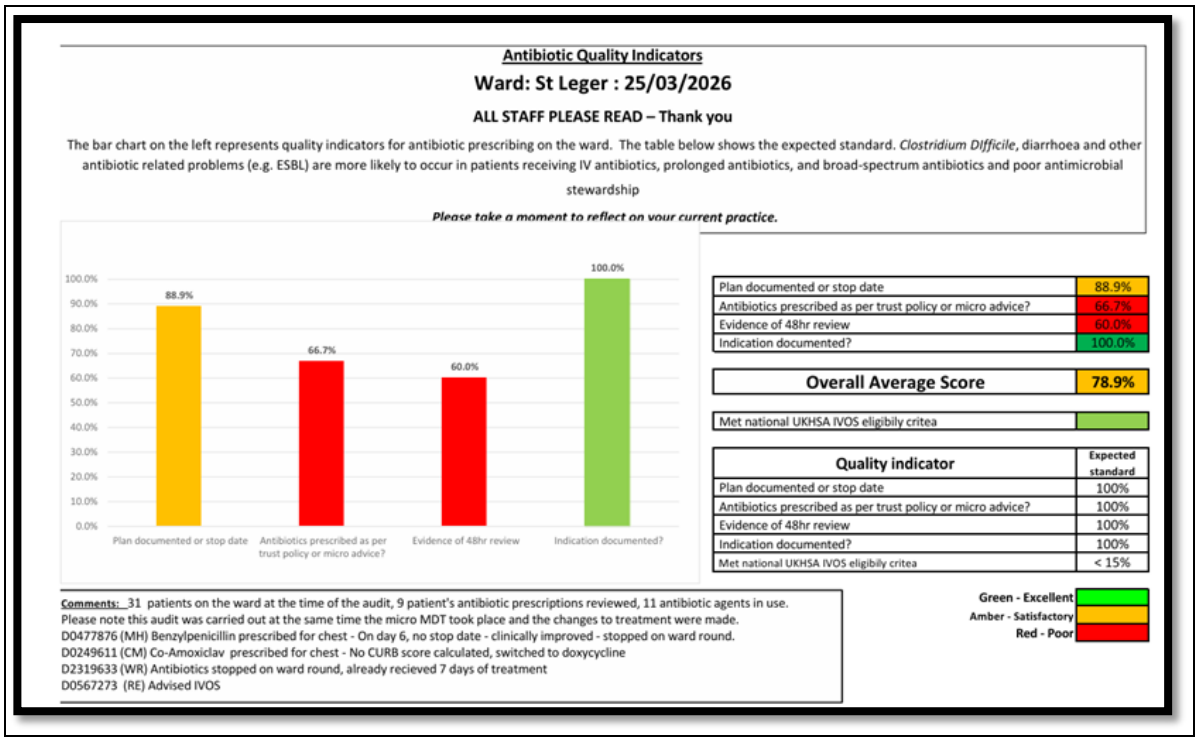
The IPC and AMS teams undertake a minimum of one audit per ward area each quarter. Paediatric clinical areas are audited bimonthly, with data shared with the Yorkshire paediatric AMS (pAMS) network to support regional benchmarking.

In addition, routine data collection includes assessment of community onset versus hospital onset infection, appropriateness of antibiotic de-escalation, whether relevant diagnostic samples and sepsis screens are taken, and consideration of source control.

Audit findings are fed back directly to clinical teams to support learning and improvement. Where appropriate, outcomes are escalated through clinical governance meetings and the

Trust Wide Infection Group (TWIG) to raise awareness and drive targeted quality improvement.

See below for an example of such an AMS ward audit:



Antibiotic Quality Indicators

Ward: St Leger : 25/03/2026

ALL STAFF PLEASE READ – Thank you

The bar chart on the left represents quality indicators for antibiotic prescribing on the ward. The table below shows the expected standard. *Clostridium Difficile*, diarrhoea and other antibiotic related problems (e.g. ESBL) are more likely to occur in patients receiving IV antibiotics, prolonged antibiotics, and broad-spectrum antibiotics and poor antimicrobial stewardship

Please take a moment to reflect on your current practice.

Plan documented or stop date	88.9%
Antibiotics prescribed as per trust policy or micro advice?	66.7%
Evidence of 48hr review	60.0%
Indication documented?	100.0%
Overall Average Score	**78.9%**
Met national UKHSA IVOS eligibily critea	

Quality indicator	Expected standard
Plan documented or stop date	100%
Antibiotics prescribed as per trust policy or micro advice?	100%
Evidence of 48hr review	100%
Indication documented?	100%
Met national UKHSA IVOS eligibily critea	< 15%

Comments: 31 patients on the ward at the time of the audit, 9 patient's antibiotic prescriptions reviewed, 11 antibiotic agents in use.
Please note this audit was carried out at the same time the micro MDT took place and the changes to treatment were made.
D0477876 (MH) Benzylpenicillin prescribed for chest - On day 6, no stop date - clinically improved - stopped on ward round.
D0249611 (CM) Co-Amoxiclav prescribed for chest - No CURB score calculated, switched to doxycycline
D2319633 (WR) Antibiotics stopped on ward round, already recieved 7 days of treatment
D0567273 (RE) Advised IVOS

Green - Excellent
Amber - Satisfactory
Red - Poor

7. Blood Culture QI

Improving the Blood Culture Pathway

Improving the blood culture pathway is a key component of strengthening antimicrobial stewardship (AMS) for patients with sepsis.

National key performance standards for blood cultures include:

- Contamination rate <3%
- ≤4 hours from collection to analyser.
- Two sets of blood cultures obtained.
- 8–10 ml blood per bottle.
- Use of aseptic non touch technique (ANTT).

Quality Improvement Work

We have engaged with multiple specialties, including DRI ED, Bassetlaw ED, AMU and Paediatrics, to improve diagnostic quality of blood cultures. The focus has been on reducing transport times, increasing blood volumes to improve yield and reducing contamination. This builds on blood culture QI work initially launched in DRI ED in January 2025 and expanded during this financial year.

Method

The first QI session was held on 16 January 2025 and facilitated by the Trust QI team. A multidisciplinary group including ED clinicians, Sepsis and Education leads, Facilities, Infection Prevention and Control, Infection and Microbiology/Pathology teams participated. The session explored current practices, challenges and operational priorities influencing blood culture quality and contamination within ED at DRI.

Blood Culture Journey Time – DRI ED

Baseline data (Jan–Mar 2025) showed a mean collection to analyser time of 4 hours 34 minutes.

Key improvement interventions included:

- Introduction of a blood culture transport SOP.
- Awareness posters highlighting the 4-hour target.
- Logging of transport times by service assistants to identify delays.
- Targeted education across staff groups.

Results – DRI ED

Metric	Q2 (Jun–Aug 2025)	Q3 (Oct–Dec 2025)
Collection to lab receipt	1h 35m	1h 29m
Lab receipt to booking in	48m	41m
Average collection to booking in	2h 24m	2h 20m

Due to a change in blood culture analyser at DRI, booking in time was used as a proxy for analyser loading, in line with regional data collection.

Roll out to Bassetlaw ED

Following success at DRI, the QI initiative was implemented in Bassetlaw ED in October 2025. At BH, tele tracking identified low transport priority for blood cultures. The priority was increased to level 1 (urgent), aligning with DRI practice.

Results – BH ED

Metric	Q2 (Jun–Aug)	Q3 (Oct–Dec)
Collection to lab receipt	4h 08m	2h 53m
Lab receipt to booking in	5m	14m
Booking to analyser	39m	1h 08m
Total needle-to-analyser time	4h 53m	3h 59m

Sustainability and Nex Steps

Roll out of QI work to Paediatrics (with the regional paediatric network) and AMU across DRI and BH in 2026/27

- Ongoing education and awareness in ED.
- Continued monitoring of contamination rates, journey times and number of sets taken.
- Regular ED QI meetings every 6–8 weeks at both sites.
- Explore Kurin diversion devices with Procurement to further reduce contamination.

8. AMU AMS Initiatives

We set up a multidisciplinary team in April 2026 to improve antimicrobial stewardship within AMU at DRI. Our aims were to improve antimicrobial prescribing, reduce unnecessary broad-spectrum antibiotics and ensure good diagnostic stewardship by introducing a weekly 'Infection Round'. In addition, we undertook a Qi project to improve diagnosis and antibiotic treatment of community acquired pneumonia (CAP).

Method:

A multidisciplinary Team meeting was set up every Tuesday lunchtime in the AMU Doctors office to discuss each patient on antibiotics. The staff members included Consultants in Infectious Diseases/ Microbiology, AMU doctors, AMU Nursing team, Antimicrobial Stewardship Nurse, Sepsis Nurse, and Pharmacists. Recommendations were made on indication for use, dose, course length, antibiotic choice, IV to oral switch or antibiotic cessation and need for further investigation or source control.

Quarterly audits, on four random dates took place to evaluate the impact of the regular MDTs and antibiotic prescribing.

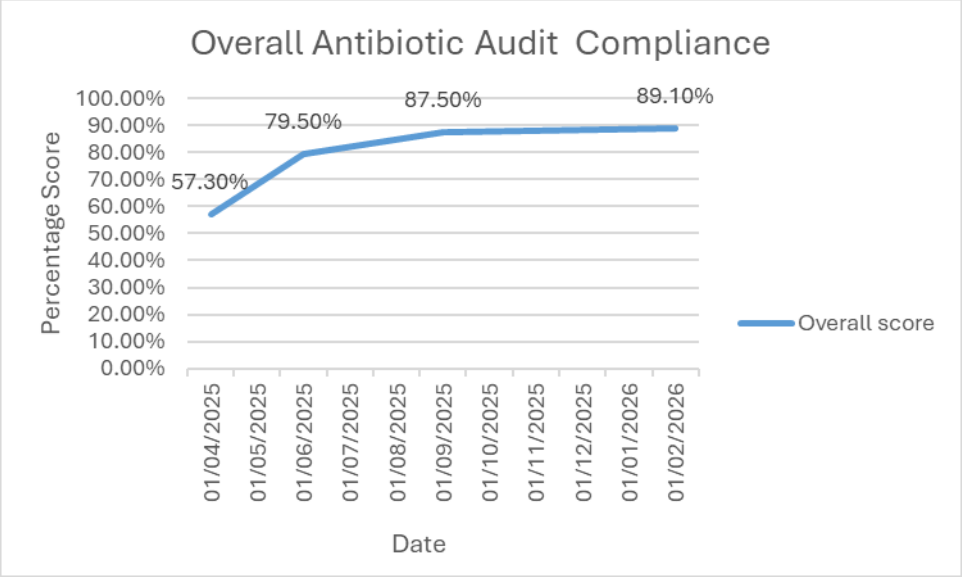
The composite audit score assessed the following key AMS indicators:

- Documentation of a clear indication for antibiotic therapy.
- Documentation of a review or stop date.
- Evidence of a 48–72-hour antibiotic review.
- Antibiotic choice in accordance with local guidelines or microbiology advice.

Results

A total of 79 patients were included in the audits carried. Overall compliance with trust antimicrobial prescribing standards improved significantly from 57.3% to 89.1%.

	26/03/25	25/04/25	17/06/25	18/09/25	03/02/26
Plan documented or stop date	82.6%	66.7%	100.0%	81.3%	93.8%
Antibiotics prescribed as per trust policy or micro advice?	69.6%	54.2%	69.6%	81.3%	68.8%
Evidence of 48hr review	34.8%	12.5%	57.1%	100.0%	100.0%
Indication documented?	95.7%	95.8%	91.3%	87.5%	93.8%
Overall Average Score	**70.7%**	**57.3%**	**79.5%**	**87.5%**	**89.1%**



Plans to maintain sustainability:

- Weekly AMU Infection rounds have now become an embedded practice within AMU.
- Plans for a twice weekly AMU ward round to be introduced
- Ongoing quarterly AMS audits and feedback will ensure continued compliance and prevent regression.
- Ongoing education updates will maintain antibiotic stewardship awareness and awareness of current issues/challenges.
- The AMU model can be replicated in other departments to support hospital-wide antimicrobial stewardship and long-term reduction in resistance.
- The AMS initiative on AMU has been recognised and accepted for an oral presentation at the Society of Acute Medicine conference in April 2026.

Other improvement work to improve antimicrobial stewardship on AMU included:

Improving Community Acquired Pneumonia (CAP) prescribing practices:

- Educated staff on calculating a CURB score for patients diagnosed with CAP and local prescribing guidelines to select the most appropriate antibiotic. This included face-to-face training with the medical and nursing teams, as well as educational posters.

- Updated electronic systems (Nervecentre) to ensure the most up-to-date guidelines were embedded within the electronic CURB score.

Diagnostic stewardship and source control education:

- Provided face-to-face training and posters (see below) for medical and nursing teams
- Following the MDT ward round the AMS nurse discussed with staff on the ward if microbiology samples and/or if source control such as change of a urinary catheter was required.
- Updated the ICE system to allow urine pneumococcal and urine legionella tests to be requested appropriately (instead of incorrect requests for pneumococcal antibody testing).

Penicillin Allergy Delabelling (PADL):

- Developed PADL guideline, patient leaflets and posters to raise awareness and educate.
- Promoted PADL throughout AMU, and now project has been rolled out to the renal department.

9. Penicillin Allergy Delabelling (PADL) and Renal QI

Penicillin allergy assessment and de-labelling is an important patient safety, antimicrobial stewardship and cost effectiveness intervention, which is aligned with Trust IPC/AMS priorities and national AMR objectives. It will help to reduce Watch and Reserve antibiotic use and promote the use of Access antibiotics in line with national targets.

It is well recognized that although 1 in 10 people will state they are allergic to penicillin, in reality only 1 in 100 people will have a genuine penicillin allergy.

Our aim is to reduce inappropriate penicillin allergy labels and improve detail and accuracy of allergy history documentation in patients' clinical records to optimise infection treatment and antimicrobial stewardship. Additional gains of penicillin allergy de-labelling include reduction in length of hospital stay, better outcomes in severe pneumonia, fewer MRSA infections/colonisation, reduced C. difficile diarrhoea and potential cost savings as outlined below.

Evidence from a UK acute hospital comparable in size to Doncaster Royal Infirmary demonstrates that a penicillin allergy label is associated with significant adverse impacts on both antimicrobial stewardship and operational efficiency. Patients with a penicillin allergy label were found to incur a 28.4% increase in antibiotic costs and experience a 5.5% increase in length of hospital stay compared to patients without this allergy. Modelling from the same setting that successful de-labelling of 50% of patients incorrectly labelled as penicillin-allergic

could deliver substantial financial benefits, with an estimated annual saving of £5,501 in antibiotic costs and a further £503,932 from reduced bed-days, reflecting improved treatment effectiveness and shorter admissions.

To kickstart our intervention, we have written and developed a local PADL guideline for the Trust in July 2025. We have delivered numerous teaching sessions to different specialty clinical teams and resident doctors over the past year to promote its use. We have disseminated an educational poster developed by NHSE which we have adapted for local use.

In February 2026, the AMS team set up a Qi project in partnership with the Renal team to identify and de-label patients with documented penicillin allergy within the Ward 28 dialysis cohort. We have identified 11 patients with penicillin allergy label and have successfully de-labelled 2 patients to date when they attended their dialysis session. Work is progressing to interview and offer oral penicillin challenges to any suitable low or medium risk patients.

In the next financial year, we aim to measure the numbers of patients at DBTH that have been successfully de-labelled.

10. Extended beta lactam infusions on DCC/ITU

Optimising antibiotic dosing and pharmacodynamics is an important consideration in treatment of critically ill patients admitted with sepsis. Beta lactam antibiotics demonstrate time-dependent bactericidal activity, where their efficacy relates to the length of time plasma and tissue concentrations remain above the minimum inhibitory concentration (MIC) of the bacteria. Utilising prolonged infusions of beta lactams, compared to shorter infusions, has been shown to provide better clinical outcomes for critically ill patients.

In September 2025, we developed new DBTH guidelines for extended infusion beta-lactams (Piperacillin-tazobactam and Meropenem) for use in critically ill patients admitted to DCC and ITU.

In October 2025, the British Infection Association (BIA) and Intensive Care Society released a position statement on the use of continuous infusion for piperacillin-tazobactam and meropenem within critical care settings within the UK, advocating its use and highlighting the key benefits including:

- Evidence accumulated from 17 trials, including the large BLING III trial, provides convincing evidence of benefit of increased survival at 90 days.
- Less costly with regards to nursing time and with similar drug costs and lower use of consumables.
- Reduced carbon footprint due to lower use of consumables compared to intermittent bolus regimens.

11. Specialty Ward Rounds & MDTs

The Consultants in Infection conduct regular antibiotic ward rounds and specialist infection MDTs. We also provide input at governance meetings for several specialties within DBTH. This includes:

- Haematology MDT.
- AMU Infection rounds (weekly DRI and monthly Bassetlaw rounds).
- Vascular MDT.
- Orthopaedic MDT.
- Arthroplasty MDT for prosthetic joint infections.
- Renal MDT.
- Ad hoc presence at regional South Yorkshire infective endocarditis MDT.

The Infection team meets on a weekly basis to discuss complex cases around the hospital and review antimicrobial stewardship concerns.

12. Paediatric AMS

The DBTH Paediatric AMS group includes Paediatric consultants, Resident doctors, Pharmacist, AMS Nurse and Consultant in Infection. We link in with the regional paediatric South Yorkshire group (SYB pAMS) on a quarterly basis. This group has now expanded to include the whole of Yorkshire.

The DBTH Paediatric AMS team has been very engaged and active in driving AMS improvement in 2025/2026:

- Reducing Chest x-rays in acute wheezy illness in apyrexial children as this is recognised to reduce inappropriate antibiotic use.
- Bimonthly data collection on antibiotic prescribing practices – including appropriate indication, choice of agent, duration/review. See below graphs showcasing our audit results and benchmarking with neighbouring Trusts from February 2025 - January 2026.
- Daily review of antibiotics at handover and huddles
- AMS Paediatric QI project with introduction of IVOS sticker on drug Kardex, IVOS Decision Support tool and move to weight-based dosing – see below for more information*
- Revising antimicrobial guidelines in line with UKPAS which include guidance on duration of treatment and options for both low risk and high-risk penicillin allergy
- Education for resident doctors on current guidelines and treating common infections

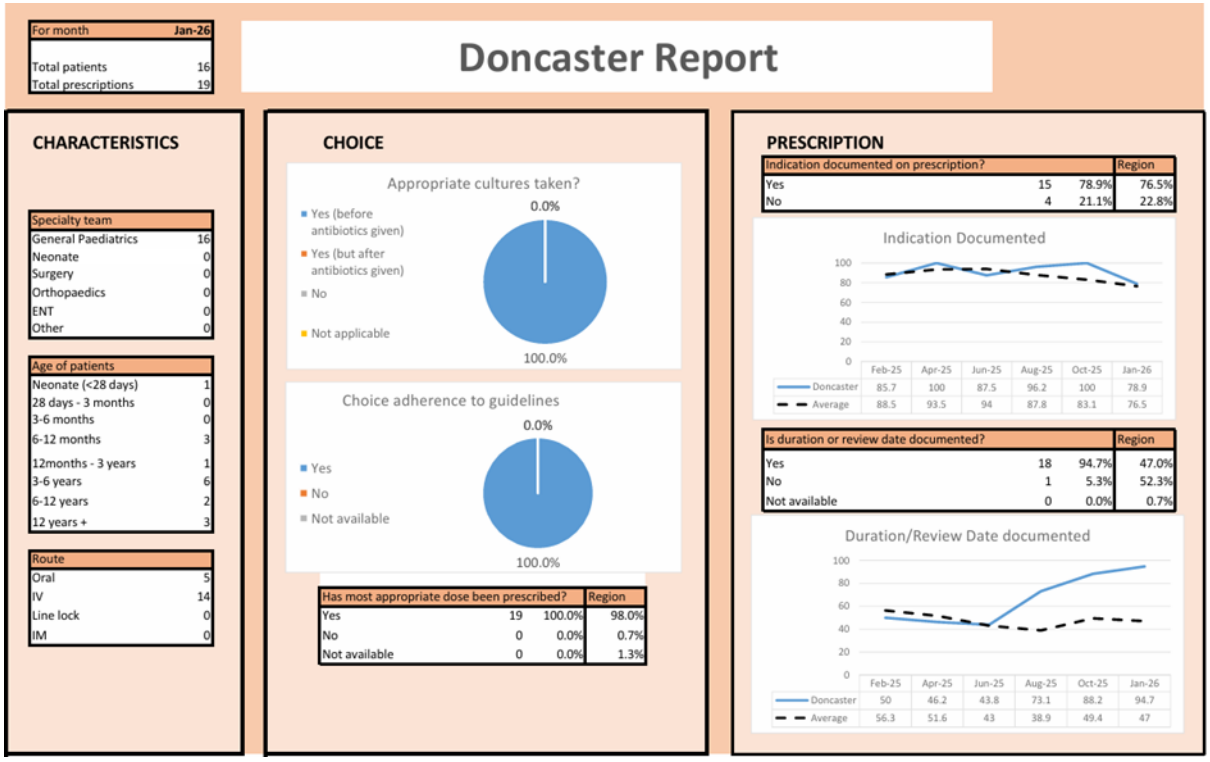
- Improving diagnostic stewardship around urine sampling methods. Collected and shared data on quality of paediatric urine sample requesting in order to drive improvement in sample collection methods. We removed 'bag urines' from ICE requests 2 years ago to reduce contaminated samples which often lead to unnecessary antibiotic use.
- Launched a paediatric blood culture Qi initiative in March 2026 to improve both sepsis management and reduce AMR, by ensuring blood cultures are taken before antibiotics, adequate volumes are taken and blood culture journey times are reduced. This work will carry on into the next financial year.

*The paediatric AMS Qi initiative adopted a multidisciplinary approach involving paediatric clinicians, pharmacists and the AMS team, with the aim of optimising antimicrobial prescribing and reducing the risk of antimicrobial resistance. The work focused on improving documentation of indication, ensuring accurate weight-based dosing, and increasing adherence to local antibiotic guidelines through audit and feedback, educational posters, ward-based teaching, and reinforcement of good prescribing practice (including limiting IV antibiotics to 48 hours where appropriate and considering IV to oral switch).

Ongoing audits demonstrated improvements in documentation and guideline compliant prescribing over time, and a post education re audit in April 2026 showed antibiotic choice compliant with policy in 6 of 7 patients, with indication and weight-based dosing documented in 4 of 7 patients, acknowledging small sample sizes.

The work has increased awareness of AMS principles across paediatrics, including engagement with ENT and General Surgery governance groups, and further improvement work is ongoing focusing on review dates and IVOS practice.

DBTH Paediatric AMS audit results – Feb 2025 – Jan 2026:



For month	Jan-26
Total patients	16
Total prescriptions	19

Doncaster Report

CHARACTERISTICS

Specialty team	
General Paediatrics	16
Neonate	0
Surgery	0
Orthopaedics	0
ENT	0
Other	0

Age of patients	
Neonate (<28 days)	1
28 days - 3 months	0
3-6 months	0
6-12 months	3
12months - 3 years	1
3-6 years	6
6-12 years	2
12 years +	3

Route	
Oral	5
IV	14
Line lock	0
IM	0

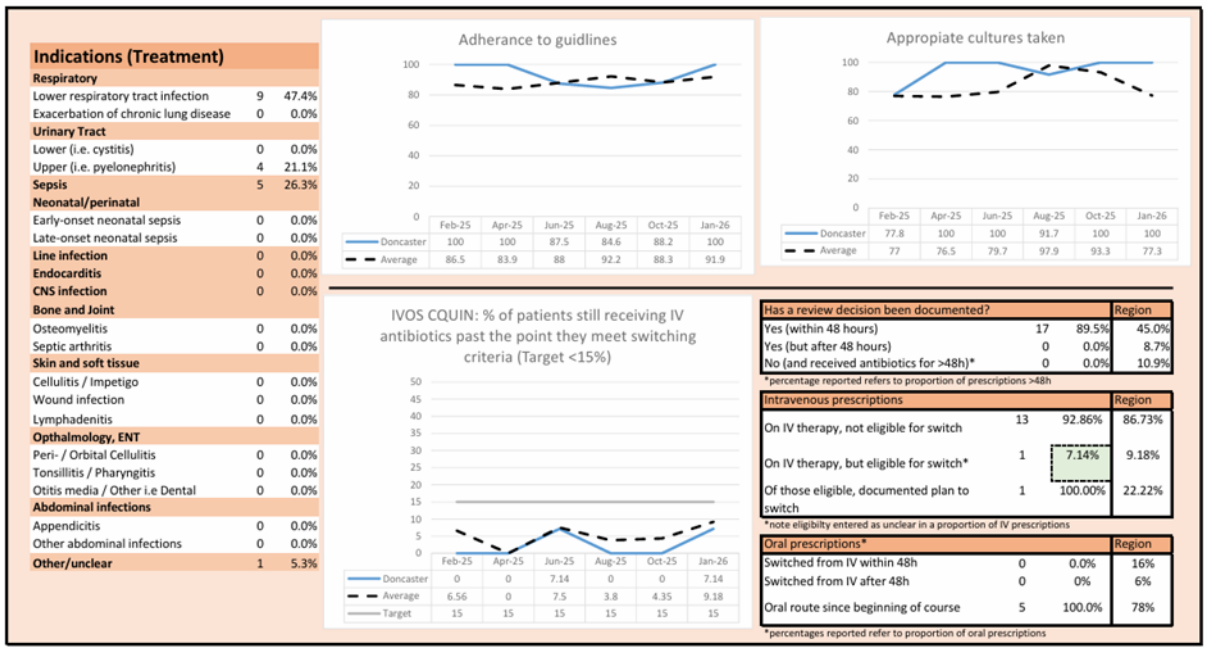
CHOICE

Has most appropriate dose been prescribed?			Region
Yes	19	100.0%	98.0%
No	0	0.0%	0.7%
Not available	0	0.0%	1.3%

PRESCRIPTION

Indication documented on prescription?			Region
Yes	15	78.9%	76.5%
No	4	21.1%	22.8%

Is duration or review date documented?			Region
Yes	18	94.7%	47.0%
No	1	5.3%	52.3%
Not available	0	0.0%	0.7%



Indications (Treatment)

Respiratory		
Lower respiratory tract infection	9	47.4%
Exacerbation of chronic lung disease	0	0.0%
Urinary Tract		
Lower (i.e. cystitis)	0	0.0%
Upper (i.e. pyelonephritis)	4	21.1%
Sepsis	5	26.3%
Neonatal/perinatal		
Early-onset neonatal sepsis	0	0.0%
Late-onset neonatal sepsis	0	0.0%
Line infection	0	0.0%
Endocarditis	0	0.0%
CNS infection	0	0.0%
Bone and Joint		
Osteomyelitis	0	0.0%
Septic arthritis	0	0.0%
Skin and soft tissue		
Cellulitis / Impetigo	0	0.0%
Wound infection	0	0.0%
Lymphadenitis	0	0.0%
Opthalmology, ENT		
Peri- / Orbital Cellulitis	0	0.0%
Tonsillitis / Pharyngitis	0	0.0%
Otitis media / Other i.e Dental	0	0.0%
Abdominal infections		
Appendicitis	0	0.0%
Other abdominal infections	0	0.0%
Other/unclear	1	5.3%

Has a review decision been documented?			Region
Yes (within 48 hours)	17	89.5%	45.0%
Yes (but after 48 hours)	0	0.0%	8.7%
No (and received antibiotics for >48h)*	0	0.0%	10.9%

*percentage reported refers to proportion of prescriptions >48h

Intravenous prescriptions			Region
On IV therapy, not eligible for switch	13	92.86%	86.73%
On IV therapy, but eligible for switch*	1	7.14%	9.18%
Of those eligible, documented plan to switch	1	100.00%	22.22%

*note eligibilty entered as unclear in a proportion of IV prescriptions

Oral prescriptions*			Region
Switched from IV within 48h	0	0.0%	16%
Switched from IV after 48h	0	0%	6%
Oral route since beginning of course	5	100.0%	78%

*percentages reported refer to proportion of oral prescriptions

13. Stewardship in Surgery – LEAP project

The Antimicrobial Stewardship (AMS) nurse has undertaken the LEAP programme, a nine-month mentoring initiative designed to empower healthcare professionals to lead AMS in local clinical areas. It focuses on embedding AMS into routine practice and combating antimicrobial resistance.

The focus of this programme has been Ward 19 (Urology), with the primary aim of improving antibiotic review plans for intravenous (IV) antibiotics at 48 hours.

Method and results

Total patients audited

- 131 patients were audited over the six-week period.
- Audits were conducted once weekly, with the day and time alternating each week.
- The audit standard aligned with trust AMS policy on: Documentation of indication, compliance with trust policy or microbiology advice, Documented evidence of a stop/review date or initial antibiotic plan and reviewed at 48 -72 hours.

Patients on antibiotics

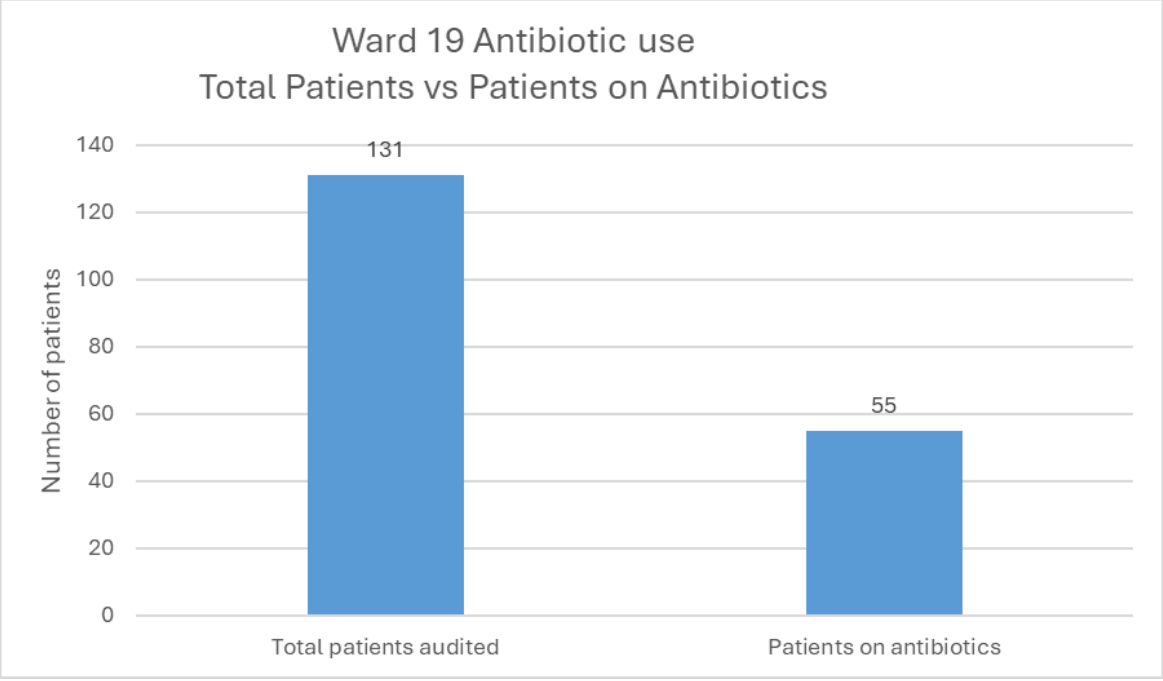
- 55 patients were receiving intravenous (IV) or oral antibiotics at the time of audit.

Number of antibiotic agents in use

- A total of 58 antibiotic agents were being administered.

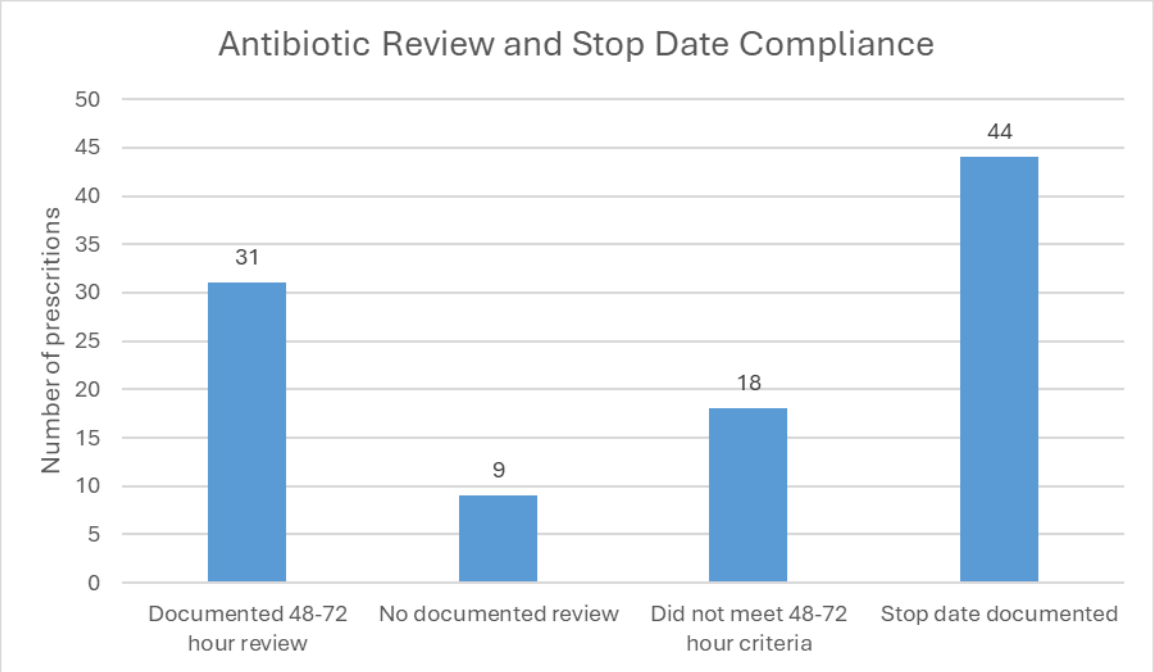
Proportion of patients on antibiotics

- 41.9% of patients admitted to Ward 19 during the audit period were receiving at least one antibiotic.



Review of antibiotics

- Documented review at 48–72 hours:
  31 antibiotic prescriptions had evidence of a review — 53.4%.
- No documented review at 48–72 hours:
  9 antibiotic prescriptions had no recorded review — 15.5%.
- Did not meet 48–72-hour review criteria:
  18 antibiotic prescriptions did not meet the review criteria — 31.1%.
- Use of stop dates:
  44 antibiotic prescriptions had a documented stop date — 75.8%.



Actions and interventions:

- Real time feed back to the urology nursing and medical team at the time of the audit.
- Education and reinforcement: Micro teaching on the ward and posters.
- Staff questionnaire to identify areas of improvement.
- Proposed antibiotic care bundle to improve documentation of antibiotic review plans.
- This quality improvement work is still ongoing.

14. Orthopaedic AMS activities

A targeted antimicrobial stewardship programme was undertaken within Trauma and Orthopaedics (T&O) to review quality of antimicrobial prescribing, identify risks contributing to healthcare associated infection (HCAI), and address the outlier position for surgical site infections (SSI) following hip and knee arthroplasty. The programme combined prospective

audit, multidisciplinary feedback, orthopaedic antibiotic MDT and revision of orthopaedic antibiotic guidelines.

Method:

- Prospective point prevalence audits conducted across 7 antibiotic ward rounds between April–June 2025.
- 75 patients reviewed (54 on St Leger Ward; 21 across Wards 1 and 3).
- Audit standards aligned with Trust AMS policy, focusing on:
  - Documentation of indication.
  - Compliance with Trust policy or microbiology advice.
  - Presence of stop/review date or documented plan.
  - Evidence of antimicrobial review at 48 hours.

Results:

- Overall compliance across audited parameters was high, with an average score of 88.9%.
- Indication documentation:
  - 100% compliance – indication for antimicrobials documented in all audited cases.
- Stop date or documented plan:
  - Generally strong performance, though extended courses without clear indication were identified as a recurring issue.
- 48-hour antimicrobial review:
  - Most patients had documented review where criteria were met, though missed or delayed reviews were identified on selected ward rounds.
- Compliance with Trust policy / microbiology advice:
  - Lower than other domains (approximately 77% overall), highlighting this as the key area for improvement.

Learning identified:

Audit and AMS team led ward reviews highlighted several recurrent risks:

- Unnecessary prolongation of prophylactic antibiotics, particularly:
  - Open fractures continued beyond the recommended maximum 72 hours.
- Broad spectrum antibiotic overuse:
  - Meropenem extended without documented review.
- Dosing and monitoring concerns:
  - Incorrect teicoplanin dosing (not weight adjusted).
  - Gentamicin given before levels were available
- Treatment without clear evidence of infection:
  - Asymptomatic bacteriuria treated as UTI, increasing C. difficile risk.
- Missed antimicrobial stewardship opportunities:
  - Limited IV to oral switching.
  - Inaccurate CURB score calculation.

- Inadequate microbiological sampling and delayed source control (e.g. catheter management in UTIs).

Governance Actions and Interventions:

- Real time feedback provided to orthopaedic teams during AMS ward rounds.
- Education and reinforcement of:
  - Antimicrobial stop dates using electronic prescribing systems (WellSky/NerveCentre).
  - Importance of timely 48-hour review and IV oral switch.
- Findings escalated through Orthopaedic Governance.

Guideline Review:

In response to the SSI outlier position and audit learning, the Orthopaedic & Trauma Antimicrobial Guideline was formally reviewed and updated:

- Review of teicoplanin prophylaxis dosing to optimise tissue penetration and reduce under dosing.
- Cefuroxime as second line prophylaxis where first line agents contraindicated.
- Clearer guidance on:
  - Duration of prophylaxis for open fractures.
  - Management of revision arthroplasty and suspected prosthetic joint infection.
  - Use of gentamicin with renal function and weight safeguards.
- Alignment with NHSE guidelines on 'Surgical Antibiotic Prophylaxis: Principles for Primary Arthroplasty' published in June 2025.

Impact and plans for sustainability:

The audit findings and intervention demonstrate:

- Strong baseline antimicrobial stewardship practice within T&O.
- Identification of specific, actionable risks linked to prolonged or inappropriate antibiotic use and SSI.
- Effective use of audit, feedback, and guideline revision to reduce unwarranted antimicrobial exposure, support C. difficile prevention, and strengthen SSI prevention measures.
- Ongoing weekly Orthopaedic AMS rounds to be delivered by Consultant in Infection and AMS nurse to carry on the stewardship improvement in 2026/2027.

15. Restricting fluoroquinolone use

Background and National Context

Fluoroquinolones are broad spectrum antibiotics used to treat infections including urinary tract, respiratory and gastrointestinal infections. However, their use is associated with increased risk of antimicrobial resistance, Clostridioides difficile infection and rare but

potentially disabling or irreversible adverse effects, including tendon rupture, peripheral neuropathy, cardiac arrhythmias and psychiatric effects.
In January 2024, the Medicines and Healthcare products Regulatory Agency (MHRA) issued updated safety guidance further restricting fluoroquinolone use. These agents should only be prescribed when alternative recommended antibiotics are inappropriate due to resistance, contraindication, intolerance, or treatment failure. Fluoroquinolones are also classified as UKHSA AWaRe "Watch" antibiotics, highlighting the need for enhanced oversight and monitoring.

Local Situation

Fluoroquinolone use at Doncaster and Bassetlaw Teaching Hospitals (DBTH) is low and tightly controlled. The main agents prescribed are ciprofloxacin and levofloxacin. Prescribing is restricted, requiring authorisation by the Consultant in Infection when used outside Trust guideline recommendations. This approach supports appropriate use, minimises risk, and ensures informed discussions with patients regarding risks and benefits.

In response to the MHRA safety update, DBTH adopted the MHRA patient information leaflet for quinolones. Pharmacy teams ensure this leaflet is supplied whenever an oral fluoroquinolone is dispensed.

Trust antibiotic policies have been reviewed and updated to minimise fluoroquinolone use and promote safer alternative agents where possible. Where fluoroquinolones remain indicated, guidelines now include a clear safety warning reinforcing prescribing restrictions, risk counselling requirements and signposting to the patient information leaflet.

Surveillance and Audit Programme

From April 2025, the Antimicrobial Stewardship (AMS) team implemented weekly surveillance and audit of fluoroquinolone prescribing across the Trust, providing real time review and feedback to clinical teams.

- Pharmacy teams generate a weekly list of patients prescribed fluoroquinolones
- Prescriptions are reviewed by the AMS team for indication, choice, dose, route and duration.
- Feedback is provided directly to prescribers and ward teams, with escalation to the Consultant in Infection where required.

Audit Findings (Quarter 1 2025/26)

Between April and June 2025:

- 57 fluoroquinolone prescriptions were identified.
- 45 prescriptions were reviewed as part of the audit.
- Ciprofloxacin accounted for the majority of use, followed by levofloxacin.
- Prescribing occurred predominantly at Doncaster, with lower activity at Bassetlaw.

The highest ward level use was seen in Haematology (Ward 18). All prescriptions in this area were compliant with Trust guidance for ciprofloxacin prophylaxis in neutropenic AML patients receiving chemotherapy, providing assurance regarding appropriate use in high-risk populations.

Across the Trust, higher use was observed in divisions including Trauma & Orthopaedics, General Surgery, Respiratory Medicine, Emergency Medicine and Urology, varying by month.

Of the prescriptions reviewed:

- Most were compliant with local policy
- A minority required intervention, primarily related to inappropriate agent selection, route, duration or deviation from guidance
- All identified issues were addressed promptly through direct discussion with clinical teams, with prescriptions amended in line with Trust policy or following Consultant in Infection input

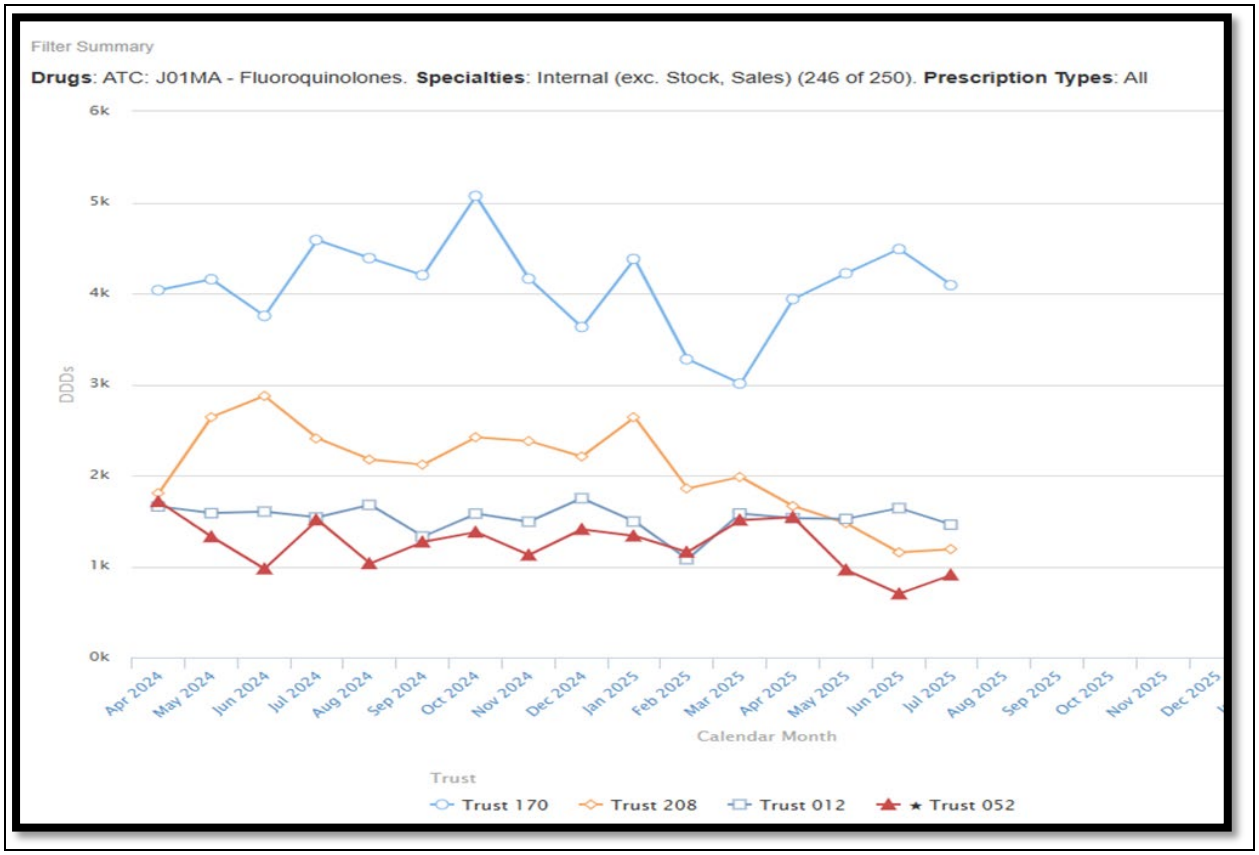
Impact and Assurance

The introduction of regular surveillance and real time feedback has been associated with a reduction in overall fluoroquinolone consumption at DBTH – see graph below. Audit findings demonstrate generally good adherence to prescribing guidance, particularly in high-risk specialist areas.

Where issues were identified, timely intervention and feedback proved effective in improving individual prescribing decisions and reinforcing good antimicrobial stewardship practice. The programme provides assurance that fluoroquinolone use is appropriately restricted, monitored and aligned with national safety guidance.

Ongoing Monitoring and Next Steps

- Weekly fluoroquinolone surveillance will continue as part of routine AMS activity.
- Regular feedback will be maintained to support safe prescribing and ongoing learning.
- Guideline compliance and prescribing trends will continue to be reviewed through AMS and governance forums.



16. <u>Reducing MSSA bacteraemia in Renal dialysis patients</u>

Due to high numbers of MSSA bacteraemia within the renal unit in recent years, we have introduced measures to mitigate this:

- Strong IPC presence on renal unit.
- Post infection reviews with presence of renal consultant, dialysis lead nurse, ward manager, IPC Nurse and Consultant in Infection for any identified case of MSSA bacteraemia in renal patients.
- Encouraging the use of Prontoderm foam for patients on dialysis days.
- Enhanced MSSA screening to include patients with tunnel lines (as before), now extended to patients with AV grafts and those with buttonhole fistula.
- Introduction of topical decolonisation for all patients going for new tunnel line insertion pending swab results.
- Introduction of BioPatch dressing for patient's intolerant of the chlorhexidine dressings following a successful local trial to assess optimal dressings.

In the 2025/2026 financial year, we report only 4 cases of MSSA bacteraemia in renal patients which is a significant reduction from previous figures.

17. Trust Antimicrobial policies

The antimicrobial policies are updated and reviewed in monthly Drugs and Therapeutics Committee meetings. See table below for overview of guidelines reviewed in 2025/2026.

Table: Guideline updated and approved April 2025 – March 2026

Guidelines	Date of approval
Diagnosis & Management of Peritoneal Dialysis catheter-related infections and peritonitis (updated)	May 2025
Penicillin allergy de-labelling (PADL) guidance in adult patients (NEW guideline)	September 2025
DCC Beta lactam extended infusion (NEW guideline)	September 2025
DCC Continuous Vancomycin infusion (updated)	September 2025
Gastrointestinal tract infections – Antimicrobial management (amended)	September 2025
Policy for treatment of Central Nervous System Infections in Adults (updated)	October 2025
Guidelines for Antimicrobial Use in the Orthopaedic and Trauma Department (updated)	December 2025
South Yorkshire and Bassetlaw Antifungal Guidelines for adult patients (updated)	January 2026
Policy for Treatment of Lower Respiratory Tract Infections (amended)	January 2026

18. Infection Virtual Wards

In 2025/2026, we have continued to develop and expand the 2 x Virtual Ward pathways for Infection Management and Orthopaedic infections. This has been useful in facilitating earlier discharge from hospital and monitoring antibiotic regimens, both IV and complex po antibiotics.

19. AMS Educational activities

a. The AMS and Sepsis teams marked World Sepsis Day on 12th September 2025 by delivering teaching on the following topics:

- Sepsis IPOC.
- DRI ED Blood culture pathway QI.
- Blood cultures in Sepsis.

- Antimicrobial stewardship and Penicillin Allergy De-labelling.
- Neutropenic sepsis.

b. We launched World Antibiotic Awareness Week in November 2025.

The theme for WAAW 2025 was 'Educate, Advocate, Act now'. As part of our educational programme we focused on the following areas:

- Update from the AstraZeneca team.
- AMS: A practical approach.
- Improving AMS in the Acute Assessment Unit.
- Access and AWaRe antibiotics / Update of Trust guidance.
- Penicillin Allergy Delabelling.

c. AMS Nurse and Sepsis Nurse delivered Blood culture education to DRI ED teams.

d. AMS team delivered Sepsis/AMS teaching to Foundation Year 1 doctors in Feb 2026.

20. Regional committees and networks

We participate in several external AMS network meetings, including SYB AMS/IPC group, Yorkshire Paediatric AMS group, Yorkshire & Humber Regional Antimicrobial Pharmacist group and AMS nurse network.

21. Priorities for 2026/2027

Priority 1 – Reduce Total Antibiotic Consumption

- To track antibiotic use and trends across the Trust, particularly in relation to selected broad spectrum antibiotics in the Watch and Reserve category.
- To increase Access antibiotic use over the next 12 months through education and guideline revisions where appropriate.
- Reduce Carbapenem consumption.
  - Achieve a 10% reduction in carbapenem use in the next financial year, compared with the previous financial year.

Priority 2 – Diagnostic Quality & Blood Culture Improvement

- The target transport time for blood cultures is <4 hours, and optimal adult bottle volume is 8–10 mL. We aim to sustain the improvement work with ED DRI and ED Bassetlaw and expand the blood culture QI work to other areas within the Trust.
- SYB Pathology aims to submit this dataset to the regional network once data quality issues have been addressed.

- Our specific quality improvement aims over the next financial year:
- Emergency Department (ED):
  - Reduce blood culture contamination rate by 5% - Reduce blood culture contamination rate to <4% in ED.
  - Reduce blood culture journey time to <4 hours.
  - Ensure two sets of blood cultures are collected separately in adult patients admitted with sepsis to improve diagnostic yield
- Paediatrics:
  - Ensure blood cultures are taken prior to antibiotic administration where possible
  - Ensure blood culture journey time to the laboratory is <4 hours

Priority 3 – Strengthen AMS Workforce & Clinical Capability

- Regular FY1/FY2 educational sessions on AMS/IPC/Sepsis.
- AMS Nurse and Sepsis Nurse to deliver teaching to nursing staff and doctors throughout the Trust.
- All ward areas to complete quarterly antibiotic audits using the agreed audit template and SOP. Findings to be fed back to the AMS team and shared at the Trust Wide Infection Group meeting.

6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

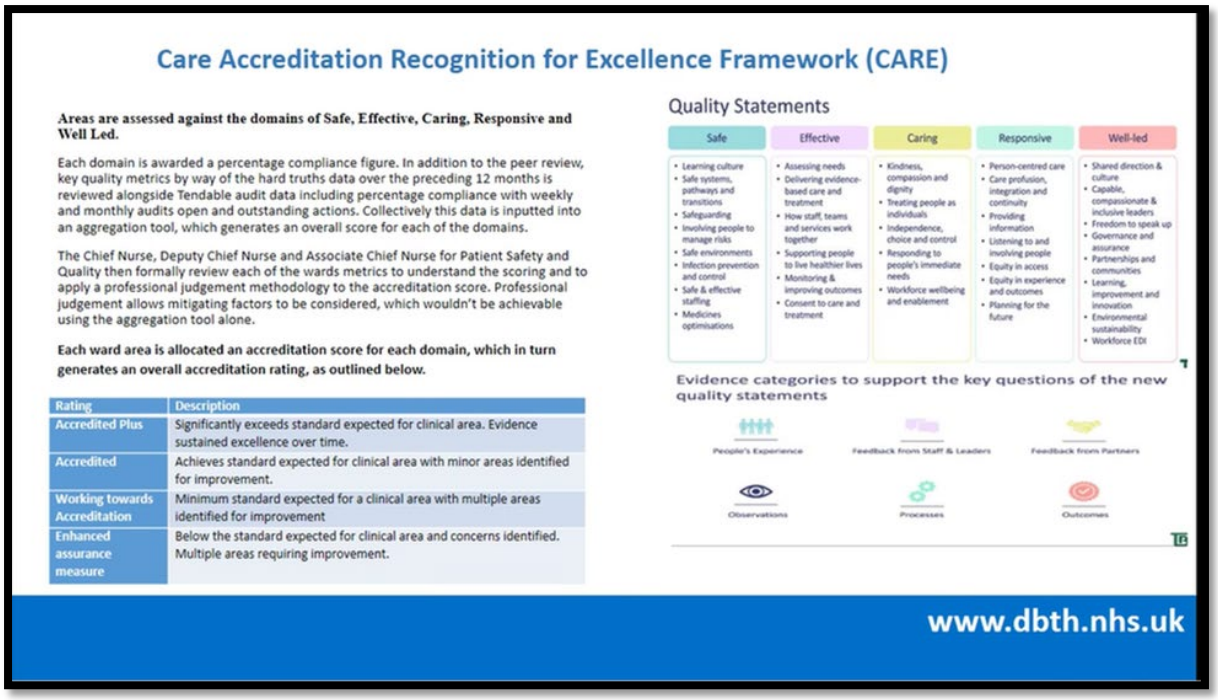
Care Accreditation Recognition for Excellence Framework

It is vital an organisation has systems and structures in place to measure, evaluate and improve the delivery of care to their patients and service users. A governance framework provides a clear structure which enables the organisation to benchmark practice standards, identify areas of concern and most importantly identify sources of support for challenges and blockages which may occur preventing improvement.

The processes within the Care Accreditation Recognition for Excellence framework, allow DBTH to monitor and review concerns or declining performance, celebrate excellence in care, identify sources of support for challenges or blockages that will not be overcome without corporate or wider support.

Wards/Departments are assessed against the domains; Safe, Effective, Caring, Responsive and Well Led. The Infection Prevention and Control elements, sit within the Safe element.

The IPC Nurse Consultant or Lead Nurse attends the Chief Nurse Oversight Group to identify areas requiring additional support from an IPC perspective.



FOCUS

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Infection Prevention and Control

F.O.C.U.S

Framework for Observation, Collaboration, Understanding and Support

The FOCUS (Framework for Observation, Collaboration, Understanding and Support) programme is a structured Infection Prevention and Control (IPC) initiative designed to support clinical areas in meeting regulatory requirements and improving patient safety. Its purpose is to:

- Provide intensive, ward-based IPC support over a defined period, enabling real-time identification and resolution of risks.
- Strengthen compliance with the Health and Social Care Act 2008 (Regulation 12) by ensuring safe care, effective infection prevention, and reduction of avoidable harm.
- Promote collaborative working between the IPC team and ward staff, fostering open dialogue and shared ownership of IPC practice improvement.

- Deliver targeted audits, education, and practical support, including “bite-sized” teaching, to embed consistent IPC standards in daily practice.
- Focus on key domains including environmental cleanliness, antimicrobial stewardship, staff responsibilities, patient information, and prompt identification and management of infection risks.

Overall, FOCUS is intended to drive sustainable improvements in IPC practice, enhance staff knowledge and behaviours, and ensure patients receive safe, high-quality care.

The Infection Prevention and Control Team (IPCT) supported delivery of the FOCUS programme within one clinical area during 2025–2026. However, due to workforce challenges, including vacancies, a reduction in the established staffing levels, and competing IPC priorities, the team did not have the capacity to undertake additional FOCUS weeks within the reporting period.

The FOCUS programme provided a structured, supportive mechanism to improve IPC standards at ward level. The review of the clinical area that participated, demonstrated that intensive IPC engagement, combined with real-time feedback and education, can drive rapid and measurable improvements in practice. Key themes included the importance of reinforcing core IPC principles, strengthening environmental cleaning processes, improving hand hygiene and PPE compliance, and supporting early identification and management of infection risks. Importantly, the programme also highlighted the value of staff engagement and collaborative working in sustaining improvements and enhancing patient safety.

Audit and Surveillance

The wards and department teams are required to achieve defined standards in hand hygiene audits, patient’s environment, Link Practitioner activities and the cascade of information. In addition, appropriate observations and feedback are undertaken which reinforce practical actions that clinical staff must undertake every time they carry out a procedure to reduce the risk of HCAI. These include:

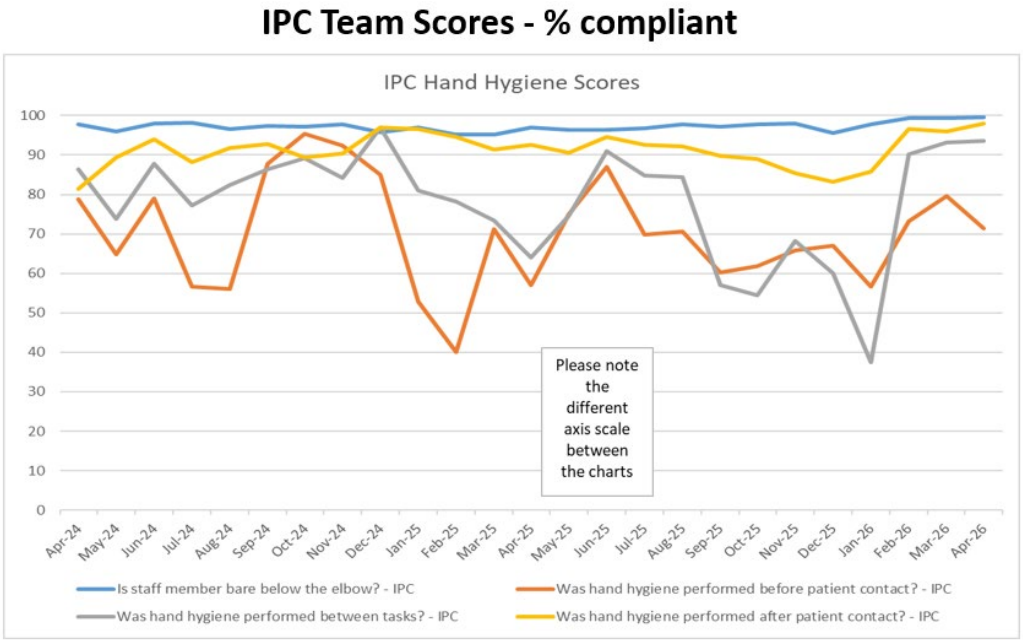
- Preventing surgical site infection.
- Urinary Catheter care.
- Peripheral line care.
- Central Venous Catheter Care.
- Ventilator care.
- Clostridioides difficile.
- Antimicrobial stewardship.
- Hand Hygiene.
- PPE compliance.

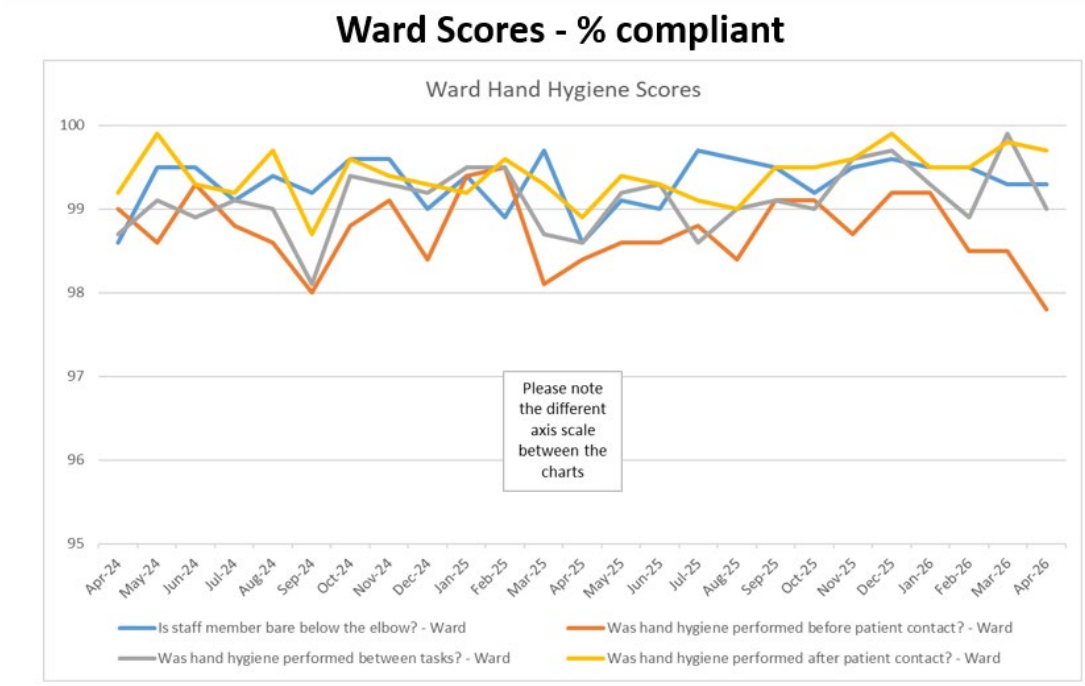
Hand Hygiene

Hand hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team have continued to promote hand hygiene compliance incorporating the WHO five moments tool but simplifying the moments to enable staff to concentrate on aspects that can easily influence hand hygiene compliance. Hand hygiene compliance including bare below the elbows is an expectation for all staff in areas where patients are receiving care.



Hand Hygiene observations are recorded on Tendable.





Where alert infections had been identified, for example, C Difficile and MRSA cases, IPC have monitored compliance with general practices through Snapshot auditing and feedback.







A rapid review by the Infection Prevention and Control (IPC) team has been completed using the NHSE Standard Infection Control Precautions Monitoring Tool. Where an outbreak was suspected, this included environmental audits, assessment of hand hygiene compliance, glove use, and adherence to appropriate PPE. Screening of both staff and patients was also undertaken to determine the extent of the outbreak.

IPC elements are incorporated into the weekly and monthly audits conducted by ward and departmental managers, as well as matrons, via the Tendable system. The IPC team also undertakes regular audits of the environment and care-related practices through Tendable. These include monthly hand hygiene audits, VIP scores, PICC line surveillance, PPE compliance, urinary catheter care and antibiotic audits. All clinical areas received an environmental audit during 2025–2026.

Training and Education

It is widely recognised that ongoing education in infection control is required in order to improve healthcare workers compliance with infection prevention and control practices.

The infection prevention and control computer-based learning (SET and eLearning) packages are accessible for all staff via the Trust Intranet site. The Infection Prevention and Control Team have contributed to provide formal and informal teaching sessions within the clinical areas, and where appropriate in face to face forums and formal sessions with medical colleagues.

IPC Education has been delivered on the Foundations of Care programme for Healthcare Support Workers, International Nurses programme and the link nurse education/training meetings have continued throughout the year.

Quality Improvement Activity

During the reporting period, the Infection Prevention and Control Team (IPCT) has led and supported a number of Quality Improvement (QI) initiatives aimed at strengthening infection prevention practices, improving patient outcomes, and reducing healthcare-associated infections across DBTH.

Clostridioides difficile (CDI) Quality Improvement Project

The CDI QI project was established in response to an increase in Clostridioides difficile infections (CDI) locally and nationally.

The aim of the project was to reduce the number of CDI cases through earlier identification, improved clinical practices, and strengthened multidisciplinary collaboration. A structured QI methodology was applied, involving staff engagement, patient pathway mapping, and the use of Plan-Do-Study-Act (PDSA) cycles to test targeted interventions.

Key areas for improvement identified included delays in stool sampling, inconsistent documentation, variable adherence to IPC measures, and communication gaps between staff.

Interventions implemented included:

- Daily IPC presence on pilot wards to support early identification of symptomatic patients.
- Promotion of prompt stool sampling and improved documentation practices.
- Development of staff education informed by a knowledge survey.
- Exploration of improvements to electronic recording systems.

Initial outcomes demonstrated improved identification of CDI and carrier cases, enabling earlier isolation and management, with emerging evidence of a reduction in overall CDI cases over time initially. During the reporting period, the project has developed to include, DCC, Urology Ward, Gresley Unit in addition to Ward 26.

Clean Smart: Improving Decontamination of Patient Equipment

A separate QI initiative focused on improving the efficiency and reliability of patient equipment decontamination processes. This project responded to identified gaps in compliance with existing cleaning practices, which posed a risk for healthcare-associated infections.

The project tested the introduction of ready-to-use disinfectant wipes with point-of-care dispensers across multiple clinical areas, replacing more complex processes requiring access to cleaning solutions stored in sluice areas.

Process mapping identified that the new approach significantly simplified workflows, reducing the number of steps required to clean equipment.

Evaluation of the intervention demonstrated:

- Improved staff confidence in when and how to clean equipment.
- Reduced time required to locate cleaning materials and complete decontamination.
- Increased accessibility of cleaning products at the point of care.
- Positive feedback from frontline staff regarding usability and efficiency.

Overall, the intervention was associated with a significant reduction in time taken to decontaminate equipment, releasing valuable clinical time and supporting improved compliance with infection prevention standards.

Together, these QI projects demonstrate DBTH's commitment to continuous improvement in infection prevention and control. Through staff engagement, targeted interventions, and

real-time evaluation, the Trust has strengthened its approach to early identification of infection, improved environmental and equipment decontamination practices, and supported safer care delivery in line with regulatory requirements.

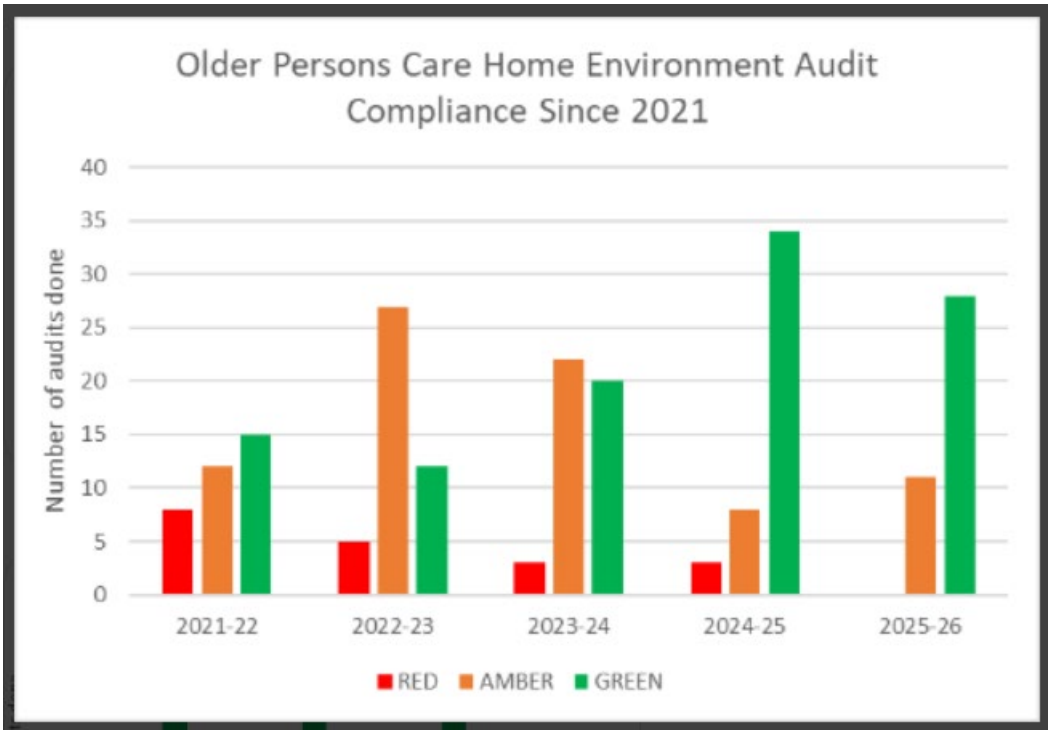
DBTH Hosted Community Infection Prevention and Control Service

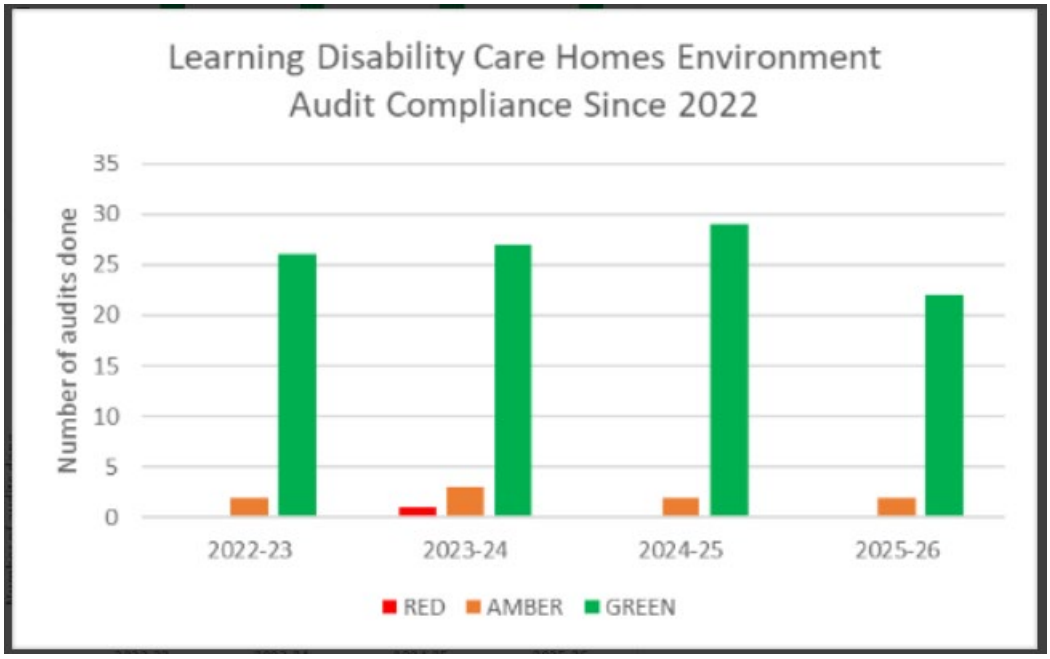
The Infection Prevention and Control (IPC) Team continued to deliver comprehensive support across care homes and community settings in Doncaster, maintaining strong multi-agency collaboration with health and social care partners.

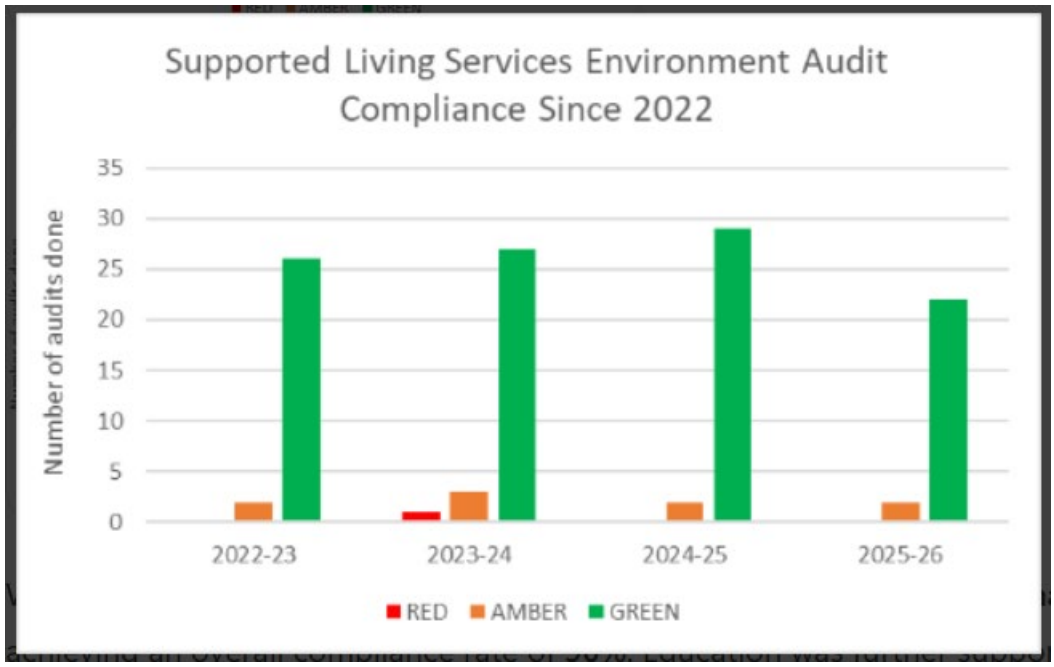
A high level of service visibility was sustained, with 859 face-to-face visits conducted, including routine support, outbreak management, environmental audits and education sessions. All eligible care settings received regular IPC visits and audits in line with the service specification.

The team supported 105 outbreaks during the year, primarily respiratory and gastrointestinal, providing rapid response and ongoing support to minimise transmission.

Environmental audit outcomes demonstrate continued improvement in compliance, with a growing proportion of services achieving full compliance (≥85%) and reduced low compliance scores.







Workforce development remained a priority, with 866 staff assessed for hand hygiene competency, achieving an overall compliance rate of 90%. Education was further supported through monthly virtual sessions and targeted face-to-face training.

Innovative health promotion initiatives, including hydration campaigns and engagement events, were well received and supported infection reduction messaging.



The team played a key role in managing complex community infection risks, supporting incidents such as *Group A Streptococcus*, scabies and tuberculosis, and strengthening partnerships across services.

Antimicrobial stewardship and surveillance activities remained robust, with proactive review of antibiotic use, follow-up of key infections (including Clostridioides difficile), and ongoing patient support to reduce recurrence and transmission.

Priorities for 2026 include maintaining responsive outbreak management, expanding education and hydration-focused initiatives, and introducing a seasonal IPC newsletter to further support care providers.

7. Secure adequate access to laboratory support as appropriate.

Microbiology laboratory

The Microbiology Laboratory continues to work closely with the Infection Prevention and Control (IPC) team to ensure appropriate testing of clinical samples and the rapid communication of results. This collaboration is particularly important for key pathogens, including SARS-CoV-2, influenza viruses and RSV, *Clostridioides difficile*, norovirus, Group A *Streptococcus*, *Mycobacterium tuberculosis*, MRSA, and other designated alert organisms such as carbapenemase-producing Enterobacteriaceae (CPE) and vancomycin-resistant *Enterococci* (VRE).

A regularly generated line list of alert organisms is produced—often in advance of formal result authorisation—to support the IPC team in taking proactive action. This enables timely isolation decisions and early interventions to reduce the risk of healthcare-associated infection transmission.

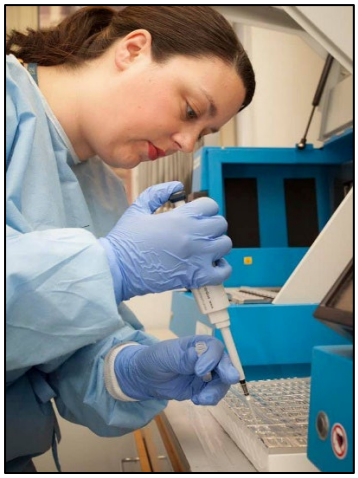
The laboratory also supports the collection, packaging, and onward referral of high-risk specimens for testing at specialist national reference laboratories. These include, but are not limited to, measles, pertussis, mpox, viral haemorrhagic fevers, and Creutzfeldt-Jakob disease (CJD). Results are actively tracked and communicated back promptly to Consultant Infection clinicians and the IPC team.

The laboratory is fully UKAS-accredited and now operates an extended-day service alongside a seven-day working model, both of which have improved turnaround times and enabled earlier clinical and IPC action on significant isolates.

As outlined previously, antimicrobial resistance in Gram-negative organisms continues to evolve, and the laboratory has implemented enhanced CPE screening protocols in line with UKHSA guidance. The FilmArray platform has been switched to Qiastat in 2025 and is now fully validated and embedded within laboratory practice, supporting the rapid identification of bacterial and viral pathogens in cerebrospinal fluid samples.

Work has also been completed to ensure that Communicable Disease Reports (CDR) and Antimicrobial Resistance (AMR) data are securely transferred from the pathology Laboratory Information Management System (LIMS) to the Second-Generation Surveillance System (SGSS).

Regional consultations for the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Pathology Network have now concluded, and the Microbiology Department at Doncaster Royal Infirmary is integrated within Sheffield Teaching Hospitals, while remaining based at DRI. The rollout of the SYB Pathology Oracle Cerner PathNet LIMS commenced in April 2024 but this project in on hold currently.





The COVID-19 PCR lab in microbiology at Doncaster Royal Infirmary.

8. Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.

Infection Prevention and Control Policies

The following policies were updated and approved by the Infection Prevention and Control Strategic Steering Group during 2025-2026.

Policy title	Policy number	Date approved IPCSSG
Management of Sharps Injuries and Blood and Body Fluid Exposure Incidents	PAT/IC 18 v.9	April 2025
Chickenpox / Shingles Management	PAT/IC 15 v.8	June 2025
Isolation Policy	PAT/IC 16 v.10	August 2025
Cleaning and Disinfection of Ward Based Equipment	PAT/IC 24 v.9	August 2025
Animals on Trust Premises – including Pets As Therapy	PAT/IC 33	August 2025
Faecal Microbiota Transplantation Policy	PAT/IC 34 v.3	October 2025
Laundry Policy Bagging Procedure for Linen	CORP FAC 12 V 2	October 2025
Vascular Access Device Policy	PAT/T 73 v.4	December 2025
Spillage of Blood and Other Body Fluids Policy	PAT/IC 18 v.9	December 2025
Variant Creutzfeldt-Jakob Disease (vCJD) and Transmissible Spongiform Encephalopathy Agents (TSE): Minimising the Risk of Transmission	PAT/IC 4 v.7	December 2025
Hand Hygiene Policy	PAT/IC 5v.10	February 2026
Hazard Group 4 Viral Haemorrhagic Fevers Policy	PAT/IC 32v.7	February 2026

9. Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Safe Use and Disposal of Sharps Group

The Safe Use and Disposal of Sharps Group is a formal sub-group of the Trust's Health and Safety Committee and the Trust-wide Infection Control Group, providing oversight and assurance on the safe management of sharps across Doncaster and Bassetlaw Teaching Hospitals.

The group is responsible for monitoring practices related to the safe use and disposal of sharps, reviewing trends in sharps-related incidents, and advising on prevention strategies to reduce the risk of injury and harm to staff, patients, and visitors. It supports compliance with Trust policy and national health and safety requirements.

Core activities undertaken by the group include:

- Monitoring sharps incidents reported through DATIX and Occupational Health systems.
- Reviewing trends and themes to identify risks and areas for improvement.
- Promoting a culture of sharps safety and prevention across the organisation.
- Supporting education, training, and awareness initiatives.
- Coordinating the trial and implementation of safer sharps devices.
- Providing assurance and escalation to the Health and Safety Committee and Infection Control governance structures.

During the reporting period, sharps incidents continued to be monitored across the Trust, with data reviewed by role, division, location, and theme to better understand patterns of occurrence and inform targeted interventions.

Analysis of incident trends demonstrated variation within expected limits, indicating that while incidents occur consistently, there were no significant system-level deviations requiring escalation.

Thematic reviews of incidents, including those occurring out of hours, supported identification of common contributory factors and informed prevention strategies.

The group includes representation from Infection Prevention and Control, Health and Safety, Occupational Health, Waste Management, Procurement, and clinical services, ensuring a multidisciplinary approach. Regular updates are provided across professional groups, supporting coordinated action on sharps safety.

An action plan framework is used to monitor compliance with health and safety standards and track progress against improvement actions at organisational and ward level.

The Safe Use and Disposal of Sharps Group provides a structured framework for monitoring, reviewing, and improving sharps safety across the Trust. Through robust governance arrangements, multidisciplinary engagement, and ongoing analysis of incident data, the group supports the reduction of sharps injuries and promotes a culture of safety, contributing to the delivery of safe care in line with regulatory and organisational requirements.

Sharps-related incidents are recorded via the DATIX system; however, the completeness of the data is limited. This is due to challenges in aligning reporting and follow-up processes with Occupational Health services, which has impacted the consistency of data capture and the ability to fully support

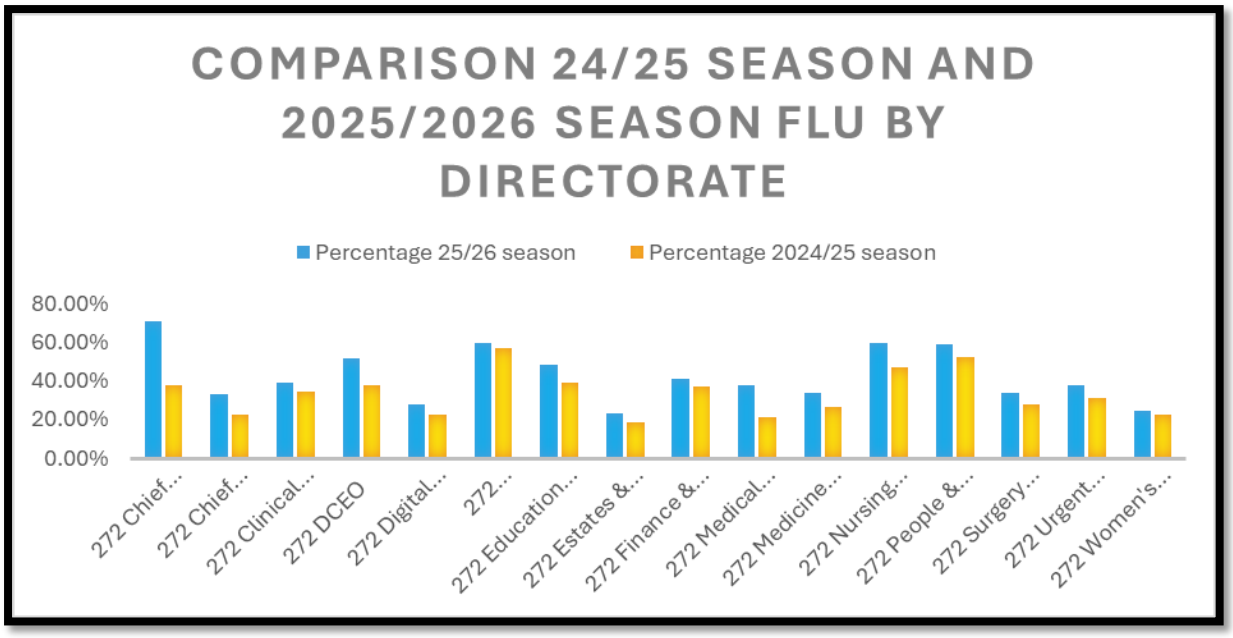
prevention and staff protection initiatives. Strengthening this interface remains important to support robust oversight, staff safety, and targeted prevention work.

DBTH has a statutory responsibility to ensure the workforce is protected from occupational exposure to infectious diseases. Vaccination programs reduce transmission risk, protect workforce health, and maintain service delivery.

Staff influenza vaccination

The influenza vaccination program aims to protect workforce health and maintain service continuity. Overall, in 2025/2026 uptake was 34.42% (2,489 vaccinations), below the Trust target of 48.2%. Uptake varied significantly across divisions, ranging from 23.57% to 71.43%, indicating inconsistent engagement and access. The 2025/26 flu vaccination programme demonstrates clear and consistent improvement across all Directorates from the previous 2024/ 2025 season, reflecting progress in engagement and delivery.

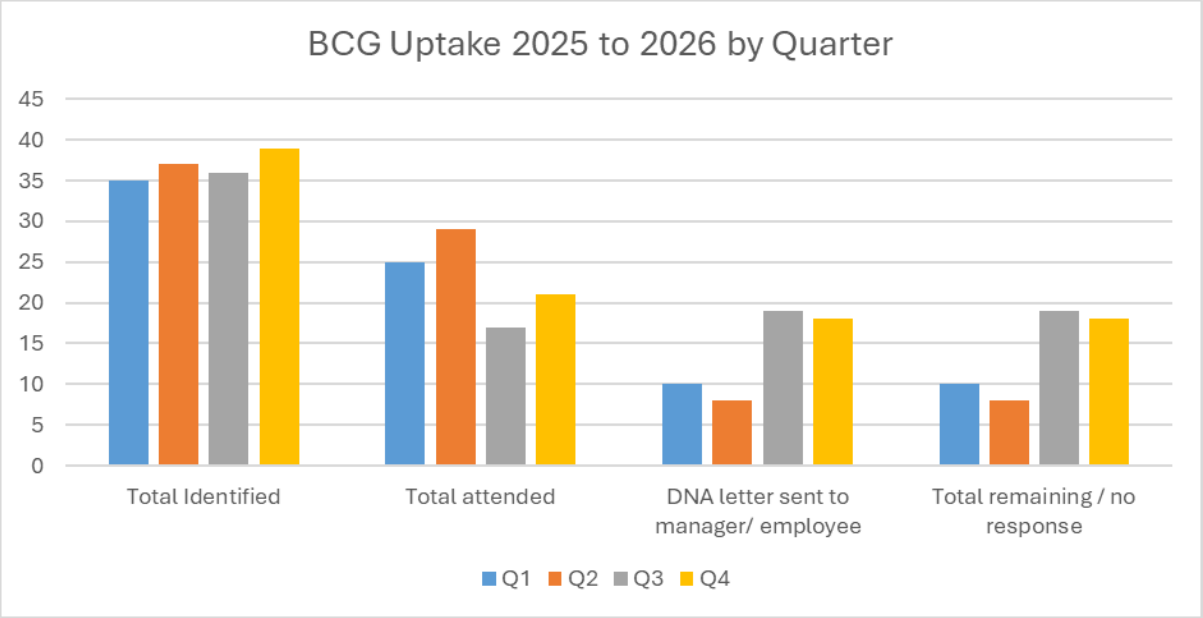
Division or Directorate of DBTH	Vaccination count	Percentage 25/26 season	Percentage 2024/25
272 Chief Executive Directorate	20	71.43%	37.84%
272 Chief Operating Officer	105	33.55%	22.74%
272 Clinical Specialties Division	654	39.26%	34.46%
272 DCEO	15	51.72%	37.84%
272 Digital Transformation Directorate	45	27.78%	22.70%
272 Doncaster & Bassetlaw HC Services Ltd	9	60.00%	57.14%
272 Education and Research Directorate	47	48.45%	39.39%
272 Estates & Facilities	165	23.57%	18.94%
272 Finance & Healthcare Contracting Directorate	37	41.11%	36.94%
272 Medical Director Directorate	8	38.10%	21.43%
272 Medicine Division	442	33.61%	26.76%
272 Nursing Services Directorate	49	59.76%	46.94%
272 People & Organisational Directorate	57	59.38%	52.58%
272 Surgery Division	391	33.97%	28.22%
272 Urgent and Emergency Care Division	240	38.22%	31.50%
272 Women's & Children's Division	205	24.43%	22.59%
Grand Total	**2489**	**34.42%**	**28.24%**



BCG (TB) Vaccination Summary

The BCG program protects against tuberculosis. Uptake April 2025 50 March 2026 was 62.6% (92 out of 147 identified workforce members), with 37.4% non-attendance. Engagement declined across the year, particularly in later quarters.

BCG Vaccination 25/26	Total Identified	Total attended	DNA letter sent to manager/ employee	Total remaining / no response
Q1	35	25	10	10
Q2	37	29	8	8
Q3	36	17	19	19
Q4	39	21	18	18
Total	147	92	55	55



Both vaccination programs demonstrate that systems are in place but variation in uptake and engagement limits assurance. Further targeted action is required to strengthen workforce protection and compliance.

Summary

This Annual Report provides assurance to the Trust Board that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has maintained effective and robust Infection Prevention and Control (IPC) arrangements throughout 2025/26, despite sustained operational pressures and increasing clinical demand.

While the year has been characterised by continued system-wide challenges, the Trust has demonstrated resilience, strong governance, and a clear commitment to patient and staff safety, supported by well-embedded IPC frameworks and multidisciplinary collaboration.

The report evidences continued progress against the IPC Action Plan for 2025/26, with surveillance data, audit outcomes, and assurance systems demonstrating measurable impact in the prevention and reduction of healthcare-associated infections (HCAIs). Where increases or emerging risks have been identified, these have been subject to timely investigation, structured review, and organisational learning, with clear accountability and oversight.

The Trust has maintained a comprehensive IPC system encompassing surveillance, risk assessment, incident response, audit, education, and assurance, delivered through close partnership working with clinical services, Estates and Facilities, and system partners. This integrated approach has enabled early identification of risk, rapid implementation of control measures, and continuous improvement in IPC practice.

Strategic Priorities for 2026/27

Looking ahead, the Trust will maintain a strong focus on sustained risk reduction, prevention of avoidable harm, and preparedness for emerging threats, with key priorities including:

- **Reducing reportable HCAIs:**
  Maintaining downward trajectories and ensuring preventable infections are minimised wherever possible
- **Hand hygiene compliance:**
  Sustaining and improving adherence, recognising its critical role in preventing transmission, including respiratory infections
- **Antimicrobial stewardship (AMS):**
  Strengthening prescribing practice to reduce antimicrobial resistance (AMR), aligned to NICE and national guidance
- **Gram-negative bloodstream infection reduction:**
  Continued focus on preventable infections, particularly those associated with indwelling urinary catheters
- **Clostridioides difficile reduction:**
  Sustaining an evidence-based approach through antimicrobial optimisation and environmental controls
- **Emerging and high consequence infectious diseases:**
  Maintaining vigilance and preparedness for infections such as tuberculosis, mpox, measles, pertussis, viral haemorrhagic fevers, and Creutzfeldt-Jakob disease
- **Decontamination assurance:**
  Ongoing oversight of decontamination services, including specific risk mitigation relating to dental chair infrastructure at Montagu Hospital
- **Water safety management:**
  Ensuring continued compliance with statutory and national standards
- **Ventilation and air quality:**
  Strengthening oversight through the Ventilation Safety Group and supporting prevention of airborne transmission
- **Education, training and audit:**
  Maintaining staff competence and ensuring IPC policies remain current, embedded, and consistently applied
- **Safe and clean care environments:**
  Sustaining delivery of high standards through collaborative working with Estates and Facilities, including cleaning, deep cleaning, waste, linen, equipment decontamination, transport, and health and safety assurance

<u>Overall Assurance Statement</u>

In summary, the Trust has continued to strengthen its IPC maturity, embedding learning and maintaining a proactive, risk-based approach to infection prevention during a challenging year.

The Trust can provide significant assurance that IPC systems are effective, with robust governance, strong multidisciplinary working, and clear evidence of impact in reducing infection risk. These arrangements provide a solid foundation for continued improvement, supporting the Trust's strategic commitment to delivering safe, high-quality care for patients, visitors, and staff

Appendix 1: Breakdown of Trust acquired C. difficile cases by ward and division 2025-26

Year	2025/26
MESS Organism	C.diff

Count of Episode			Month												
Category	Division	Location	2025/04	2025/05	2025/06	2025/07	2025/08	2025/09	2025/10	2025/11	2025/12	2026/01	2026/02	2026/03	Grand Total
HOHA	Surgery and Cancer	DR1							1			2			3
		DR19	1			1	1	3	1						7
		DR26		1	1	1	1	1						1	6
		DR3										1		1	2
		DR7		1			1								2
		DR8				1									1
		DR9	1												1
		DRS11	1	1					1						3
		DRS12	2												2
	Surgery and Cancer Total		5	3	1	3	3	4	3			3		2	27
	Clinical Specialities	DRDCC	1												1
	Clinical Specialities Total		1												1
	Medicine	DGC2								1	1				2
		DR16						1			1				2
		DR17								1					1
		DR18				2			1				1		4
		DR20											1		1
		DR22		1								2			3
		DR24			1										1
		DR25			1										1
		DR32		1										1	2
		DRKES		1						1		1			3
		DRKIN						1	1	1	2	1	1		7
		MALL								1		2	1		4
		STIR											1		1
		VIRTUAL								1					1
	Medicine Total			3	2	2		2	2	6	4	6	5	1	33
	Urgent and Emergency Care	DRAE				1									1
		DRASSM			1		1		1		1	1	3		8
	Urgent and Emergency Care Total				1	1	1		1		1	1	3		9
HOHA Total			6	6	4	6	4	6	6	6	5	10	8	3	70
COHA	Surgery and Cancer	DGC4		1			1								2
		DR19	1										1		2
		DR3		1											1
	Surgery and Cancer Total		1	2			1						1		5
	Children and Families	DGCAU		1											1
	Children and Families Total			1											1
	Medicine	DGA4											1	1	2
		DR16											1		1
		DR24		1											1
		DR25		1				1	1						3
		DRKES							1						1
		DRKIN				1									1
		RHB2		1											1
	Medicine Total			3		1		1	2				2	1	10
	Urgent and Emergency Care	DRASSM									2			1	3
	Urgent and Emergency Care Total										2			1	3
COHA Total			1	6		1	1	1	2		2		3	2	19
Grand Total			7	12	4	7	5	7	8	6	7	10	11	5	89

Appendix 2: Trust-attributed MSSA BSI cases by ward and division for 2025/26

Year	2025/26
MESS Organism	MSSA

Count of Episode			Mont												
Category	Division	Locati	2025/04	2025/05	2025/06	2025/07	2025/08	2025/09	2025/10	2025/11	2025/12	2026/01	2026/02	2026/03	Grand Total
HOHA	Children and Families	DGA2									1				1
	Children and Families Total										1				1
	Clinical Specialities	DRDCC	1					2			1				4
	Clinical Specialities Total		1					2			1				4
	Medicine	DGC1				1									1
		DGC2	1								1				2
		DR17						1		1					2
		DR18								1					1
		DR20		1	1			1				1			4
		DR21	1	1				1							3
		DR22			1										1
		DR24	1	3			1	1			1		1		8
		DR25					1							1	2
		DR32	1					1							2
		DRCCU				2									2
		DRKIN										1		1	2
		MALL	1												1
	Medicine Total		5	5	2	3	2	5		2	2	2	1	2	31
	Surgery and Cancer	DR26								1				1	2
		DR9							1						1
		DRS12					1								1
		DR19												1	1
		DR7								1					1
	Surgery and Cancer Total						1		1	2				2	6
	Urgent and Emergency Care	DRAE			1										1
		DRASSM			1					1					2
	Urgent and Emergency Care Total				2					1					3
HOHA Total			6	5	4	3	3	7	1	5	4	2	1	4	45
COHA	Children and Families	DGCAU			1										1
	Children and Families Total				1										1
	Medicine	DGB5												1	1
		DR22						1							1
		DR32		1										1	2
		DRCCU							1						1
		RHB1					1								1
	Medicine Total			1			1	1	1					2	6
	Surgery and Cancer	DR19	1												1
	Surgery and Cancer Total		1												1
	Urgent and Emergency Care	DGAE											2		2
		DRAE				3			1	1					5
	Urgent and Emergency Care Total					3			1	1			2		7
COHA Total			1	1	1	3	1	1	2	1			2	2	15
Grand Total			7	6	5	6	4	8	3	6	4	2	3	6	60

Year	2025/26
MESS Organism	Pseudomonas aeruginosa

Count of Episode			Mont												
Category	Division	Location	2025/04	2025/05	2025/06	2025/07	2025/08	2025/09	2025/10	2025/11	2025/12	2026/01	2026/02	2026/03	Grand Total
HOHA	Surgery and Cancer	DR27	1												1
		DR19			1		1								2
		DR7						1							1
	Surgery and Cancer Total		1		1		1	1							4
	Medicine	DR21											1		1
		DGA4		1											1
		DR16												1	1
		DR25	1												1
		DRKIN		1						1					2
	Medicine Total		1	2						1			1	1	6
HOHA Total			2	2	1		1	1		1			1	1	10
COHA	Surgery and Cancer	DR19					1								1
	Surgery and Cancer Total						1								1
	Children and Families	DRCHOU												1	1
	Children and Families Total													1	1
	Medicine	STIR					1			1					2
		MALL							1						1
		DR32									1				1
		DR25								1					1
	Medicine Total						1		1	2	1				5
	Urgent and Emergency Care	DRAE	1							1					2
		DRASSM						1							1
	Urgent and Emergency Care Total		1					1		1					3
COHA Total			1				2	1	1	3	1			1	10
Grand Total			3	2	1		3	2	1	4	1		1	2	20

Year	2025/26
MESS Organism	Klebsiella

Count of Division			Mont												
Category	Division	Location	2025/04	2025/05	2025/06	2025/07	2025/08	2025/09	2025/10	2025/11	2025/12	2026/01	2026/02	2026/03	Grand Total
HOHA	Clinical	DRDCC									1				1
	Clinical Specialities Total										1				1
	Surgery and Cancer	DRS10								1					1
		DR26									1				1
		DRS12				1							1		2
		DR27						1		1					2
		DR19				1			2	2					5
	Surgery and Cancer Total					2		1	2	4	1		1		11
	Medicine	DR24		1											1
		STIR				1						1			2
		DR21							1	1					2
		DR16							1						1
		DR17							1						1
		DR18		1	1	1				1					4
		DR25										1			1
		VIRTUAL3									1				1
	Medicine Total			2	1	2			3	2	1	2			13
	Urgent and Emergency	DRAE					1								1
		DRASSM						1					1		2
	Urgent and Emergency						1	1					1		3
HOHA Total				2	1	4	1	2	5	6	3	2	2		28
COHA	Surgery and Cancer	DR3			1										1
		DRS12								1					1
		DR19											1		1
	Surgery and Cancer Total				1					1			1		3
	Medicine	DR17					1								1
		DR25							1						1
		DRKIN										1	1		2
		DGC1										1			1
		DGC2		1											1
		DR22					1								1
	Medicine Total			1			2		1			2	1		7
	Urgent and Emergency	DRASSM						2							2
		DRAMU				1									1
	Urgent and Emergency					1		2							3
COHA Total				1	1	1	2	2	1	1		2	2		13
Grand Total				3	2	5	3	4	6	7	3	4	4		41

Appendix 4 - Hospital acquired MRSA colonisation cases detected 2025-26

description	MRSA Colonisation

Count of description	ort												
division_name	WardName	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	Grand Total
Children and Families	NEONATAL UNIT DRI	1												1
Children and Families Total		1												1
Medicine	MALLARD WARD										1			1
	Ward 32 - RENAL WARD											1		1
	Ward A4								1					1
	Ward 22				1	1								2
	Ward 25					1							1	2
	Ward C1	1	1							1				3
	KESTREL WARD - DO NOT USE FOR IPC	1	1											2
	KINGFISHER WARD - DO NOT USE FOR IPC							1		1				2
	Ward 20 & 21 RESPIRATORY UNIT						1					1		2
Medicine Total		2	2		1	2	1	1	1	2	1	2	1	16
Surgery and Cancer	S11												1	1
	ST LEGER WARD (Wards 7, 8 and 9)		2											2
	Wards 1 and 3					1					1			2
	Ward 26							2			1			3
	Ward B5				1							1		2
Surgery and Cancer Total			2		1	1		2			2	1	1	10
Grand Total		3	4		2	3	1	3	1	2	3	3	2	27

Glossary of terms

Antimicrobials	Antibiotics
AWaRe	Access, Watch and Reserve Antibiotics category in the WHO essential medicines list.
Bacteraemia	The presence of bacteria in the blood
COVID-19	Coronavirus respiratory infection, highly contagious, high mortality.
C. difficile	The organism most frequently identified as the cause of antibiotic-associated diarrhea.
CLABSI	Central Line Associated Bloodstream Infection
CR-BSI	Catheter Related Bloodstream Infection
Colonisation	The presence of a bacteria on or in the body without causing infection.
Dashboard	A way of presenting data in a visual format.
ESBL	Extended-Spectrum Beta-Lactamases are enzymes produced by bacteria, making them resistant to broad-spectrum antibiotics.
MRSA	Methicillin resistant Staphylococcus aureus is a bacterium that is resistant to commonly used antibiotics such as Flucloxacillin.
PIR	Post Infection Review is a systematic review of an incident to determine why it happened and lessons to be learnt.

2609 - I1 ANNUAL SAFEGUARDING REPORT 2025/26

Information Item | Karen Jessop, Chief Nurse | 12:50

REFERENCES

Only PDFs are attached

I2 - Annual Safeguarding Report 2025-26.pdf

I2i - Annual Safeguarding Report 2025-26.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Annual Safeguarding Report 2025/2026**			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Denise Phillip, Head of Safeguarding			
Appendices:	N/A			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Proposed assurance Level (For assurance papers only)	N/A			
Assurance Rationale				
Impacts on Strategic Risks (BAF 1-7)	BAF 1			

Executive Summary – Key messages and Issues

This report is the annual report of safeguarding activity and provides the Board with information regarding the effectiveness of safeguarding arrangements. The report demonstrates continued organisational improvement through strengthened governance, increased safeguarding activity, enhanced workforce capability, expansion of specialist services, and positive progress against national safeguarding assurance frameworks. Safeguarding referrals increased significantly across adults, children and maternity services, reflecting improved recognition and escalation of safeguarding concerns by staff. Additional progress has been achieved through the expansion of the Domestic Abuse Liaison Service, strengthened Mental Capacity Act and Deprivation of Liberty Safeguards arrangements, implementation of the Person in a Position of Trust (PiPoT) framework, policy development, enhanced audit activity and improved compliance with key safeguarding standards. External assurance mechanisms, benchmarking activity and partnership assessments support the conclusion that safeguarding arrangements remain effective and continue to mature. Residual risks relating to safeguarding supervision, MCA/DoLS compliance and Child Protection Information Sharing (CP-IS) remain subject to active management and oversight through the Trust's governance framework.

Recommendations

The Board is asked to receive and note the Safeguarding Annual Report 2025–2026 and note that effective safeguarding arrangements are in place across the Trust. The report evidences strengthened governance, increased safeguarding activity, enhanced workforce capability, expansion of specialist safeguarding services, positive external assurance findings and improved organisational safeguarding maturity. Whilst residual risks remain in relation to safeguarding supervision, MCA/DoLS compliance and Child Protection Information Sharing (CP-IS), these are recognised, actively managed and supported by clear improvement plans and governance oversight. The Board is asked to note the continued progress made during 2025–2026 and support delivery of the 2026–2027 safeguarding priorities aimed at further reducing risk and strengthening assurance.

Healthier together – delivering exceptional care for all	
Patients	Safe and Effective Care
People	n/a
Partnerships	n/a
Pounds	n/a
Health Inequalities	n/a

Legal/ Regulation:	CQC Safe Care and Treatment, Health and Social Care Act
Partner ICB strategies	n/a
Assurance Route	
Previously considered by - including date:	Strategic Safeguarding Group
Any outcomes/next steps / time scales	June 2026 Approved for QC

Safeguarding Annual Report 2025 – 2026



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Executive Summary

This report provides the Board with assurance on the effectiveness, oversight and continued development of safeguarding arrangements across DBTH during 2025–2026. It summarises safeguarding activity, governance, risk, workforce capability and partnership working, and sets out the Trust's position against key safeguarding priorities and assurance requirements.

Taken together, the evidence presented provides an overall position of **reasonable to strong assurance** that safeguarding arrangements at DBTH are effective and continuing to strengthen. This judgement is supported by stable governance, increased safeguarding activity, improved access to specialist support, strengthening workforce capability, positive progress against national assurance frameworks and a clear programme of work to address the remaining areas requiring further embedding.

Key areas of progress during the year include strengthened governance through the Strategic Safeguarding Group; increased safeguarding referrals indicating improved recognition and escalation of concerns; expansion of the Domestic Abuse Liaison Service; continued development of MCA/DoLS arrangements; implementation of the PiPoT framework; revised policy and procedural controls; and continued delivery of safeguarding, MCA and sexual safety training. Benchmarking and external assurance activity also indicate a stronger safeguarding position than in previous years.

Notwithstanding this progress, residual risk remains in relation to safeguarding supervision, MCA/DoLS compliance and CP-IS. These risks are recognised on the Trust risk register, are subject to formal oversight through the Strategic Safeguarding Group and are supported by defined mitigation plans and improvement actions. Assurance in these areas is therefore reasonable rather than full, pending further embedding and sustained compliance.

The 2026–2027 priorities appropriately focus on reducing residual risk, strengthening assurance and embedding consistent practice across the organisation. These include improving safeguarding supervision compliance, progressing MCA/DoLS quality improvements, strengthening CP-IS implementation, maintaining training performance and continuing to develop partnership and thematic learning arrangements. Overall, the report provides the Board with a clear line of sight on current safeguarding performance, the principal risks requiring continued oversight, and the actions in place to support further improvement.

1. Foreword:

This report provides the Board with assurance on the effectiveness, maturity and continued development of safeguarding arrangements across the Trust during 2025–2026.

The report evidences a year of stable progress, with safeguarding remaining embedded within safe, high-quality care. Increased activity, alongside improved training, accessible specialist advice and greater team visibility, provides assurance of a more confident workforce that is identifying and escalating concerns more consistently.

Prior investment in safeguarding resource has strengthened organisational capacity, improved responsiveness and increased support to frontline teams. This is reinforced by robust governance through the Strategic Safeguarding Group, which provides formal oversight of performance, risk, delivery and partnership priorities.

Overall, the evidence in this report provides reasonable to strong assurance that safeguarding arrangements at DBTH continue to strengthen, with clear priorities in place for the remaining areas requiring further embedding during 2026–2027.



Karen Jessop
Chief Nurse



Simon Brown
Deputy Chief Nurse

2. Introduction

Doncaster and Bassetlaw NHS Teaching Hospitals (DBTH) provides acute services for approximately 420,000 people across South Yorkshire, North Nottinghamshire, and the surrounding areas. As a Trust we employ over 7000 colleagues.

This Annual Report summarises safeguarding activity, performance and development during 2025–2026 and provides assurance on the Trust's arrangements to safeguard unborn babies, children, young people and adults at risk.

Safeguarding within DBTH is underpinned by a clear organisational commitment that recognises safeguarding as everyone's responsibility. Throughout this year, the Trust has continued to build on established foundations, demonstrating progress through increased safeguarding activity, strengthened governance, stable workforce capability and enhanced multi-agency collaboration. Collectively, these elements provide assurance that safeguarding is being managed through an increasingly robust and visible organisational framework.

This report highlights key areas of activity, including referrals to social care, Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS), domestic abuse, and partnership working. It also sets out areas of good practice, learning from audits and reviews, and the proactive steps taken to address identified risks and emerging themes.

The report reflects a year of increasing demand and in the context of continued complexity in safeguarding practice. In response, there has been a continued focus on strengthening workforce knowledge and confidence through training, supervision, and direct support from the safeguarding team. This has contributed to improved recognition and escalation of safeguarding concerns, ultimately supporting safer outcomes for patients.

Alongside operational activity, the report demonstrates the Trust's robust governance arrangements, including oversight provided by the Strategic Safeguarding Group.

Overall, the report provides reasonable assurance that safeguarding arrangements are effective and continuing to strengthen, while recognising that further work is required in relation to supervision, MCA/DoLS compliance and CP-IS before full assurance can be demonstrated in all areas.

3. Safeguarding Governance

Figure 1: Safeguarding lines of Accountability at DBTH (March 2026 position)

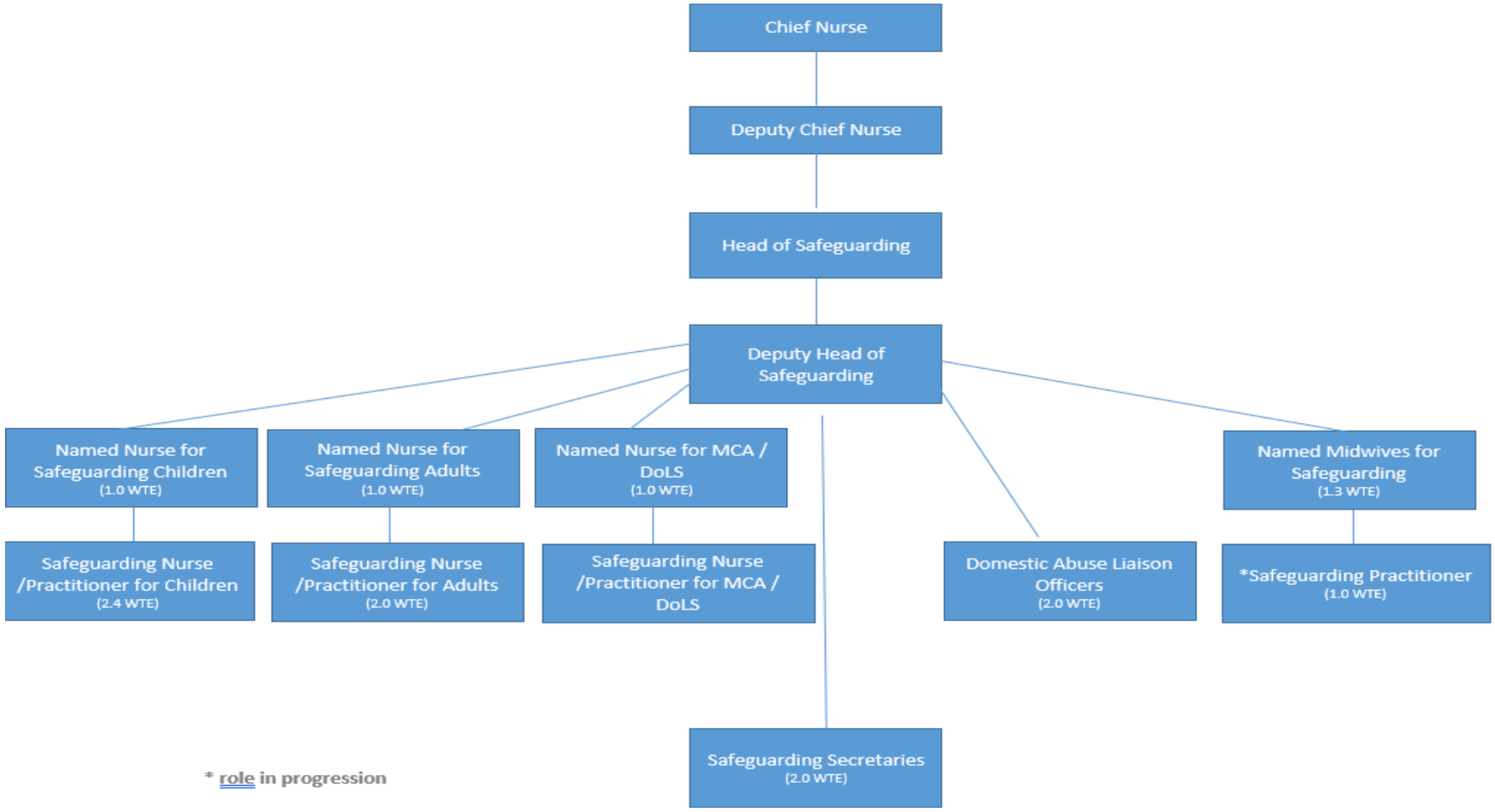


Figure 1.1: Evidences the governance flow and oversight at year end.

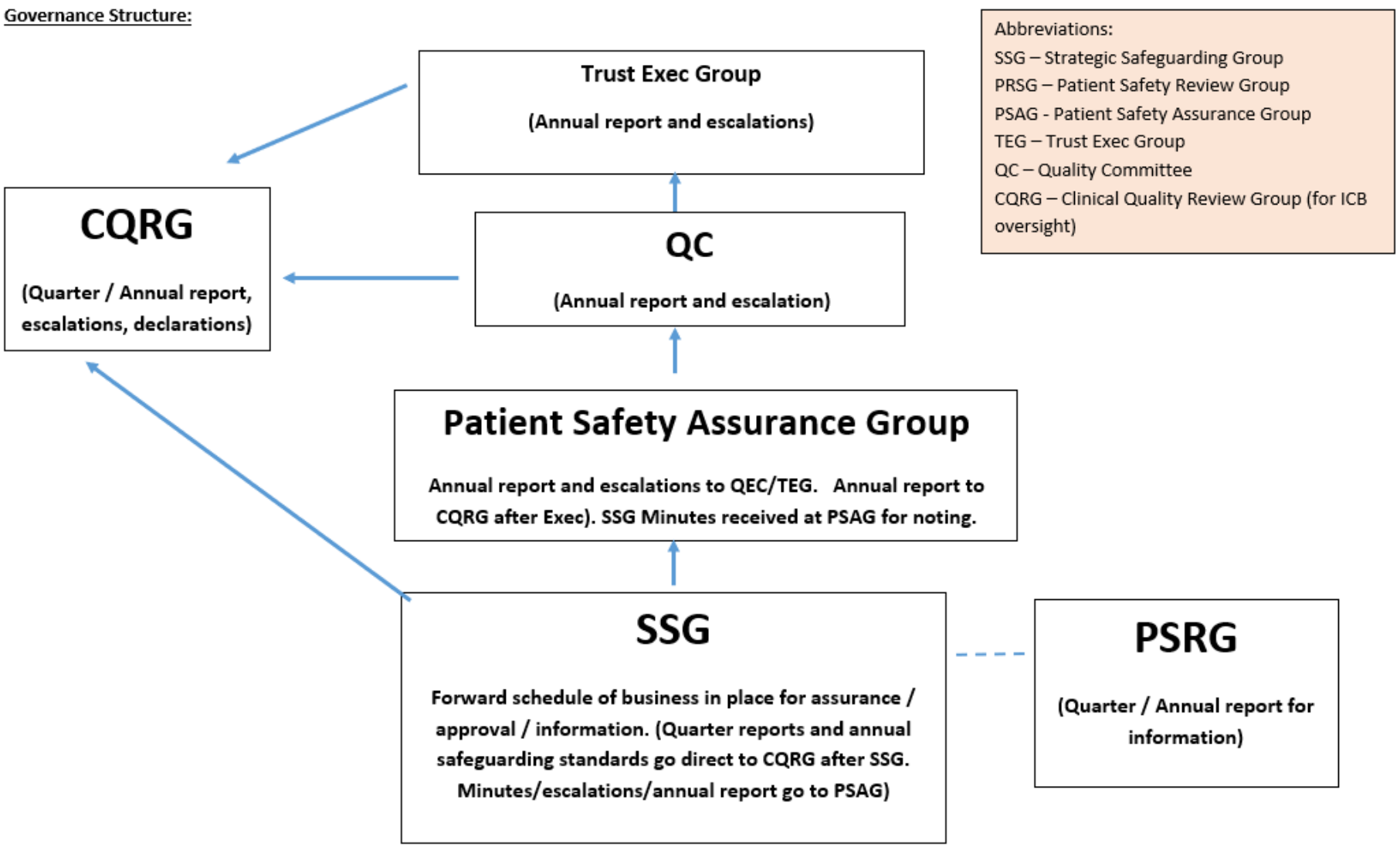


Figure 1 and 1.1 illustrate clear lines of accountability for safeguarding governance within DBTH. During this year the team structure and Strategic Safeguarding Group (SSG) membership have remained stable, supporting continuity of oversight and accountability. The SSG remains the Trust's principal forum for the scrutiny and coordination of safeguarding information, with divisional and ICB representation supporting

triangulation of performance, risk, audit, training and workplan delivery. Appendix 1 provides an overview of scheduled business discussed throughout the reporting year, Appendix 2 provides a year-end summary of the safeguarding work plan, and Appendix 3 provides details of the current safeguarding team members. Taken together, this governance framework provides strong assurance that safeguarding responsibilities are clearly allocated, subject to routine scrutiny and supported by defined mechanisms for escalation and oversight.

4. Overview of Safeguarding Activity:

A key indicator of safeguarding activity is the number of referrals made by Trust colleagues to social care in relation to unborn babies, children and adults.

5. Safeguarding Referrals:

Figure 2: highlights the number of referrals made to social care, where abuse or harm was identified relating to patients accessing DBTH services:

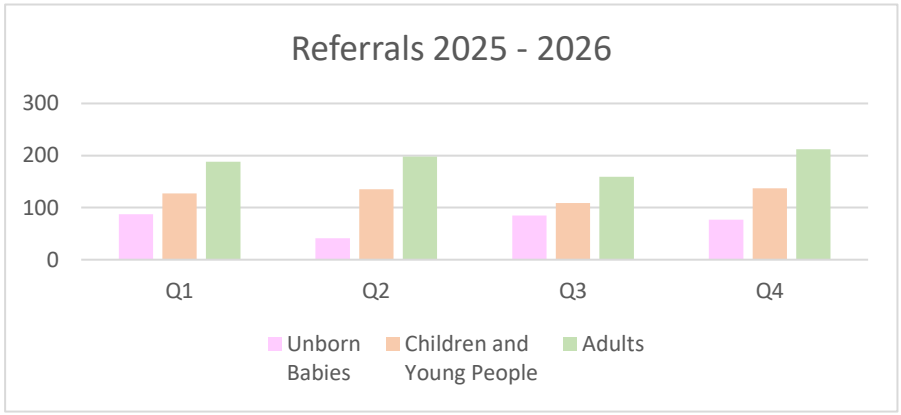


Figure 3: Highlighted comparison referral figures from the previous reporting year.

	Unborn Babies	Children and Young People	Adults
Q1	87	127	188
Q2	41	135	198
Q3	85	109	159
Q4	77	137	212
Total 2025 - 2026	**290**	**508**	**757**
Comparison to 2024 - 2025	**191**	**452**	**504**

The data in **Figure 2 and 3** demonstrate a significant increase in safeguarding referral activity across all areas during this reporting year. Compared with the previous year, unborn referrals increased by 51.8% (from 191 to 290), children and young people referrals increased by

12.4% (from 452 to 508), and adult referrals increased by 50.2% (from 504 to 757). In total, safeguarding referral activity across the Trust increased by 35.6% (from 1,147 to 1,555 referrals). When viewed alongside continued safeguarding liaison meetings, divisional engagement and improved training compliance, this increase provides assurance of improved recognition, professional curiosity and escalation of safeguarding concerns across the workforce, rather than a passive increase in activity alone.

6. Deprivation of Liberty Safeguards (DOLS):

Figure 4: Deprivation of Liberty Safeguard (DOLS) Applications submitted

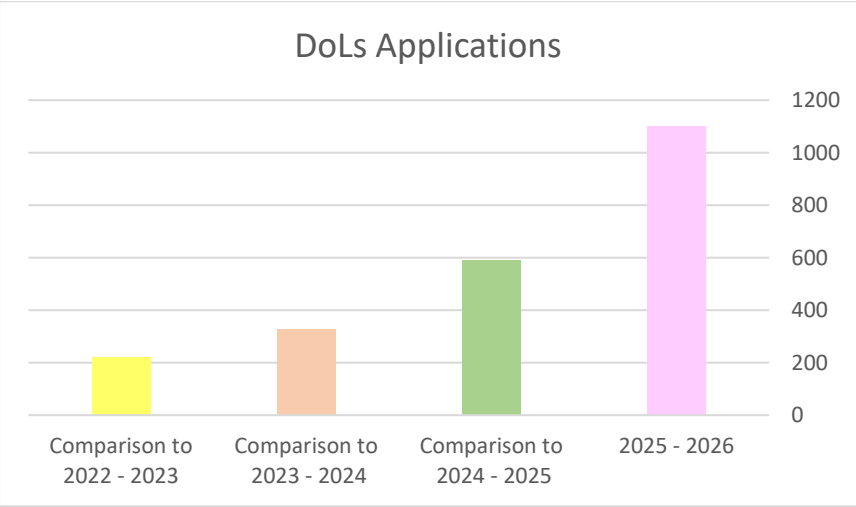


Figure 5: DOLS breakdown by reporting Quarter 2025 - 2026

2025 - 2026	DoLs applications
Q1	270
Q2	261
Q3	272
Q4	299
2025 - 2026	**1102**
Comparison to 2024 - 2025	**589**
Comparison to 2023 - 2024	**326**
Comparison to 2022 - 2023	**222**

The data in **Figures 4 and 5** enable comparison of DoLS activity across recent reporting years (2022–2025) and demonstrate a continued upward trajectory, with applications increasing from 222 in 2022–2023, to 326 in 2023–2024, 589 in 2024–2025 and 1,102 during this reporting period. This represents an 87% increase compared with 2024–2025 and provides assurance that awareness of deprivation of liberty and the need for legal safeguards is becoming more consistently recognised across clinical areas.

The established MCA/DoLS specialist resource has continued to support colleagues through guidance, resources, training and bespoke support. This strengthening of internal expertise provides reasonable assurance that the Trust is improving its ability to identify, evidence and progress DoLS applications appropriately. However, as reflected elsewhere in the report and on the Trust risk register, full assurance remains dependent on further embedding of MCA/DoLS practice and consistent compliance across all services.

Figure 6: Number of DoLS standard applications authorised by the Local Authority 2025 - 2026

2025 - 2026	DoLS Standard applications authorised by local Authority
Q1	1
Q2	4
Q3	1
Q4	1
Total	**7**

The above data in **Figure 6** evidences the number of DoLS standard applications that were authorised by the relevant Local Authorities in this reporting year. An established working relationship and escalation process has been formed with our Local Authorities to ensure our patients who are significantly restricted of their liberties or are objecting to their hospital stay have urgent oversight of the Local Authority and are consulted about the need for a priority assessment by a Best Interest Assessor and Section 12 Doctor. There has been a 40% increase in the number of authorised standard applications in this reporting year, but the numbers remain low, with the increase from 5 in 2024-2025 to 7 in this reporting year. There is national recognition that local authority authorisations remain low.

7. Mental Capacity Act (2005): Embedding the framework:

During 2025–2026, the Trust continued to strengthen its approach to the Mental Capacity Act and Deprivation of Liberty Safeguards through governance, workforce development, quality assurance and specialist support. This work provides assurance of improving organisational capability and a stronger focus on legal compliance and patient-centred decision-making.

Here is a summary of key activity and workstreams:

- Trust Safeguarding resources have been strengthened to support an increased focus on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), enabling colleagues across the Trust to meet their responsibilities and legal duties.
- The team's DoLS data collection matrix has been redesigned to enhance monitoring of applications received and to identify trends in requests for further information, documentation or clarification from ward areas. This is in addition to the ongoing collection of patient demographics, ward area, date of receipt, date forwarded to the relevant local authority, extension activity and CQC notification. The matrix also allows the Trust Safeguarding team to highlight actions required by themselves.
- Work has continued to raise the profile of the MCA-related tools and information available within NerveCentre to support ward teams in identifying when MCA processes may be required. These include the DoLS flag, uploading of relevant documentation (Mental Capacity Assessment and DoLS forms), and the safeguarding narrative box, which enables relevant information to be recorded to support patient care and allows colleagues to identify MCA specialist involvement at a glance.
- The Daily Mental Capacity Assessment within NerveCentre has been updated to strengthen the quality of narrative recording. The assessment has also been adapted to support consideration and assessment for DoLS, following feedback and requests from ward colleagues.
- The MCA Trust Forum has now become embedded within Trust governance arrangements. The inaugural forum commenced in June 2024 and is now an established bi-monthly forum for Trust colleagues. It provides a platform for sharing national and local MCA developments, alongside updates on Trust workstreams. The forum also provides an opportunity for the Safeguarding team to hear concerns, ideas and operational feedback from colleagues responsible for implementing MCA, helping to ensure workstreams remain meaningful, achievable and responsive to service need. Good practice and shared learning are promoted through regular guest speakers. Divisions also present highlight reports outlining local achievements and progress in embedding MCA within their areas. Key themes and updates from the forum are escalated to the Strategic Safeguarding Group through an overarching highlight report.
- Safeguarding HIVE resources continue to be reviewed and restructured to improve accessibility for Trust colleagues. This has enhanced access to relevant forms, policies, 7-minute briefings and other key resources that support understanding and practice. Contact details for the Trust Safeguarding team have also been clearly signposted to support timely access to advice and guidance.
- Strong collaborative working has continued across key roles within DBTH. The Named Nurse and Nurse Specialist for MCA/DoLS have worked alongside other safeguarding leads, including the Named Professional for Safety in Caring, Learning Disability Nurse Specialists, Transfer of Care, the Drug and Alcohol Team, Mental Health Teams and divisional colleagues. This collaborative approach has supported delivery of bespoke training, assistance with assessments and practical support to colleagues caring for patients, helping to ensure the Mental Capacity Act is appropriately applied and evidenced within Trust processes.
- Regular attendance at complex case meetings has continued, providing specialist MCA support for patients within Care of the Elderly services who present with complex needs and high levels of vulnerability.
- Ongoing support has been provided in relation to best interest processes and best interest meetings across the Trust.

- The Named Nurse has achieved the Best Interest Assessor qualification, strengthening the Trust's internal expertise and helping to ensure local arrangements remain current, legally robust and informed by current case law and national guidance.
- A quality improvement project is ongoing within the Emergency Department to support the embedding of MCA from the earliest stage of the patient journey. Consideration of mental capacity is now incorporated within the triage assessment process.
- A screening question around 'concerns regarding capacity' has been included in the ED triage assessment.
- A revised audit tool has been introduced to review both the incidence and quality of MCA and DoLS documentation. This tool has been used as part of the quarterly audit programme for 2025 – 2026 to strengthen assurance and identify themes for further improvement.
- Training continues to be supported through e-Learning for Healthcare (eLfH) modules, in line with national guidance. In addition, bespoke training is widely utilised across the Trust to support area-specific learning and strengthen understanding of how MCA should be applied within particular clinical settings and fields of practice.
- MCA proformas are now available within NerveCentre, following direct requests from frontline staff to improve accessibility and support timely completion of MCA documentation.
- MCA-specific questions continue to feature within the weekly Tendable ward-based audits. These include prompts relating to the five principles of the Mental Capacity Act and the actions colleagues should take when a patient's capacity is in doubt.
- MCA-focused questions have also been incorporated into the Trust's Care Accreditation process, further strengthening organisational assurance and promoting consistent application of MCA principles across clinical areas.
- A year-long Trust Quality Priority focusing on MCA practice was established for 2025 – 2026, complementing existing safeguarding workstreams. This priority has contributed to reducing the Trust's significant risk score relating to MCA practice from 15 to 12.
- The MCA lead has contributed to Trust-wide learning and governance through attendance at Grand Round, including a joint session with the Trust Solicitor to clarify thresholds for involving legal services. Attendance at divisional governance meetings has also supported the sharing of good practice and learning across the organisation.
- A Trust Lead physician and ED physician have been appointed to support with the endorsement MCA projects and workstreams.
- A patient and family information leaflet has been developed to enhance the quality and consistency of information provided when a patient is subject to a DoLS authorisation. The leaflet is intended to promote transparency regarding identified restrictions and deprivation, while also facilitating open discussions between patients, families, carers and Trust colleagues.

8. Allegations against the Trust:

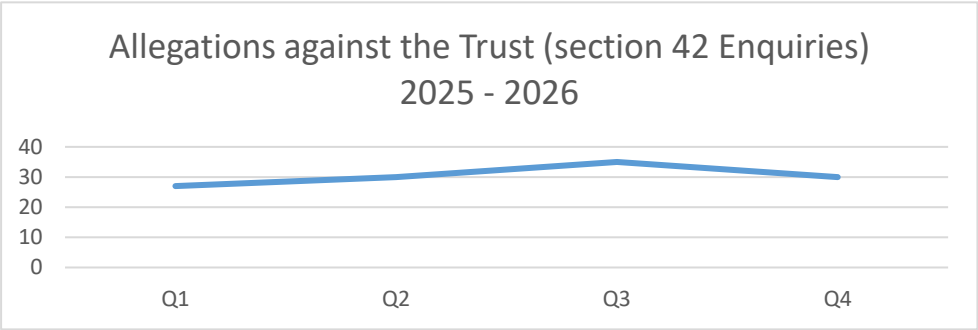
Allegations against the Trust are received centrally via the safeguarding team and recorded on DATIX. Concerns are investigated where appropriate or directed to the relevant division for response, with completed outcomes returned to the Local Authority, including any actions taken and learning identified.

Responses are returned to the Local Authority on completion with a clear outline of what actions have been taken by the Trust. Where allegations are substantiated, this may also include sharing any learning identified and how this will be embedded as part of the process.

During this reporting period, focused work has been undertaken to strengthen and embed the process for managing allegations (see Appendix 4). This has included incorporating allegations management into level 3 safeguarding training, providing ad hoc support to colleagues completing responses, and embedding an internal escalation pathway with monthly divisional reporting for oversight of open cases, including those carried over from previous quarters. These arrangements provide assurance that allegations are subject to clearer oversight, improved timeliness and more consistent escalation where responses are delayed, outstanding or require further action to secure learning and resolution.

The number of allegations, along with the top three recurring themes, continue to be reported within the Trust Safeguarding Quarterly Report (see Appendix 5).

Figure 7: provides details of allegations against the Trust that have been received for 2025 - 2026



	2025 - 2026	2024 - 2025
Q1	27	33
Q2	30	31
Q3	35	30
Q4	30	35
Total	**122**	**129**

Positively the above data in **Figure 7** indicates a 5% decrease in the number of allegations against the Trust that were received in this reporting year.

During this reporting year, the predominant themes have remained consistent, with concerns most frequently relating to discharge processes, neglect, and medication management.

Significant work has been undertaken in collaboration with the DBTH Discharge Team to support improvements in discharge practices across the Trust. This programme of work has now been completed, and the discharge checklist has been successfully implemented within Nerve Centre and is now live for colleagues to use.

It is anticipated that these enhancements will contribute to a reduction in concerns relating to discharge. More importantly, they strengthen the control environment around discharge practice and provide reasonable assurance that the Trust is responding to recurrent themes through targeted system improvement, with the intention of improving patient safety, experience and overall quality of care.

9. Domestic Abuse:

During this reporting year, the Domestic Abuse Liaison Service expanded to provide a mirrored service at Bassetlaw Hospital. This increased the number of people supported to 576, of whom 37 were repeat attendances by survivors who felt sufficiently safe and supported to disclose further abuse to DBTH colleagues. Of the 539 new disclosures, 109 resulted in referral to a Multi-Agency Risk Assessment Conference (MARAC) because the level of risk was assessed as high. The remaining disclosures were signposted or referred to relevant community services, including domestic abuse services, adult and children's social care, mental health services, fire services and substance use services. Collectively, this provides assurance that the Trust is strengthening its capacity to identify, respond to and appropriately escalate domestic abuse disclosures across its sites.

The Domestic Abuse Liaison Officers have retained 399 trained champions across the Trust. This network strengthens workforce capability by improving confidence in recognising abuse, asking sensitive questions and escalating concerns appropriately, supported by regular update briefings and expert input.

In addition to supporting disclosures, the Domestic Abuse Liaison Officers have led a number of initiatives to strengthen the Trust response and improve staff and patient safety.

- **Out of hours DA grab packs**: by working collaboratively with the Expert by Experience Survivor Liaison service, a new resource for out of hour DA attendances/disclosures has been launched in the DRI emergency department. The packs contain support for the member of staff (pathways, flowcharts, processes) and for the victim/survivor (leaflets, helplines, signposting).



- **Personalised Safety Plan:** A Manager's Tool – Knowing that statistically domestic abuse affects 1 in 4 women and 1 in 6 men during their lifetime, we recognise this means a significant proportion of our DBTH workforce may be impacted personally. To help keep our colleagues safe, we've introduced a Personalised Safety Plan. We recognise that risks linked to domestic abuse can extend into the workplace, and this tool is designed to address those risks. It provides tailored safety interventions so staff can continue working in a safe and supportive environment. Each plan is customised to the individual's circumstances, focusing on the specific risk factors they face.
- **Public protection alerts**: Through MARAC, we receive intelligence from the police regarding risks not only to the victim/survivor, but also to the wider public. This includes concerns such as assaults on emergency workers and the carrying of weapons. In response, we have developed alerts that are applied to electronic patient records to inform colleagues of potential risks. To avoid judgmental language, the alert is worded neutrally and simply states: "Do not see this person alone."
- **16 days of activism**: Social media campaign with the 2025 theme of tech facilitated abuse, below is an infographic view of some of the briefing shared out in the Trust during this time:

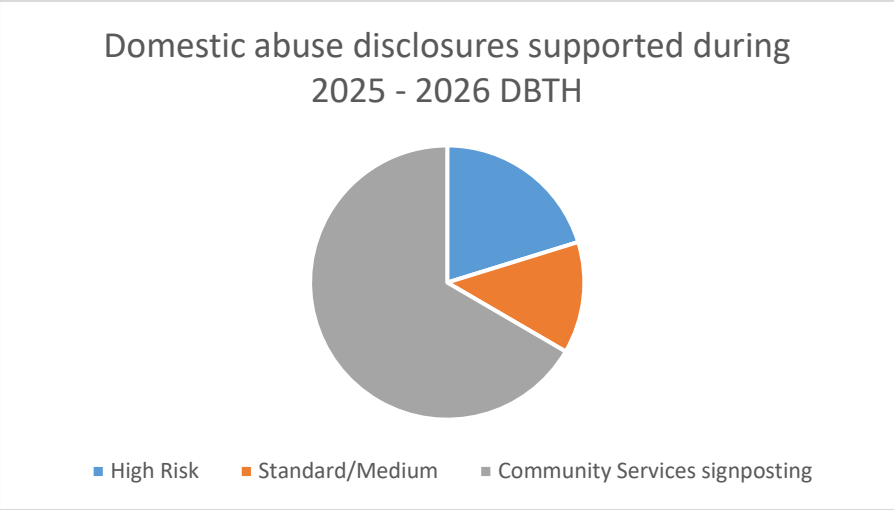


Looking forward to the future the DA officers have set their sights on common themes highlighted in the Violence Against Women and Girls (VAWG) strategy and DHR/DARDR recommendations. These include:

- Promoting the DA Commissioner's Victims in their own Right report and government recommendations, for comprehensive, specialist training for all frontline professionals who work with babies, children and young people, the team are planning to expand domestic abuse training across maternity and children's services.
- In its annual report, the Domestic Homicide Project has recorded an increase of 85 deaths from the previous year, of which most are suspected suicides following domestic abuse. Frontline agencies must do more to recognise the signs of domestic abuse, especially when combined with mental health crises. With key learnings from DHRS, we are planning to embed learning and to work in collaboration with our mental health service providers.

- Domestic Homicide Reviews (DHRs) have highlighted significant, recurring themes regarding the intersection of substance misuse and domestic abuse. Key learning focuses on the need for trauma-informed care, enhanced professional curiosity, and integrated support services. Our intention is to embed the learnings.
- To strengthen oversight and patient safety, we are developing a reporting process to identify any out-of-hours attendances by known high-risk victims/survivors across DBTH sites. This will enable review and audit of those attendances, ensuring safe practice, appropriate support and safeguarding responses are consistently offered.
- Taken together, the work outlined above provides reasonable assurance that the Trust has significantly strengthened its domestic abuse response, while recognising that further embedding is required in relation to out-of-hours assurance and continued thematic learning.

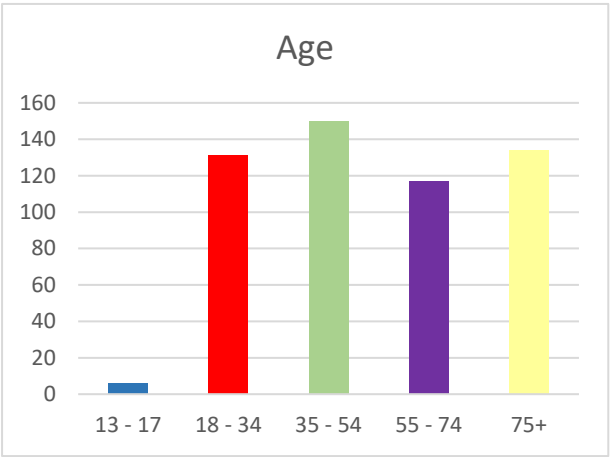
Figure 8: indicates the number of people supported by DBTHs Domestic Abuse (DA) liaison officers (539 in total during 2025-2026)

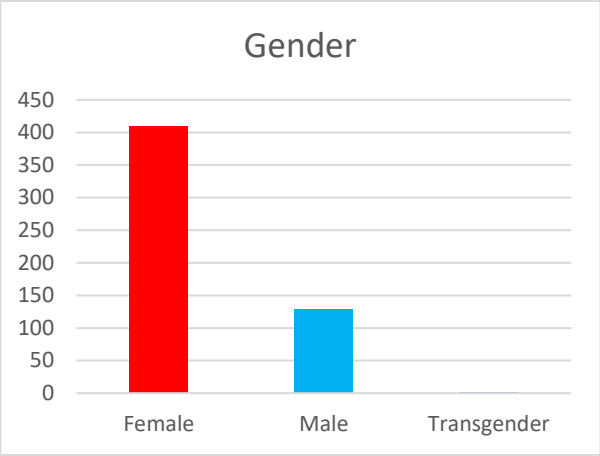


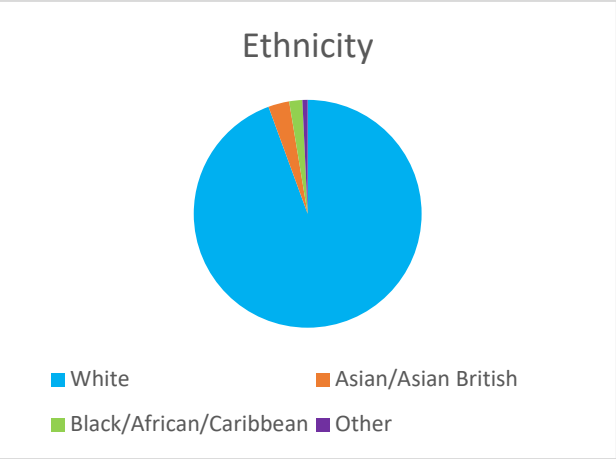
All crimes that are disclosed by patients are reported to the police, in total we made 131 referrals.

The above data in **Figure 8** shows an 85.9% increase in comparison to the number of referrals received in 2024 – 2025 (290). Work is progressing in the year ahead to ensure any out of hour's disclosures are captured more robustly and patients are consistently supported to disclose their experiences.

Figure 9: The below charts break the data down in terms of Age, Gender and Ethnicity.







The above date in **Figure 9** indicates a change in categories of highest prevalence. In this reporting year the highest age bracket was 35-54 years, however in 2024 – 2025 the highest age bracket for disclosures at DBTH was the 18 - 34 years bracket. In comparison to National data female disclosures still remain significantly higher than males. However it is positive to note an increase in male disclosures in this reporting year (going from 57 in 2024 – 2025 to 129 in 2025 – 2026, a 126% increase).

10. **Safeguarding Policy updates:** During the year, key safeguarding policies were reviewed or implemented to strengthen the Trust control framework.

- FII Policy (new policy)
- Sexual Safety Policy (updated)
- Domestic Abuse Policy (updated)
- Chaperone Policy (updated)

In addition, the safeguarding team developed a number of Standard Operating Procedures to support consistent operational practice. All SOPs are approved through the Strategic Safeguarding Group.

- **Nerve Centre checks for 16-17 year olds:** this outlines daily safeguarding checks to adult wards where 16/17 year olds may be placed

- **Children and Unborn referrals to Children's Social Care:** this outlines the process of referrals to Social care
- **SERAC:** (Slavery Exploitation Risk Assessment Conference) – this outlines the process of contribution to Notts SERAC meetings
- **Realtime Surveillance:** this outlines the process of contribution to information requests for deaths related to suicide, drugs or alcohol
- **MARAC Research Alerts:** this outlines the process of contribution to the MARAC process
- **Adult Referrals:** this outlines the process of referrals to Social care
- **Pregnancy Liaison Meetings:** this outlines the process of referrals to the Pregnancy Liaison Meeting
- **MAPPA:** this outlines the process for patients at our Trust that are managed by multi-agency public protection arrangements
- **Allegations against the Trust:** this outlines how we respond to concerns raised by the Local Authority
- **Known Child Exploitation Alerts:** this outlines how alerts are applied to clinical records to share known risk notification on exploitation
- **High Intensity User Group:** this outlines how the Safeguarding team contributes and supports the Trust HIUG.
- **Interim Care Order:** this outlines Trust roles in supporting the Local Authority when they are seeking a legal order following birth
- **Processing a Domestic Abuse Datix:** this outline the Trust process of progressing a DA referral via Datix
- **Hospital Acquired Pressure Ulcer:** this outlines the safeguarding responsibility for sharing relevant HAPU information with the local authority in line with National guidance.

11. Safeguarding Audit activity:

Safeguarding questions continued to feature within weekly divisional Tendable audits. In addition, a number of focused safeguarding audits were completed during the year to test compliance, identify themes and inform targeted improvement work.

- **MCA documentation:** (quarterly audit) to review the incidence and quality of documentation relating to MCA processes: results show marked improvements in both the frequency and incidence of evidence. Results show further work is needed to evidence consistent and robust compliance, plans for improvement are outlined in the 2026 - 2027 Safeguarding work plan.
- **DoLS returns:** Audit to review common themes and reasons for DoLS being returned to ward areas for further action, and to review time scales between deprivations being identified and DoLS document being forwarded to local authority. Results showed support is needed for ward areas in submitting forms in Word format, along with key ward areas where further learning is needed around DoLS completion. This work is outlined in the 2026-27 work plan.
- **Domestic Abuse – out of hours**: Following the reaudit, there is evidence of improvement in the management of out-of-hours domestic abuse disclosures. Patients are more consistently provided with appropriate resources, and referrals are being completed with greater robustness to inform the DASH risk assessments. Ongoing work will continue in collaboration with the Emergency Department colleagues and Domestic Abuse Liaison Officers to further embed and sustain these improvements.
- **FGM Audit:** This audit was presented at SSG in September 2025 and indicated that safeguarding processes for FGM in maternity services were being followed consistently.

- **Under 18 Stabbing and Sharp injury:** This focused on ED attendances for patients under 18 years who have had an injury method recorded as sharp injury. The outcome of the quarterly audits indicated that children and young people were safeguarded, learning in relation to record keeping and curiosity when supporting 16/17 year olds that may present in adult workstreams.
- **Mechanism of Injury documentation in emergency departments:** This audit was undertaken following a local safeguarding practice review which highlighted the importance of clear documentation of the mechanism of injury in Emergency departments, the outcome indicated 80% of cases audited has this clearly on discharge summaries, the remainder had clear mechanism of injury in the child's clinical record.

In addition to Trust audits the team continue to contribute to Multi-agency audits:

- **Multi**-agency audit Domestic Abuse (Children)

12. Promotion of the H.O.P.E Boxes:

DBTH Charity has continued to support the rollout of H.O.P.E. boxes across the Trust. This work has helped embed a trauma-informed resource to support families experiencing loss, trauma or separation. ('H.O.P.E: Hold on Pain Eases')

HOPE boxes support families by providing tangible connections to a baby and the memories created, which can be especially important during times of loss, trauma, or separation. The inclusion of comforting and familiar items, such as baby tags, a milestone book, and photographs, helps families to acknowledge their experiences, preserve meaningful moments, and validate their relationship with their baby. These items can offer ongoing comfort, encourage reflection, and support emotional processing, helping individuals and families navigate grief and begin to heal in their own time.

The Safeguarding Midwife has played a key role in supporting ward colleagues with the provision of HOPE boxes, ensuring they are used appropriately and sensitively within a trauma-informed framework. They provide guidance and advice to colleagues caring for women experiencing separation from their babies, helping teams to recognise when a HOPE box may offer meaningful support. This includes raising awareness of the emotional impact of separation, promoting compassionate communication, and ensuring that the boxes are introduced in a way that respects each individual's circumstances.

During the reporting year, 12 HOPE box sets were provided to support mothers experiencing separation from their babies. These boxes were distributed with care and sensitivity by ward staff.

13. Pregnancy Liaison Meetings (PLM):

The Pregnancy Liaison Meeting process was reviewed during the year and is now aligned across Doncaster and Bassetlaw. This strengthens the multi-agency approach to early risk identification, planning and coordinated support.

To support this a PLM SOP was developed and approved to assist in a clear outline on Trust processes.

In Doncaster we have a new representative from Early help services which has streamlined the early help referrals, therefore increasing the referrals and uptake of services. The PLM aligns with the social care reforms as part of the family first partnership and also with the early help practice framework.

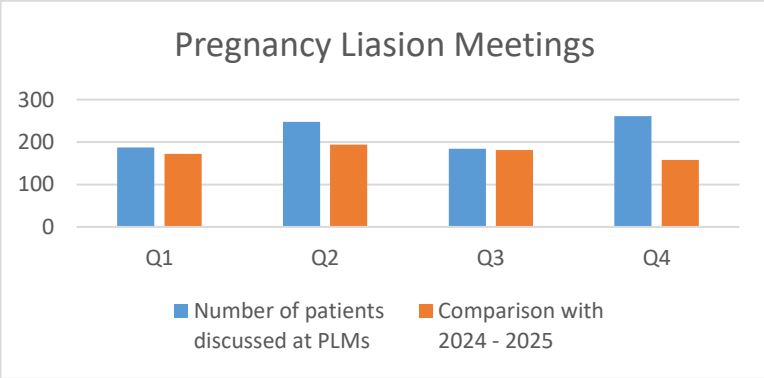
There will be further partnership opportunities to discuss how PLMs fit as part of the Family First Partnership as this new year progresses, in relation to supporting families early in their journey.

The numbers discussed at PLM remains high meaning the meetings for Doncaster have now been increased to Bi-Monthly while Bassetlaw remains a monthly meeting.

Figure 10: shows the number of PLMs completed during this reporting year, noting an overall 24.8% increase from the comparative 2024 – 2025 figures.

2025 - 2026	Number of patients discussed at PLMs	Comparison with 2024 - 2025
Q1	187	172
Q2	248	194
Q3	184	181
Q4	261	158
Total	**880**	**705**

Figure 11: Highlights the number of patients discussed in PLMs.



14. Female Genital Mutilation (FGM)

A review of multi-agency FGM processes in Doncaster has now been completed. All FGM notifications in maternity are supported by a full risk assessment at 16 weeks and information sharing with MASH to enable multi-agency consideration of risk.

The Shamso clinic guidelines were completed in August 2025 and the process is becoming embedded to support any woman who has been a victim of FGM. The Named Midwife for safeguarding has worked in collaboration with the Head of Equity, Equality & Inclusivity for maternity services to ensure processes were developed and colleagues informed. Training remains ongoing to keep the focus on FGM as part of mandatory training, 1-1 and bespoke support and development of 7 minute briefings to further support the workforce.

In this reporting period the number of FGM risk assessments completed has increased from 26 in the previous annual report to 60.

A FGM Audit was completed by the Named Midwives for safeguarding and this showed that the safeguarding process in maternity services is being followed consistently, with strong oversight ensuring full compliance with national standards. All the recorded standards were achieved with 100% compliance. This included the activation of the FGM-IS alert on the national care records for female infants identified to be at risk of FGM.

The Audit was presented at the Strategic Safeguarding Group and also the quality and performance group at Doncaster Safeguarding Children's Partnership.

Figure 12: The table indicates the FGM Trust data for this reporting year and comparison with 2024 – 2025 annual report data.

2025 - 2026	Number of FGM notifications(adults)	Comparison with 2024 - 2025
Q1	15	19
Q2	13	14
Q3	18	19
Q4	14	14
Total	**60**	**66**

15. Safeguarding liaison meetings (SLMs):

The safeguarding team continues to contribute to Safeguarding Liaison Meetings, which provide a structured forum to discuss emerging concerns, review cases and offer specialist advice to frontline teams.

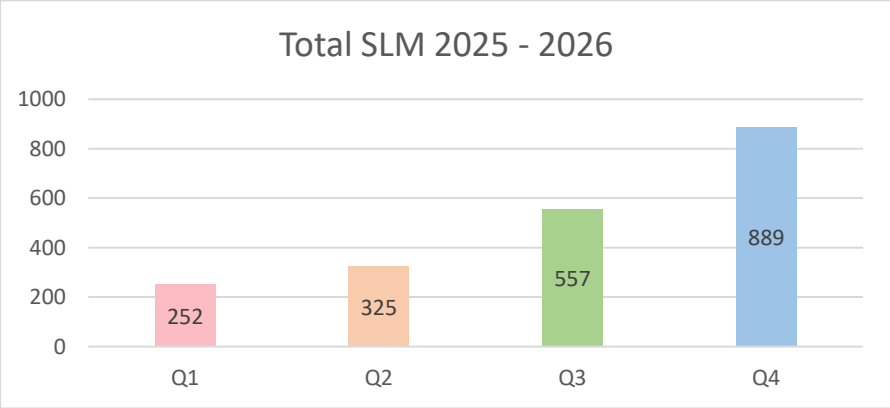
These forums offer an opportunity for robust risk assessment, the provision of expert advice, and meaningful discussion, while also ensuring that the patient's voice is considered and captured within the decision-making process

Across the DBTH footprint for all ages (Maternity, Paediatrics and Adults) there has been a total of 2023 SLMs undertaken over the reporting year.

The SLM meetings in Maternity are carried out in person and by telephone to all ward areas. Any current in-patients are discussed and advice/support given to staff on duty. It is also an opportunity to share safeguarding messages and short training sessions. It can also facilitate safeguarding supervision sessions where needed. It raises our profile in the maternity areas reminding staff where we are and what we can help with. We can also give advice to staff around safeguarding training and support in advising around discharge and pre-birth plans.

SLMs for adult and paediatric areas also take place in person.

Figure 13: Indicates the total number of SLMs.



16. Child Protection Information Sharing (CP-IS)

Child Protection Information Sharing is a nationally mandated alert system overseen by NHS England and ICBs. Implementation is being progressed through Phase 1 and Phase 2, with Trust oversight in place through safeguarding governance arrangements.

In 'Phase 1', CP-IS enables automatic alerts from a health setting to be sent to the local authority when a child subject to a **Child Protection Plan** or a **Looked After Child (LAC)** attends for unscheduled care. This provides the Local Authority responsible for safeguarding the child with awareness of where they are presenting for unscheduled health care and provides health settings with a mechanism to understand known risks for a child that may be relevant to clinical decision making and the safeguarding of a child. This is a central mechanism for collaboration on safeguarding some of our most at risk children.

The aim being that alerts should be viewed in real time to support clinical decision-making around risk and provide a mechanism for an automatic notification to be sent to the relevant local authority, which is activated when the CP-IS alert is 'viewed' by the health setting.

'Phase 1' is implemented across the following 'unscheduled' DBTH areas:

- Emergency Department (ED)
- Maternity Triage
- Minor Injury Units (MIU)
- Paediatric Assessment Areas

Current Challenges

DBTH is not yet achieving consistent organisation-wide compliance at Phase 1 due to digital system limitations and reliance on manual checks via National Care Record Service. Key gaps include:

- Alerts in ED not being viewed consistently, missing opportunities to be risk aware and provide notification to local authorities
- Inconsistent CP-IS checks across Paediatrics
- Variable use of CP-IS alerts to inform safeguarding assessment / decision making
- Smartcard permissions aligned incorrectly

As a result of the above factors, CP-IS remains on the Trust Risk Register. Compliance data is reviewed at the Strategic Safeguarding Group, although consistent reporting still requires strengthening.

Expansion – Phase 2 (Scheduled Care)

Phase 2 is to extend CP-IS into areas of scheduled care. Those being:

- Children's Outpatients (March 2026)
- Children's Dentistry (March 2026)
- Termination of Pregnancy Services (March 2026)
- All NHS-funded services seeing children/young people by September 2026, including pathways where young people attend adult services

Phase 2 will allow access to wider health settings to view the alert with the mechanism to inform risk-based decision-making. This phase will not send automatic notifications to local authorities but provides health settings with information that support enhanced awareness of risk (related to the child) and the consideration on clinical decision making and safeguarding processes that may be required for the child.

DBTH has begun scoping digital and operational requirements with support from Digital Services, Project Management and quality improvement support, and identification of clinical leads in the relevant areas.

The Safeguarding Children Team have provided briefings and information updates throughout the rollout processes.

The ICB is overseeing progress and reporting to NHS England. Regionally, other Providers are experiencing similar challenges, with widespread acknowledgment that national timescales are ambitious.

Mitigations in Place at DBTH:

- Action plan in place to drive improvements in all areas
- Dedicated improvement plan in ED
- SOPs in place (Maternity/Paediatrics), with ED SOP to follow when digital issues resolved
- Increased distribution of smart cards to broaden access
- Increase in IT equipment in Paediatric areas to support system access issues
- Digital Teams and Project Management developing a plan to improve practice and drive a coordinated implementation across Trust areas
- Daily safeguarding reminders, targeted teaching, and 7-minute briefings from the Safeguarding Children Team

- Compliance requirements now included in divisional highlight reports that are presented at the Strategic Safeguarding Group (SSG)
- CP-IS remains on the Trust risk register, with oversight at SSG and escalation to the Patient Safety Assurance Group

17. Sexual Safety:

During this reporting period, the Sexual Safety Working Group has maintained oversight of the Trust's sexual safety programme, with clear governance and twice-yearly reporting into the Strategic Safeguarding Group.

Whilst the initial Sexual Safety Policy was published in June 2024, this was revised and updated to take into account the Worker Protection Act which came into effect in October 2024 and to include newly developed additional reporting methods; Version 2 of the policy was published in May 2025, with an important aspect of the policy retaining focus on the clear standards of behaviours.

Understanding Sexual Misconduct in the Workplace Training is assigned to all roles and must be undertaken by all colleagues every 3 years. Content is the adoption of the e-Learning for Health package and March 2026 shows 95.36% of colleagues have completed this.

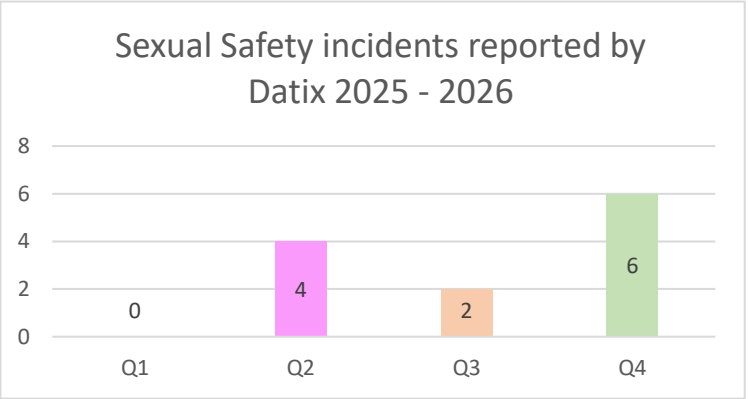
The SSWG have undertaken a review of the DBTH position against NHS England's **Sexual Safety Charter Assurance Framework** (see Appendix 6 for a summary position). Initial review scores full compliance against 7 of the 10 principles. 3 Principles RAG Rated 'Amber' due to identification of opportunities which can strengthen the position (amber areas being intersectionality, training/awareness and reporting mechanisms.) Actions are in place and progressing to develop this, these remain oversighted at the SSWG.

During this year we have changed the reporting approach. Any patient related incidents continue to be reported via Datix and reported in the Safeguarding quarterly report, whilst the introduction of the report and support form allows colleagues to raise concerns that they have experienced or witnessed; this form also allows for anonymous submission to HR. Any report and support submissions received by HR, are then considered for a screening advisory assessment meeting to consider any actions and assess risk factors. HR oversight data via casework report to the People Committee in terms of the numbers of concerns received.

Data is also oversighted at the SSWG with consideration to any developing themes and updates regarding learners, security incidents, complaints and Freedom to Speak up Guardians.

As a Trust we have also had the opportunity to support a national presentation at the Healthcare People Management Association in February 2026. The presentation outlined the DBTH journey at implementing the sexual safety charter as an acute health organisation. This presentation received positive recognition from the delegates, along with requests to share our Trust resources on Sexual Safety.

Figure 14: Indicates the number of Sexual Safety incidents reported via Datix, with patient involvement.



18. <u>Managing allegations: Person in Position of Trust (PiPoT</u>

The PiPoT policy was introduced on 1 April 2025 to strengthen the Trust framework for managing allegations about employees who may pose a safeguarding risk.

The PiPoT (Person in a Position of Trust) process is essential in ensuring that individuals working or volunteering within the Trust uphold the highest standards of professional conduct and safeguarding. It provides a structured approach to managing concerns about behaviour that may pose a risk to patients, colleagues, or the wider public, even where these concerns fall outside of criminal thresholds.

Effective implementation of the PiPoT process has had a positive engagement from all areas of the Trust, including clinical, operational, and corporate services, and has ensured timely information sharing, appropriate risk assessments, and coordinated decision-making.
A culture of openness, transparency, and shared responsibility has been key, enabling colleagues to feel confident in raising concerns and supporting proportionate responses. Through collaborative working and strong leadership, the Trust can ensure that safeguarding remains a priority and that individuals in positions of trust are held to account in a fair, supportive and consistent manner.

There has been a total of 24 referrals throughout the reporting year. Analysis of the themes highlights that physical/domestic abuse (8 cases) and professional boundary concerns (6 cases) are the most prominent issues, indicating a continued need for strong safeguarding awareness and clear expectations. While less frequent, the presence of harassment (2 cases), indecent images (2 cases), and self-neglect (2 cases) still

reflects areas of concern that require vigilance and appropriate response pathways. The occurrence of child neglect (1 case) and sexual abuse (1 case), although lower in number, represent high-risk categories where early identification and robust intervention are critical due to the potential for significant harm. Overall, the range of themes demonstrates the breadth of safeguarding challenges within the Trust and reinforces the importance of a coordinated, proactive approach, underpinned by effective reporting, training and education, and multi-agency collaboration to ensure risks are identified and managed appropriately.

The PiPoT outcomes for the reporting period demonstrate a range of findings across cases. A total of seven cases were substantiated, where concerns were supported by evidence following review. Nine cases were unsubstantiated, indicating that there was insufficient evidence to confirm the concerns raised. Two cases were identified as false, where allegations were found to be unfounded. At the time of reporting, five cases remain open and are subject to ongoing investigation, with outcomes to be confirmed once enquiries are completed. One case was not progressed due to the panel deeming the thresholds had not been met.

Figure 15: Indicates the number of referrals received between 2025 - 2026

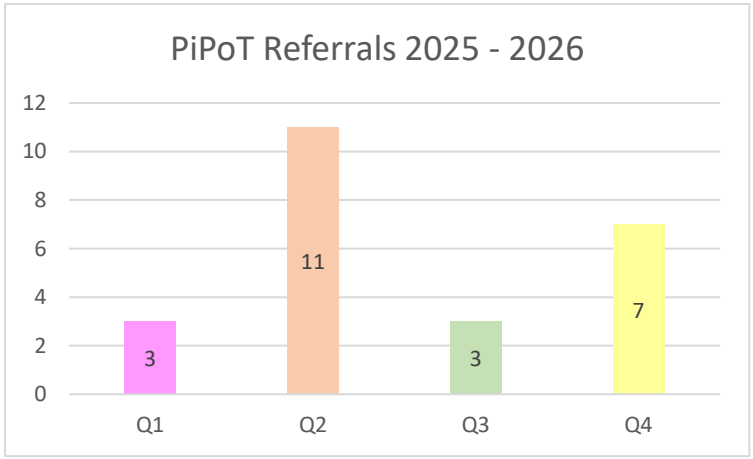
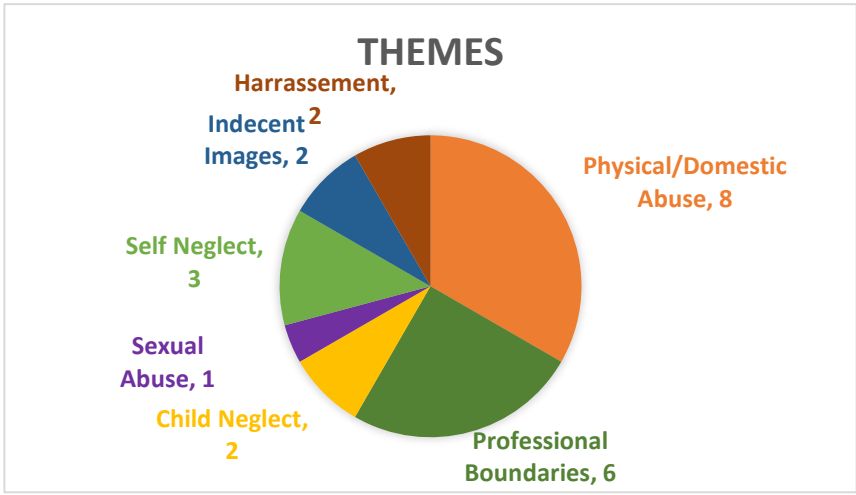


Figure 16: Shows the Themes from 2025 - 2026



19. **Self Neglect**

The Safeguarding Adults Team has continued to support colleagues to improve recognition of self-neglect and understand its association with complex life circumstances. This work is supported by collaboration with partner agencies to improve patient outcomes.

We are currently undertaking a Quality Improvement project to develop enhanced guidance on self-neglect which we anticipate will be helpful to colleagues around the trust. In addition, we have delivered a range of training sessions across the Trust, facilitated case review discussions within the Emergency Department, and circulated several "7-minute briefings." These have included topics such as the links between **Childhood Neglect and Self-Neglect in Adulthood**, and the **Relationship between Self-Neglect and Suicide.**

This wider programme of work demonstrates our commitment to safeguarding vulnerable individuals through a trauma-informed approach, ensuring that patients' views and wishes are respected and that they remain central to all aspects of care.

The Trust has also contributed to the Doncaster Safeguarding Adults Board Multi Agency Self-Neglect Audit in previous years, supporting ongoing efforts to strengthen practice and improve processes.

20. Good practice (gold standard safeguarding awards)

The Gold Standard Safeguarding Award continues to provide a valuable mechanism for recognising colleagues who demonstrate high-quality safeguarding practice.

- **April 2025 Award** presented to Abby Siddall (Midwife) - BDGH
- **May 2025 Award** presented to Umberto Piaggio (Paediatric Consultant) – DRI
- **June 2025 Award** presented to Kerri O'Halloran (Nurse ED) – DRI
- **July 2025 Award** presented to Fiona Squires & Carly Foster (Therapy Services) – DRI
- **August 2025 Award** presented to Emma Hill (Nurse) and Amy Marie Tucker (Doctor) ED – BDGH
- **September 2025 Award** presented to Natalie Glover (Midwife) – DRI
- **October 2025 Award** presented to Alice Brockwell (Lead Clinical Practitioner)– DRI
- **November 2025 Award** presented to Dr Duncan Drury (Vascular Surgeon) – DRI
- **December 2025 Award** presented to Rachael Lee (Nurse) ED – BDGH
- **January 2026 Award** presented to Esmee Cranston (Midwife) – DRI
- **February 2026 Award** presented to Luke Henfrey (Charge Nurse) ED - DRI
- **March 2026 Award** presented to Elliott Cleasby,(Physiotherapist) Todd Micklewaite (Physiotherapy Apprentice) and Tracy Higgins (Therapy Assistant) – DRI

In addition to the above Trust wide gold standard awards, the Safeguarding team were also nominated for the annual DBTH star award by the Director of Education and the Head of People Business Partners. Some key points from this nomination cited the team as showing outstanding commitment, professionalism and demonstrating a collaborative approach to supporting DBTH colleagues. It recognised the sensitive and emotionally challenging work that the team undertake with empathy, compassion and discretion. Exemplary leadership was highlighted along with the collective and significant advancements in safeguarding oversights, processes and systems around safeguarding.

Figure 17: The pictures below have captured some of the gold standard award presentations that have been shared on our Safeguarding social media page.



21. Safeguarding cases:

The team provides a quarterly case update to the Strategic Safeguarding Group covering ongoing child and adult safeguarding reviews, domestic homicides and other thematic safeguarding reviews across Doncaster and Bassetlaw.

The activity remains high and the safeguarding team have responded within timescales to all information requests in this reporting year. Specific learning for DBTH was indicated on a Child Learning review and whilst this did not meet the threshold for a multi-agency rapid review, the decision to undertake a multi-agency learning review supported identification of wider learning. Specifically for DBTH this focused on the use of Translation services and viewing pregnant people aged 16/17 years as a child in their own right, this was formulated in an action plan that was oversighted at SSG.

More generic learning themes that have been identified across the multi-agency has included the following themes:

- Self-Neglect
- Severe and multiple disadvantage
- Link between childhood neglect and self-neglect in adulthood
- Professional curiosity
- Sexual Abuse
- Emollient use and fire safety
- Mental health
- Substance use and impact on mental capacity

Learning that is identified is shared via divisional representatives who attend the SSG. Key themes are also incorporated into the DBTH Safeguarding training, safeguarding liaison meetings and work streams are developed to respond to any specific relevant areas and included on the annual safeguarding workplan.

The safeguarding quarterly reports track the ongoing number of new and ongoing safeguarding reviews and allegations against the Trust, see quarterly reports for this reporting year in Appendix 5.

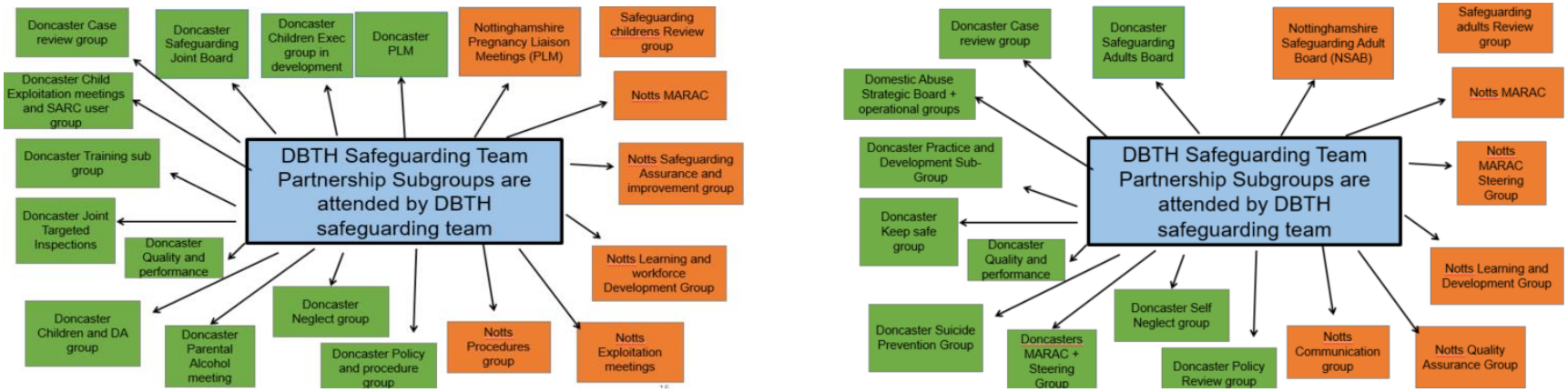
22. How we work with our partners:

During this reporting year, the team maintained representation at partnership safeguarding meetings across Doncaster and Nottinghamshire. This supports collaboration with local authorities, ICB colleagues and wider partner agencies and helps ensure shared ownership of safeguarding improvement.

The continued achievement of this is by:

1. Being able to challenge appropriately and hold one another to account
2. Early identification and analysis of emerging safeguarding risks
3. Learning being promoted, received and shared in a way that as an organisation we can become more up to date, regionally and nationally benchmarked, thus improving the way we safeguard our patients and families
4. Contribution and implementing actions within the Self Neglect Action Plan process.

Figure 18: Provides an overview of key children and adult multi-agency meetings that the safeguarding team actively contribute to *(this is not an exhaustive list)*



23. Risks

Safeguarding risks on the DATIX risk register continue to be reviewed by the Deputy Chief Nurse and Head of Safeguarding at the required frequency and are subject to quarterly scrutiny through the Strategic Safeguarding Group. At March 2026, three safeguarding risks remained open, compared with four in the previous year. The safeguarding capacity risk has closed following increased resource. The remaining open risks relate to safeguarding supervision, MCA/DoLS compliance and CP-IS compliance.

1. Safeguarding supervision (during this reporting period this risk has reduced from a grading of 9 to 6)
2. MCA and DOLS: compliance (during this reporting period this risk has reduced from a grading of 15 to 12)
3. Compliance with CP-IS (during this reporting period this risk has reduced from a grading of 12 to 9)

All open risks are supported by mitigating actions and active improvement plans. Progress is monitored through the safeguarding work plan and reviewed routinely at SSG. This provides reasonable assurance that risks are recognised, owned and actively managed; however, residual risk remains until planned improvements are fully embedded and sustained.

Figure 19: The table below provides clarity on Trust risk grading for context on the above risk position

Risk Grade	Frequency of review
Extreme 15+ risks	Monthly
High 8-12 risks	Bi-monthly or Quarterly
Moderate 4-6 risks	Annually
Low 1-3 risks	Annually

24. Training Compliance:

There has been continued focus on safeguarding training compliance and alignment of staff to the correct training level. During the year, Safeguarding Adults Level 3 was introduced and compliance reporting was expanded to include Mental Capacity, Safeguarding Supervision and Sexual Safety, strengthening oversight of workforce capability.

As a Trust we are in a strong position that roles are appropriately aligned, compliance has overarchingly been stable, with some continued focus on Level 3 Children's.

In the Trust, we will remain vigilant with safeguarding training as we recognise that a low compliance in safeguarding training, can correlate with colleagues having reduced safeguarding knowledge, which directly impacts on a reduced capacity to recognise and respond to safeguarding concerns. We also recognise wider mitigations to support safeguarding knowledge through a programme of bitesize adhoc sessions, learning and 7 minute briefs that are delivered as part of the safeguarding liaison meetings out in Trust areas. Trust acuity has at times impacted on safeguarding training but we continue to support areas with alternative ways to remain updated on safeguarding in order to continue keeping our patients safe.

Training compliance is reviewed quarterly at SSG and through divisional highlight reports, enabling formal oversight and escalation where standards are not met. Overall, the position provides reasonable assurance that safeguarding knowledge remains embedded across the organisation, although further improvement is required in relation to Level 1, Level 3 Children's and safeguarding supervision.

Of noting there has been a steady improvement on Mental Capacity training – this has allowed the impact of the MCA quality initiative to be demonstrated. Sexual safety training remains consistently on target and latterly there has been a noted decline in Level 1 training. The decline in the Level 1 training will be explored in the coming year but early reflections on the rationale for this has noted that the change may link to the change in the method of achieving compliance. Compliance was previously obtained via the Statutory and essential training - SET booklet which has now been changed with Level 1 compliance now achieved via completion of the National e-learning Level 1 Safeguarding training package. Additionally, there has been valuable feedback from learners that have compared experiences of training content from some of the other national packages to trust safeguarding face to face packages, the reflections have highlighted increased benefit and relevant content of training that is delivered by the Trust safeguarding team, which provides rich local learning from cases and a greater local (and national) context, in addition to rich reflective discussion during the sessions.

The supervision compliance will remain in focus, the process of confirming supervision completion to Education department is still being embedded and we have a noted lag on this information reflecting in the compliance data. Divisional highlight reports indicate a higher supervision compliance rate than is currently visible on our Trust compliance dashboard, this will be explored in the coming year.

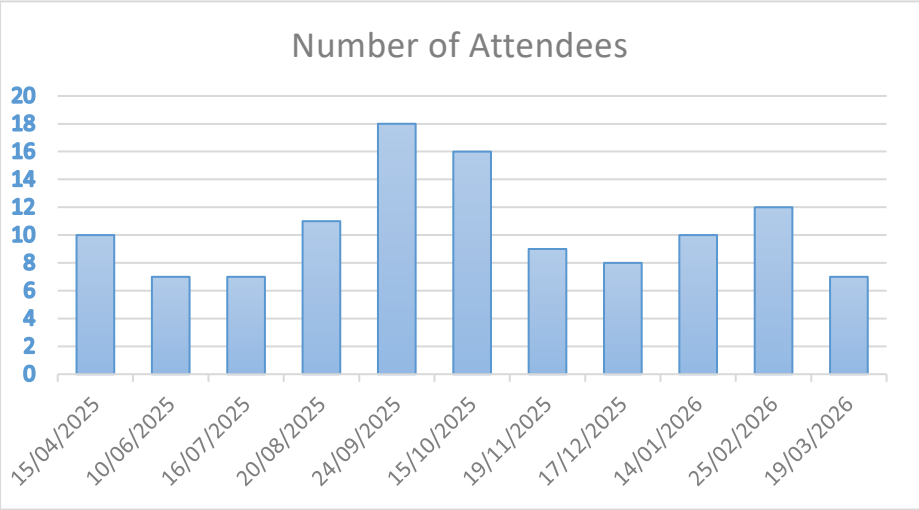
Figure 20: Provides monthly safeguarding training compliance % and highlights the year end position. New additions this reporting year being Safeguarding Adults (level 3), the split of Prevent (Basic and higher level), MCA, Sexual Safety and Supervision.

	Level 1 - Children	Level 2 – Children	Level 3 – Children	Level 4 – Children	Level 1 – Adult	Level 2 - Adult	Prevent	Basic Prevent	Sexual Safety	MCA/DoLS	Supervision
April 2025	95.02	93.61	84.93	77.78	95.03	93.83		96.64	90.63	80.04	
May 2025	94.96	92.47	85.36	88.89	94.97	92.61		95.79	91.28	81.42	
June 2025	94.80	93.26	84.27	100.00	94.81	93.77		96.34	92.70	82.14	
July 2025	94.25	93.31	83.77	100.00	94.18	93.77		95.80	93.54	83.39	
August 2025	93.61	93.35	82.76	100.00	93.68	93.66		95.68	93.99	84.07	3.91
September 2025	93.40	92.39	82.20	100.00	93.46	92.66		94.87	93.81	84.41	16.58
October 2025	92.52	92.32	82.05	100.00	92.49	92.45		94.68	94.23	84.55	22.77
November 2025	92.09	90.68	81.14	100.00	91.97	91.13	92.56	94.22	94.16	85.12	23.57
December 2025	92.99	92.69	83.38	90.00	93.05	93.03	93.10	95.18	94.59	85.79	29.91
January 2026	92.49	92.14	82.34	90.00	92.60	92.36	93.81	94.60	94.75	86.52	42.40
February 2026	89.80	90.35	81.55	100.00	89.87	90.86	92.88	91.32	94.00	86.40	44.59
March 2026 (year-end position)	86.92	91.93	81.58	100.00	86.75	91.90	92.41	90.44	95.37	87.42	39.25

Data on training sessions provided:

25. Safeguarding Children Level 3 Training data:

Figure 21: Indicates that during this reporting year there has been 11 offered Children's Level 3 safeguarding full day sessions scheduled. The availability and room capacity still provides flexibility for more colleagues to attend. In total there have been 115 colleagues trained, a 33.7% increase from the 86 colleagues trained in the previous reporting year.



Quarter	Date of training	Room capacity	Delegates attended
Q1	15/04/2025	30	10
Q1	10/06/2025	30	7
Q2	16/07/2025	30	7
Q2	20/08/2025	14	11
Q2	24/09/2025		18
Q3	15/10/2025	30	16
Q3	19/11/2025	30	9
Q3	17/12/2025	14	8
Q4	14/01/2026	30	10
Q4	25/02/2026	14	12
Q4	19/03/2026	30	7

In comparison to the last reporting year, there has been an increase in the number of sessions provided (increase from 10 sessions to 11 this reporting period). There has also been a 34% increase in the number of colleagues trained (the increase from 86 to 115 colleagues).

26. **Safeguarding Adults and Children Level 2 Training Attendance**

Figure 22: Indicates that during this reporting period there has been 2 Level 2 (Joint Adult and Children's safeguarding) training sessions scheduled, facilitating 13 colleagues to be trained during this period. In 2024 - 2025, 134 colleagues were trained, indicating this year there has been a 90.3% decrease. As with the Level 3 children's training there is still flexibility in the room capacity for further colleagues to be accommodated at each session. During this year there has been 7 cancelled sessions due to not having enough delegates booked on.

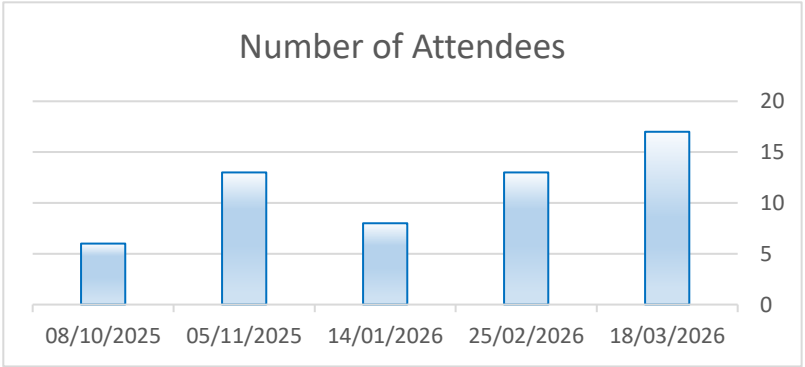
	Date of training	Location of training	Room capacity	Delegates attended
Q1	15/04/2025	BDGH Board Room	14	7
Q1	22/05/2025	Lecture Theatre	23	6

In addition to the sessions above, the Safeguarding team have continued to support delivery of Level 2 Safeguarding Training during the Foundation of Care Sessions. During this year a total of 59 colleagues accessed Level 2 training via this method, bringing the total overall to 72.

27. New Safeguarding Adults Level 3 Training Data:

Figure 23: Indicates that during this reporting year there has been 5 offered Adult's Level 3 safeguarding full day sessions scheduled. The availability and room capacity still provides flexibility for more colleagues to attend. In total there have been 57 colleagues trained.

Quarter	Date of training	Room capacity	Delegates attended
Q3	08/10/2025	**14**	**6**
Q3	05/11/2025	**20**	**13**
Q4	14/01/2026	**20**	**8**
Q4	25/02/2026	**20**	**13**
Q4	18/03/2026	**20**	**17**



28. <u>Bespoke and targeted training support:</u>

In addition to the statutory and essential training for safeguarding, the team have also continued to provide bespoke sessions to support specific identified targeted support.

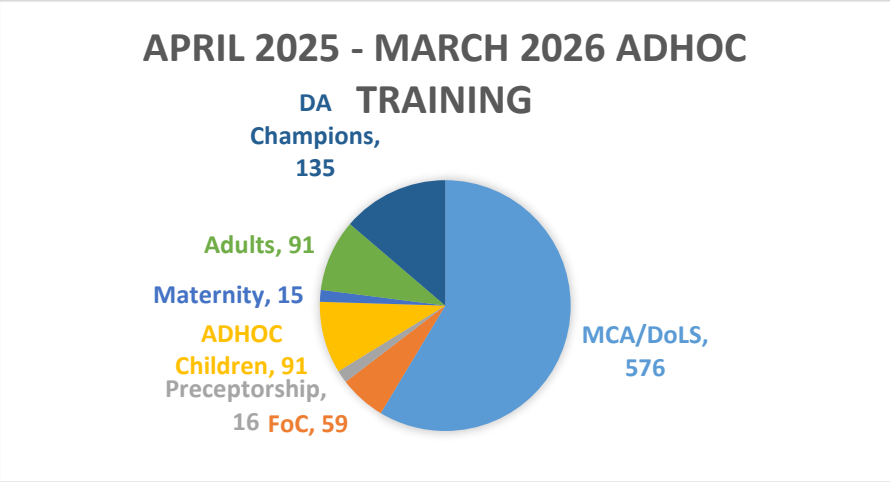


Figure 24: Indicates an overview of some key additional bespoke training that has also been provided by the Safeguarding team.

The MCA / DoLs sessions were delivered over the year 2025 - 2026. The total number of people receiving bespoke MCA/DoLS = 634. These sessions were delivered in multiple divisions, in a range of formats from impromptu snap shot briefings, diarised teachings, to Grand rounds and Governance meetings.

ADHOC Children and maternity sessions were delivered over the year 2025 - 2026 to areas to show support and guidance to topics that were requested. Throughout the year, adhoc Children training was delivered on 'was not brought', CP-IS and 16/17 year olds. These were delivered by a method of planned sessions, attendance at governance groups, adhoc briefings, doctors induction sessions and via safeguarding liaison meeting discussions. Maternity safeguarding sessions were also provided to new shift leaders and midwives new to community roles.

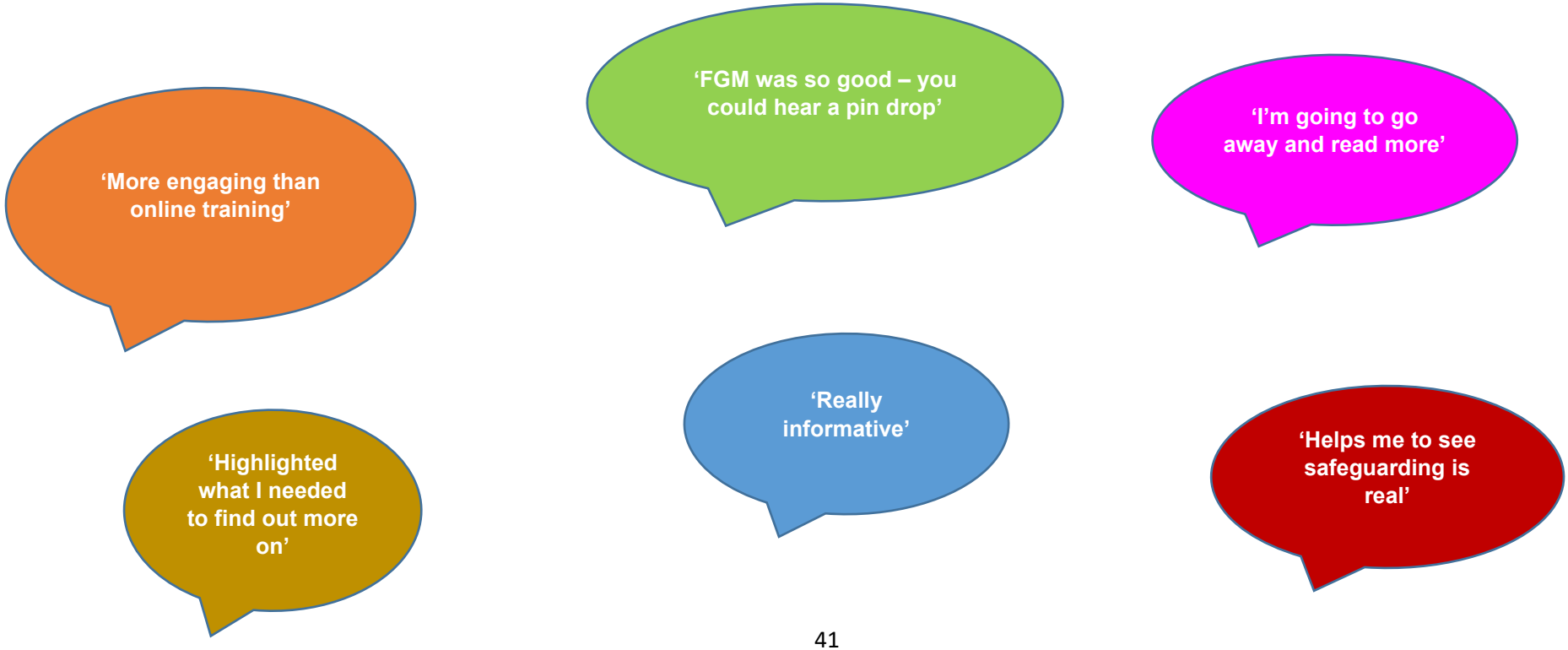
ADHOC Adult Sessions - The Adult Safeguarding Team has continued to invest considerable time and effort in increasing its visibility across the Trust. This has included reintroducing the team, clarifying our role, and promoting awareness of The HIVE through regular engagement within both specialist services and acute clinical areas.

A programme of bite-sized training sessions has been delivered, designed to be accessible and manageable within busy acute settings. These sessions have focused on key areas such as professional curiosity and self-neglect, alongside the sharing of practical resources to support staff in their roles. This has included the distribution of newly developed professional curiosity posters to reinforce learning and encourage reflective practice.

This approach to sharing knowledge and resources has been positively received, helping to embed safeguarding principles in day-to-day practice while recognising the operational pressures faced by clinical teams. Feedback received indicates that the increased visibility of the Safeguarding Team, along with the ongoing support provided, has been valued across the Trust.

29. <u>Capturing the voice of our learners:</u>

Below are some of the voices of our learners that have been captured during training evaluation:



30. Safeguarding Assurance

Section 11 reporting:

In Doncaster, 12 overarching standards are in place to assess strategic and organisational arrangements for safeguarding and promoting the wellbeing of children at risk as part of the Section 11 requirement. Although the Section 11 return was last submitted in October 2024 and therefore falls outside the current reporting period, progress against the associated action plan continues to be overseen by the Strategic Safeguarding Group, with the most recent update presented in September 2025. This provides assurance that external safeguarding assurance requirements continue to be actively monitored and embedded through internal governance processes.

The remaining area for improvement within the Doncaster Section 11 relates to safeguarding training. Trust efforts are ongoing to increase compliance, with a target of achieving 90% completion across all levels (Figure 20 highlighting the areas that still require improvement).

For Nottinghamshire, there are 9 overarching standards and partnership submission was also in October 2024. The remaining area for focus here relates to further development on exploitation identification. Whilst the Trust is in a strong position with use of record alerts to trigger risk awareness of known children and young people that attend DBTH, further work is being progressed to embed a risk assessment tool for use in the Emergency departments, this will strengthen arrangements further.

Action plan updates for both areas are oversighted at the DBTH Strategic Safeguarding Group – last presented September 2025.

Partnership Assurance Tool (PAT) – Safeguarding Adults:

The annual PAT requests from Doncaster and Nottinghamshire Adult Boards are approached in a different way to how Section 11 assurance is requested. The PAT requests for both partnerships include a number of broad narrative style questions.

Doncaster Safeguarding Adults Board (DSAB) assurance was last submitted within timescale in July 2025:

Headline Findings:

Awareness & understanding of policies and procedures:

- DBTH can evidence appropriate safeguarding policies and procedures are in place and in date.

Culture & Leadership:

- Senior Management actively promotes safeguarding culture, identified Executive lead.

Training & Development:

- Comprehensive training offer (Safeguarding, Mental Capacity, DOLS, Domestic Violence, Sexual Safety, Managing allegations – Person in a Position of Trust)

Voice of Adults at Risk:

- Referrals evidence that Adults are engaged throughout the safeguarding processes; emphasis on listening and recording views, making safeguarding personal.

Multi-Agency Working:

- Strong engagement with DSAB Board and Sub-Groups.
- Familiarity with protocols for information sharing and multi-agency meetings.

Strengths

- Clear organisational commitment to safeguarding.
- Robust policy framework and reporting mechanisms.
- Active participation in DSAB governance and learning dissemination.

Recommendations

- Maintain oversight of Safeguarding compliance through audits and referrals.
- Maintain patient centred focus and making safeguarding personal – evidenced by referral information.
- Continue proactive engagement with safeguarding adult board (SAB) strategic priorities and multi-agency work.

Nottinghamshire Safeguarding Adults Board (NSAB) assurance was last submitted within timescale in April 2025 for the deadline of May 2025:

Headline Findings:

Strategic Alignment:

- Robust safeguarding governance via Strategic Safeguarding Group chaired by Deputy Chief Nurse.
- Active engagement with Nottinghamshire Adult's Board and SAB priorities.

Risk Management:

- Key risks identified that remain open: Mental Capacity Act compliance, CP-IS checks, safeguarding supervision.

- Significant mitigation evidence: recruitment of specialist roles, MCA/DOLS practitioners, MCA quality action, improved training compliance for Adult safeguarding L2 (90%), updated supervision policy and reporting dashboard, action plan in place for CP-IS workstream.

Prevention & Early Intervention of Safeguarding concerns:

- Daily safeguarding liaison meetings embedded across trust.
- Extended Domestic Abuse (DA) services into Bassetlaw footprint.
- Sexual Safety Policy in place.

Assurance:

- Quarterly and annual safeguarding reports produced.
- Learning from Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) disseminated via training and liaison meetings.
- Safeguarding training compliance above trajectory; Level 3 adult training development planned. (This has now been implemented).

Engagement & Making Safeguarding Personal (MSP):

- Making Safeguarding Personal (MSP) embedded in referral processes and Datix system.

Strengths:

- Strong governance and assurance framework.
- Significant improvement in safeguarding training compliance.
- Expanded specialist safeguarding roles and resources.
- Proactive approach to embedding MCA and MSP principles.

Recommendations:

- Maintain oversight of MCA compliance through audits and quality priority.
- Monitor safeguarding supervision compliance and expand training for supervisors.
- Continue proactive engagement with SAB strategic priorities and multi-agency work.

Safeguarding Assurance and Accountability Framework – Benchmark 2025 – 2026:

The Safeguarding Accountability and Assurance Framework (SAAF), is the national framework that has been developed by NHS England in partnership with other professional bodies. It reflects key national safeguarding policy and legislation and clarifies the safeguarding roles and responsibilities for providers of NHS-funded care settings.

A benchmarking exercise has been undertaken against the SAAF (July, 2024 edition) to identify the following:

- Identify areas of compliance with SAAF
- Identify areas where strengthening is required
- Provide a clear picture of safeguarding risks to Trust Board Members with assurance that risk-based actions are in place to strengthen the identified areas

The benchmark review focused on the following 15 categories:

1. Sufficient safeguarding leadership
2. Identification of statutory safeguarding roles
3. Safer recruitment practices
4. Annual report
5. Safeguarding policies
6. Safeguarding Training offer
7. Safeguarding Induction arrangements
8. Safeguarding Supervision
9. Handling, storing and sharing of information for the purposes of safeguarding
10. Child Protection Information Sharing
11. Female Genital Mutilation and mandatory reporting
12. Processes in place for allegations against staff
13. Embedding safeguarding at every level of the organisation, including safeguarding governance
14. Safeguarding arrangements
15. Duty of candour processes

From the 15 areas reviewed, 3 areas of focus were identified that required further strengthening:

Safeguarding Supervision:

Whilst there is a strong supervision framework in place, underpinned by a detailed supervision policy, that clearly outlines which roles require safeguarding supervision, further work is required to strengthen divisional reporting and ensure local compliance reporting in departments is migrated onto the Trust DERICK database. This is being monitored at the Strategic Safeguarding Group via Divisional highlight reporting and

quarterly review of the compliance data. Further work in the year ahead will also focus on developing in-Trust supervisor training rather than reliance on externally commissioned training, this will enhance the number of safeguarding supervisors in the Trust.

CP-IS: Child Protection information sharing:

Child Protection Information Sharing (CP-IS) is a nationally mandated 'alert' system, which is being steered by NHS England and the National Safeguarding team, with oversight from ICBs. It is segregated into Phase 1 and Phase 2 implementation stages. Project management support and wider IT systems management is being progressed to support improvement. This has been discussed at Patient Safety Assurance Group (PSAG) as an escalation from the Strategic Safeguarding Group discussions regarding Trust compliance with this requirement.

DBTH is not yet achieving consistent organisation-wide compliance due to digital system limitations, reliance on manual checks via National Care Record Service and alignment of Smartcard access within Divisions.

Phase 2 is an extension of CP-IS to wider areas of the Trust that children and young people may access.

This position is reflective of the identified Trust risk – with continued monitoring in place via the Strategic Safeguarding Group.

Embedding safeguarding at every level of the organisation:

Clear progress has been made in embedding good safeguarding practice across Trust areas since the last benchmark review in 2023 – 2024, this is evidenced by the increased safeguarding resource and the increase of safeguarding activity as evidenced in the last and this annual safeguarding report.

This position is reflective of the work still to progress to improve the following safeguarding Trust risks:

- Supervision (Trust Risk ID 3254)
- MCA (Trust risk ID 3246)
- CP-IS (Trust risk ID 3521)

Each area of risk is supported by risk-based actions, with ongoing monitoring in place via the Strategic Safeguarding Group.

Conclusion of benchmark:

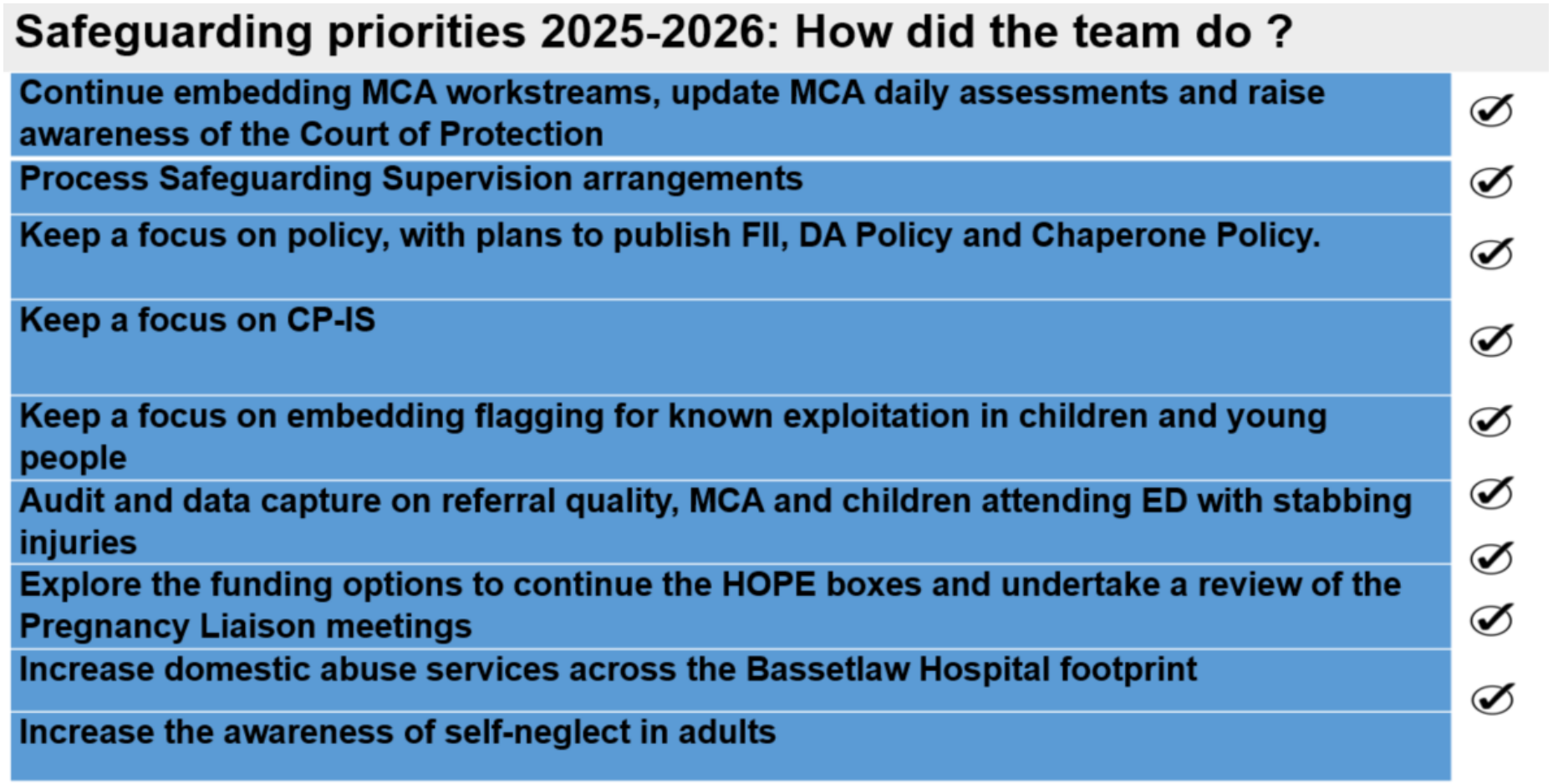
This benchmark indicates significant improvement in Trust safeguarding arrangements since the baseline SAAF benchmark in 2023–2024. The improvement reflects increased safeguarding resource, stronger governance, improved training compliance and increased safeguarding identification as evidenced through annual and quarterly reporting and the business overseen by the Strategic Safeguarding Group. It provides reasonable to strong assurance that the Trust is meeting the majority of national safeguarding expectations and is strengthening the areas where further development is required.

In addition to the Section 11, PAT and SAAF assurance processes, the Trust also submitted an annual self-assessment assurance return as part of NHS Standard Contract requirements in June 2025. Areas of focus remain aligned to those identified through Section 11, PAT and SAAF, and scrutiny of all assurance mechanisms is embedded within the Strategic Safeguarding Group agenda and forward schedule.

Taken together, external returns, benchmark work, audit findings, training compliance, governance reporting and risk review provide an overall position of **reasonable to strong assurance**. This reflects a well-established governance framework, clear evidence of progress and a credible plan for the areas requiring further strengthening.

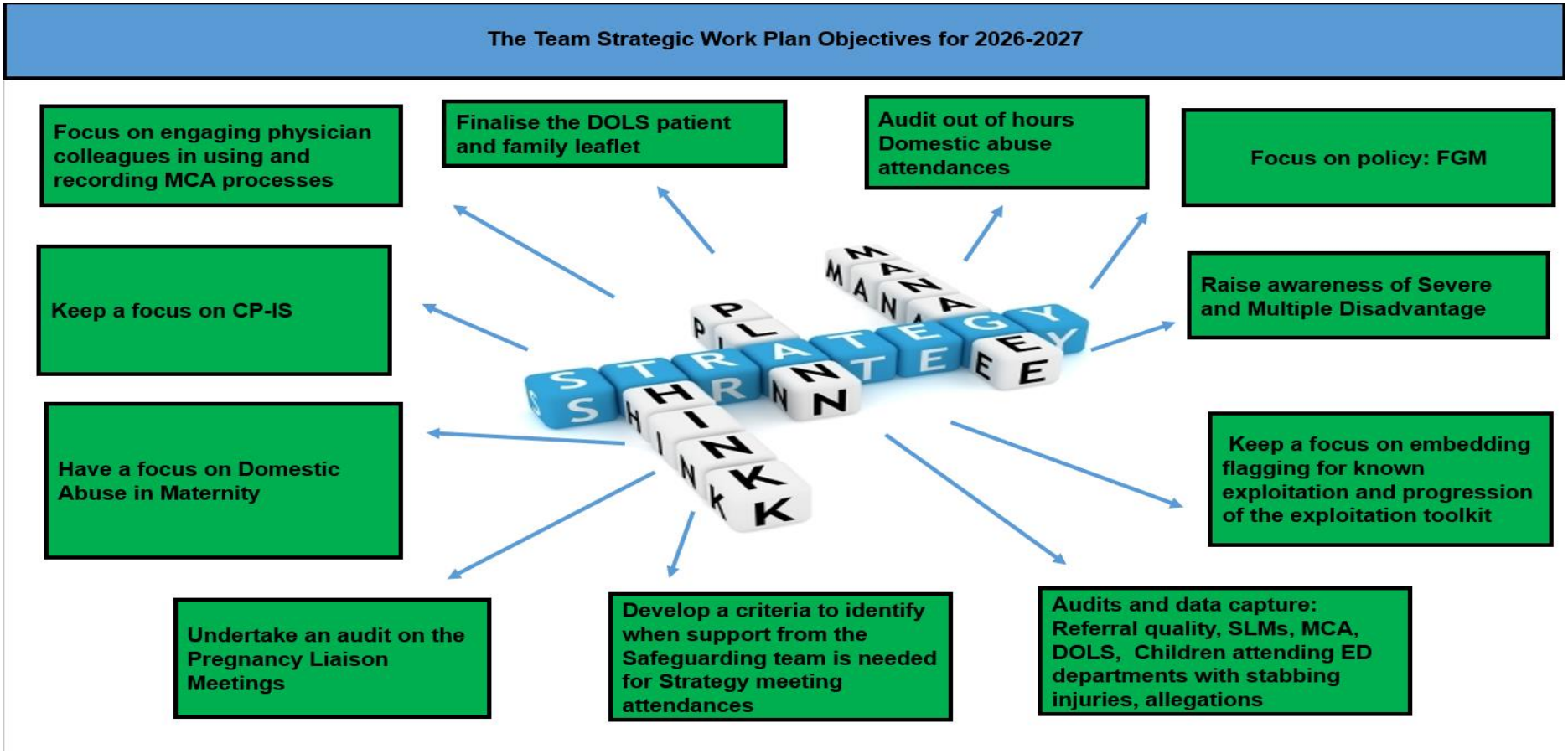
31. Looking back on our priorities

Figure 25: Provides a positive year end position with completion of key priorities that were outlined in the 2024 – 2025 annual report for achievement during 2025 – 2026. Noting that there were wider priorities as part of the work plan – a summary of which is included in Appendix 2.



32. Looking forward to our 2026 – 2027 priorities

Figure 26: The safeguarding team have identified a number of key priorities for 2026 -2027 that will strengthen safeguarding arrangements. The team work plan provides further details with ongoing oversight for progression via the SSG. Below are some of the key objectives outlined in the work plan.



33. Conclusion and closing remarks:

As we move forward into 2026 - 2027, development of this annual report has provided a valuable opportunity to reflect on the DBTH safeguarding journey. It has enabled us to recognise our progress over the past year, while continuing to refine our focus and priorities for the year ahead.

This report provides an overall position of **reasonable to strong assurance** that safeguarding at DBTH continues to strengthen in maturity, oversight and impact. During 2025–2026, safeguarding has remained a clear organisational priority, supported by strengthened governance, increased workforce capability and improving training compliance.

Progress this year reflects the contribution of both the safeguarding team and colleagues across all divisions. Improved visibility, stronger training and multidisciplinary working have strengthened the Trust's ability to recognise and respond to concerns in a timely and consistent way.

Increased safeguarding activity, alongside stronger partnership working and visible governance oversight, provides assurance that colleagues are increasingly confident in identifying and escalating concerns.

Residual risk remains in relation to safeguarding supervision, MCA/DoLS compliance and CP-IS. These areas will continue to require focused oversight and delivery of the 2026–2027 priorities to secure further embedding and sustained improvement.

In summary, the evidence presented provides reasonable to strong assurance that DBTH has effective safeguarding arrangements in place, supported by clear governance, improving workforce capability and strong partnership working.



Denise Phillip
Head of Safeguarding

Appendix 1

Meeting dates: 05.06.2025 (14:00 – 16:30), 25.09.2025 (14:00 – 16:30), 04.12.2025 (14:00 – 16:30), 19.03.2026 (14:00 – 16:30)

DBTH SSC Forward Schedule of Business (April 2025 – March 2026)				
For Assurance	**Q1 April – June 2025**	**Q2 July – Sept 2025**	**Q3 Oct – Dec 2025**	**Q4 Jan – March 2026**
SG Quarterly report	✓	✓	✓	✓
Annual Report	✓			
Training Compliance	✓	✓	✓	✓
Safeguarding Self-Assessments / Section 11 / PAT	On Completion / when scheduled			
Audit outcomes / action plans	On Completion / when scheduled			
Update on SG workplan	✓			✓
Update on SG risks	✓	✓	✓	✓
Update on SG cases	✓	✓	✓	✓
Good Practice	✓	✓	✓	✓
Outstanding Datix and Divisional responses	✓	✓	✓	✓
Looked after Children's update		✓		✓
SEND update		✓		
MCA / DoLs update	✓	✓	✓	✓
For Approval	**Q1 April – June 2025**	**Q2 July – Sept 2025**	**Q3 Oct – Dec 2025**	**Q4 Jan – March 2026**
Policies	On Completion / when scheduled			
Escalations	✓	✓	✓	✓
ToR	✓			
Group Membership	✓			
Agree Forward schedule of Business	✓			
Audit action plans	On Completion / When scheduled			
For information	**Q1 April – June 2025**	**Q2 July – Sept 2025**	**Q3 Oct – Dec 2025**	**Q4 Jan – March 2026**
SG Briefings	✓	✓	✓	✓
Key SG headlines regional/nation	When available			
Learning from other areas	When available			
Updates from ICB / DBTH Divisions	✓	✓	✓	✓

Appendix 2: 2025 – 2026 Work Plan summary

Safeguarding Work Plan 2025 - 2026:

Year end position update and summary March 2026 – Denise Phillip (Head of Safeguarding)

This has been another ambitious workplan for 2025 – 2026, with key priorities and safeguarding work streams identified following the annual review GAP analysis that was undertaken on 4th March 2025. In total there were 48 work streams identified, with some larger action carried over from the previous year.

Current areas completed:

MCA in ED (Action 2): Collaboration has occurred with ED to deliver teaching sessions, provide in person support during safeguarding liaison meetings and work with lead medics to support delivery of key messages. A Qii programme has also been outlined to support further improvements.

MCA documentation in ED (Action 3): Support has been provided to improve documentation in relation to MCA in ED, this has been via SLMs, case by case involvement and established relationships with key members in ED.

Daily NerveCentre assessment for Mental Capacity (Action 6): This has now been revised to incorporate evidencing accommodation to hospital for care and treatment. Patients that don't have capacity have a flag generated on Nerve centre record.

MCA Form 1 (Action 7): This form was reviewed and revised, following scoping with other Trusts, liaison with Trust Solicitor and circulation to Local Authority / Local Safeguarding Adult Board. The form is now in used on Nerve Centre and uploaded to the Hive as a wider resource. Communications were circulated to support the change.

The SG team will review and revise the layout of the MCA/DoLS material and content on the Hive (Action 8): Layout of Hive content enhanced and relevant resources uploaded.

The safeguarding team will review and redesign the MCA documentation audit (Action 9): Other Trusts were scoped as a benchmark prior to design of the new audit framework. The new format provided a framework to demonstrate how the application of the MCA was being evidenced across Trust areas and has provided a clear focus of areas that require strengthening. Audits have remained quarterly during this work plan period.

Fabricating and Inducing Illness policy (Action 10): This was a new policy that was developed to support safe practice and a specific detailed focus on how to manage these cases. The safeguarding team consulted with other Trusts' to benchmark different approaches, consulted with the ICB and the final policy was reviewed by Named Doctor and Designated Doctors on completion.

Review and update of the Domestic Abuse policy, including development of a support tool for managers (Action 11): This policy and support tool was completed ensuring Trust colleagues have access to up to date information to support patients and colleagues that experience domestic abuse.

Review of the Chaperone Policy (Action 13): This policy was reviewed to incorporate National guidance, following review of the information on skills net and the link to the Sexual Safety agenda. This will support the refresh of the update of DBTH Chaperone eLearning package.

Provide a mechanism to capture the additional 4 hour requirement for Level 3 Children's safeguarding training (Action 14): All colleagues that required this for their role were identified using ESR data. Comms were distributed and resources made available on the Hive to support colleagues on how this requirement can be achieved. In collaboration with education this is now reported via DERICK data since Sept 2025.

Ensure processes are in place for Doncaster to support identification and alerting for Child Exploitation (Action 15 / 16): In liaison with Doncaster and Notts partners, a pathway of information sharing was developed to alert CYP that are at risk of exploitation. This will provide an opportunity to be risk informed and act promptly to safeguard during presentation at DBTH. This has been underpinned by a SOP which includes a process to also remove any alerts when appropriate.

Audit: Quality of Chidlren's SG referrals (Action 18): Audit completed presented at SSG June 2025.

Audit: Quality of Adult SG referrals (Action 19): Audit completed presented at SSG June 2025.

Audit: Quality of Unborn SG referrals (Action 19): Audit completed presented at SSG June 2025.

Audit: Compliance with Mental Capacity Act (Action 21): Audit completed quarterly and presented each quarter at SSG.

Audit: FGM (Action 23): Audit completed of maternity records providing good assurance on FGM processes. Presented at SSG in Dec 2025 and DSCP in Jan 2026.

Audit: Children attending ED departments with a stabbing injury (Action: 24): Quarterly audit completed and data shared at SSG and DSCP. Noted area for strengthening in presentation of 16/17 year olds that present via adult pathway of ED, this is an ongoing area of focus.

Secure funding for HOPE boxes (Action 26): Funding was secured via Charitable sources, the responsibility for dissemination and funding of future HOPE boxes will now transfer to Maternity division, with ongoing support from safeguarding.

Pregnancy Liaison Meetings for both Doncaster and Bassetlaw to be standardised in process (Action 28): A review of both areas was undertaken in collaboration with partners that are involved in these meetings. This has been underpinned by a SOP and ensures the processes involve a multi-agency approach from start to finish.

Progression of learning from the Lasting Power of Attorney Webinar from the Office of Public Guardian (Action 30): Resources have been updated on the Hive, communications circulated and training material updated.

Raise awareness of Court of Protection processes (Action 31): In collaboration with Trust Solicitor sessions were presented to Trust colleagues.

Children/Unborn referral SOP (Action 32): The SOP was developed to outline the process that should occur when a copy of the referral form is received in the SG team inbox. SOP approved at SSG in Sept 2025.

Raise awareness of Mulit-Agency Public Protection Arrangements (MAPPA) – (Action 34): Level 3 training updated to include MAPPA information and MAPPA SOP completed – this was approved at SSG Dec 2025.

Development of Domestic Abuse services across the Bassetlaw Hospital footprint (Action 35): Substantive appointment of the DA Liaison officer roles supported the expansion of this resource to Bassetlaw site. Champions have been recruited, safeguarding liaison meetings from DALOs occur and additional bespoke sessions have been undertaken. DALOs have been visible across Bassetlaw areas.

Review of the DA referral process to support a safe response (Action 36): SOP approved at March SSG. DA referral's progress via Datix that now have incorporated risk based questions to support completion of DASH form. Summary of changes in Trust shared with Doncaster DA lead.

Review of the Domestic Abuse data matrix to ensure all requirements for data evidencing is being captured (Action 37): Matrix robust and allows for data breakdown across all 3 sites. Provide a clear demographic of DBTH population / staff experience and provides themes to be considered. This creates a strong basis to influence future training and workstreams.

Raise the awareness of Management of Allegations: Persons in a position of Trust (Action 38): Work has been undertaken to support Divisional awareness. Comms developed and 7 minute briefing to support further learning. This is also included in Level 3 training for children and adult safeguarding. Awareness of this is also supported by HR colleagues. This will remain an ongoing focus to ensure continued awareness.

Raise the awareness of how allegations against the Trust from the Local Authority (relating to adult safeguarding – Section 42) are managed and escalated (Action 39): Escalation process developed. Monthly reporting to Divisional / Deputy Divisional Nurses for awareness. Weekly SG team meetings with Head / Deputy Head of Safeguarding to support oversight and information gathering to inform Local Authority.

Raise awareness of the Non-Fatal Strangulation pathway / national guidelines (Action 40): 7-minute briefing and bespoke sessions undertaken to raise awareness of national guidance. DBTH NFS pathway completed and wider parter pathways supported. Anticipated further national guidance for children in the coming year.

Develop a team process to link Safeguarding learning / developments in practice back to index case of concern where relevant (Action 41): Development of a case matrix that tracks any specific learning / practice development. Quarterly oversight of this in team, this support case update at SSG. Further work planned in 2026 – 2027 for annual overview reporting on all case reviews / cases of significance.

SOP for Legal Statements (Action 42): SG team supported the outline of a SOP on management of legal statements. As all statements are managed by the Trust legal team the SOP outline was shared and no further action for the SG team. SG team continue to support the legal team where needed for any complex queries on statements.

Processing Safeguarding Referrals within K2 (Action 43): An historical 'referral door' on K2 was providing confusion for the referral process. In collaboration this was reviewed and the 'referral door' removed.

Develop a clear pathway and SOP for when an Interim Care Order (ICO) is granted following birth (Action 44): SOP approved March SSG.

DA Liaison officers to develop a SOP for recording safety information obtained via MARAC (Action 45). Scoping of other Trusts was undertaken as a benchmark on processes and a SOP developed to support required processes. This was discussed at the vulnerabilities Panel to support agreed alerts for any relevant patients. SOP agreed at SSG.

Sexual safety – establish Trust processes (Action 48): Trust working group in place with governance flow to SSG. Working group underpinned by a ToR. Policy in place that outlines Trust behaviour standards and reporting processes for cases involving Patients or colleagues. Training eLearning in place as per national recommendation and compliance above Trust target.

Ongoing areas that will transfer to 2026 – 2027 work plan:

Actions 1, 4, and 5 (Mental Capacity Act): These actions have involved multifaceted elements all of which are noted to have progress – with some actions partially completed. The remaining factors to be finalised in 2026 – 2027 are: Reporting flowcharts for MCA / DoLs / Qi project in ED / Lead Physician work / Walk through videos to support increased awareness in MCA / DOLS / Best interest form completion / DOLS leaflet. The most noted areas that has not progressed as positively is the physician work – whilst there has been an identified position to support the MCA workstream competing priorities have impacted on anything meaningful being progressed as yet. This is an area for strengthening in 2026 – 2027.

Female Genital Mutilation – update policy, (Action 12): Work has been undertaken to support a review of the multi-agency processes in Doncaster. This action has been paused due to factors outside of DBTH (awaiting for the publication of the Partnership pathway). The DBTH policy does remain in date until Aug 2026 but an earlier policy update was anticipated when the partnership process was updated. This will remain an action for the 2026 – 2027 work plan.

Child Protection Information Sharing – CP-IS (Action 17): Whilst significant work has been progressed with CP-IS in DBTH this remains a Trust risk and work is still required to strengthen compliance / reporting frameworks. NHS England has also progressed Phase 2 implementation so there is an additional requirement to embed CP-IS in all areas that see children and young people under the age of 18 years by Sept 2026 (this will include therapy areas / wider midwifery areas), with some earlier deadline dates for termination of pregnancy, outpatients and dentistry. Support from IT leads and Project Management is planned to strengthen this. There is an action plan in place to oversight progression. This is a significant piece of work and will remain in focus for the year ahead.

Audit: Out of Hours Domestic Abuse referrals (Action 22): Audit for time period 2024-2025 has been completed with result comparison to 2023-2024 identifying some areas of improvement and giving a clear focus for areas to be strengthened. Some actions to be finalised (launch of grab packs and sharing of results with ED – finalisation of this will be confirmed on next year's work plan.

Safeguarding tendable questions (Action 25): Work has been completed to update the safeguarding and MCA questions on to the weekly tendable questions but progression of these have been paused – which has been outside of the SG team control. Once these have been updated the team will be able to undertaken the planned 'peer' audit in addition to the weekly audit undertaken by divisional areas. Safeguarding / MCA questions are still on tendable (weekly) but this action won't be progressed until the question set is updated.

Evidence of impact from DA Liaison officers (Action 27): A questionnaire feedback form was developed with a QR code to capture feedback from referrers that work in Trust and a paper copy. Uptake on colleagues completing this has been slow due to competing clinical pressures. Verbal feedback from colleagues that have been supported by DA Liaison officers has remained positive and SSG feedback positive. Feedback from DRI ED has been positive and further evaluation is being undertaken at Bassetlaw.

Development of a pathway between Maternity and Paediatric areas to ensure identified risk factors are transferred (Action 29): Work is in progress to support transfer of information from maternity to

neonatal area pathway. This will continue on the 2026 – 2027 work plan. It is likely that the work will be around supporting divisional areas to develop the pathway.

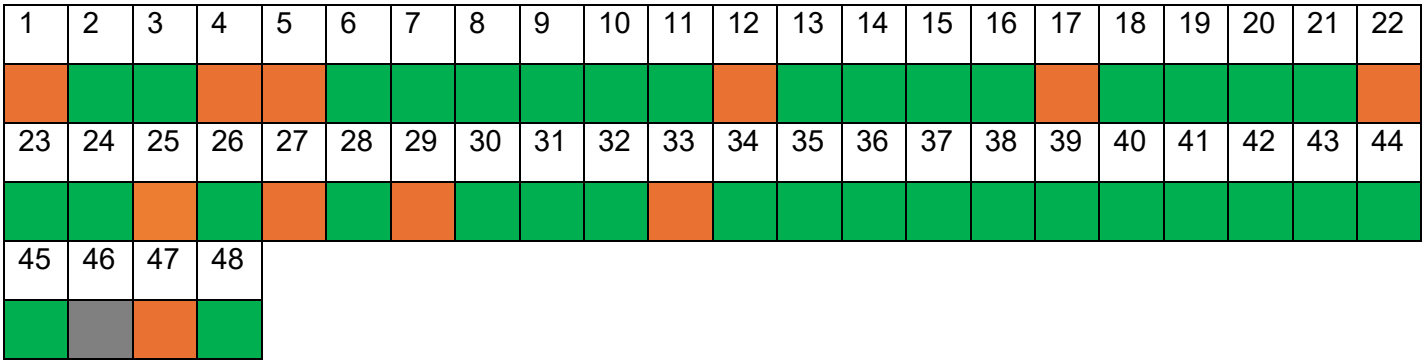
Increase awareness of self-neglect (Action 33): There has been a significant amount of work on this area. Bespoke training, increased resources, 7-minute briefings. This is an ongoing action due to the finalisation of a Qi project and development of a self-neglect tool to support clinical risk decision making. The safeguarding adult referrals for self-neglect has already notedly increased due to the work undertaken so far.

Audit of return rates and themes for DOLS submitted to DBTH Safeguarding inbox (Action 47): this action was added in November 2025, the audit registration is being progressed and this will continue on the 2026 – 2027 workplan.

Areas not progressed:

DA team to identify process for repeat attendances at MARAC (Action 46): Not progressed due to partnerships having a process in place for management of repeat MARACs – further consideration in next years work on review of repeat health attendance for any known patients with MARAC flag.

Overarching key of Work plan completion – amber areas will transfer to 2026 – 2027:

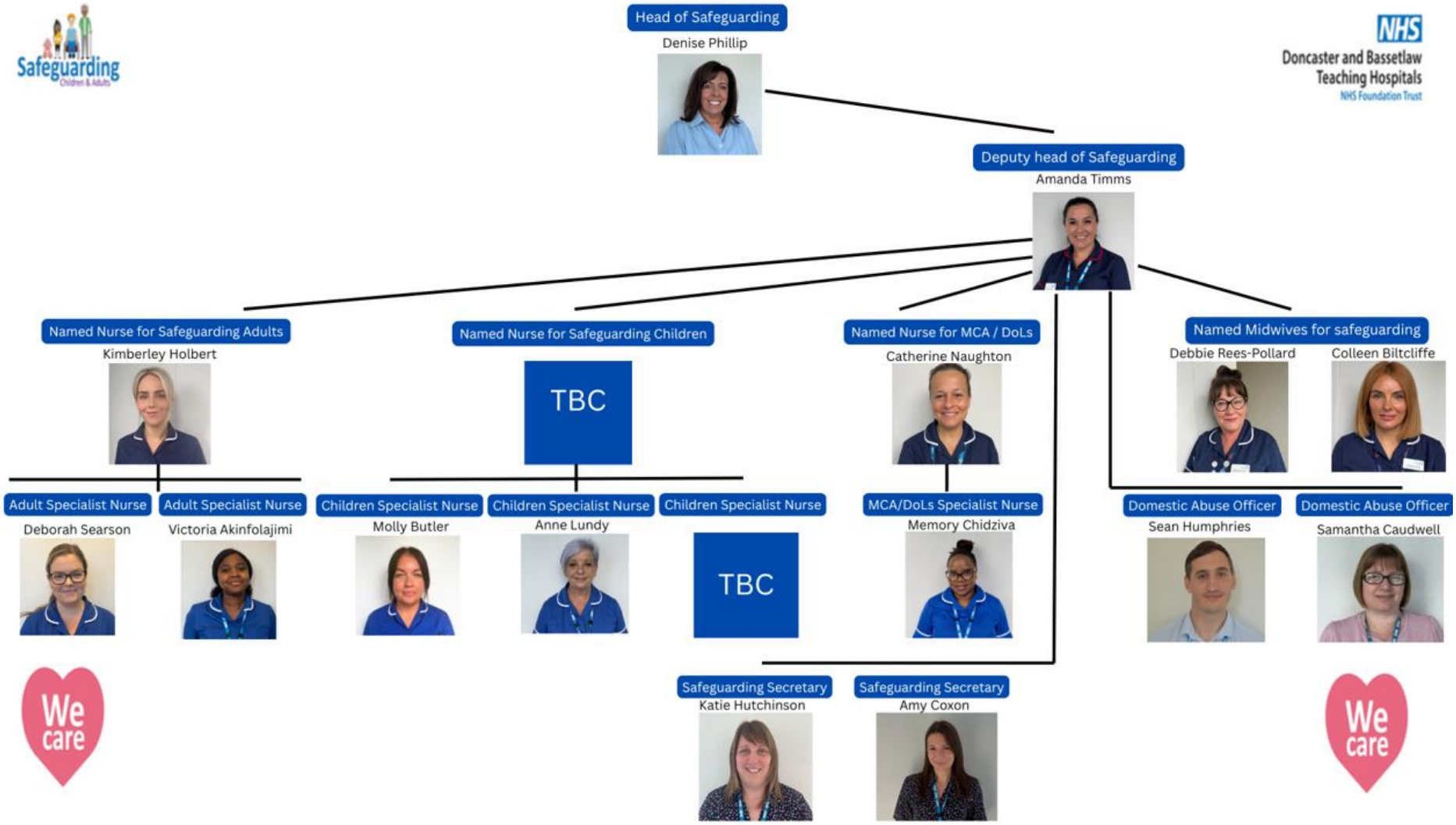


Key:

Action completed	Action in progress	Action not progressed / no longer required

- 36 out of 48 were completed by end of Q4
- 1 not progressed / no longer required
- 11 will continue to 2026

Appendix 3 – DBTH Safeguarding team



Contact us on 01302 642437 dbh-tr.safeguarding@nhs.net

What is our role?

As a Safeguarding team we provide safeguarding support, advice, safeguarding supervision and safeguarding training for colleagues working with adults and children (including maternity services) across Trust areas.

We ensure that safeguarding policies and procedures are in place in order to support safe practice to all patients whilst they are accessing care from service areas.

As a team we work closely with Partner agencies to ensure robust safeguarding arrangements are in place for children and adults in a 'think family' approach. We contribute as a Partner agency to shape and influence, local, regional and national safeguarding arrangements.

We work across South Yorkshire and Nottinghamshire to share practice, develop a shared safeguarding vision and champion a coordinated safeguarding response.

What do we offer?

The team's core hours of work are Monday – Friday (9-5pm). Outside of these hours safeguarding support resources can be found on the HIVE. We support the multi-agency safeguarding partnerships and boards to undertake reviews of serious safeguarding cases, domestic homicides and allegations that may have been made against our Trust; liaising with relevant Trust areas to provide and share information.

We support Trust colleagues with any Safeguarding advice or support that may be required to support care of an adult or child, answering any safeguarding questions that colleagues may have.

We provide Safeguarding training on a range of topics for Trust colleagues and opportunities to access safeguarding supervision.

We disseminate key local and national safeguarding information across Trust areas and signpost to internal and external safeguarding training opportunities.

We are the interface for partners and support safe sharing of safeguarding information when necessary to safeguard an unborn baby, child, young person or adult at risk

Appendix 4

Escalation Flowchart for 'Allegations against the Trust'

Safeguarding referral received from the Local authority with regards to allegations against the trust.

↓

The Safeguarding team will complete a DATIX and allocate to the Ward manager and Matron to investigate and provide a response. A response is expected within 14 days to meet the local authority thresholds. All governance leads will be added into the DATIX.

↓

There might be a few practical actions that could be taken immediately by the relevant clinical area, to help resolve a Safeguarding allegation.

↓

If the Investigator (Ward Manager / Matron) requires further support or is unable to meet the deadline, please contact the Safeguarding team, within 7 days of the initial DATIX being sent.

↓

If there is no response from the Ward Manager or Matron within 14 days, it will be escalated to the Deputy/Divisional Lead and a response will be expected within 7 days from that escalation date.

↓

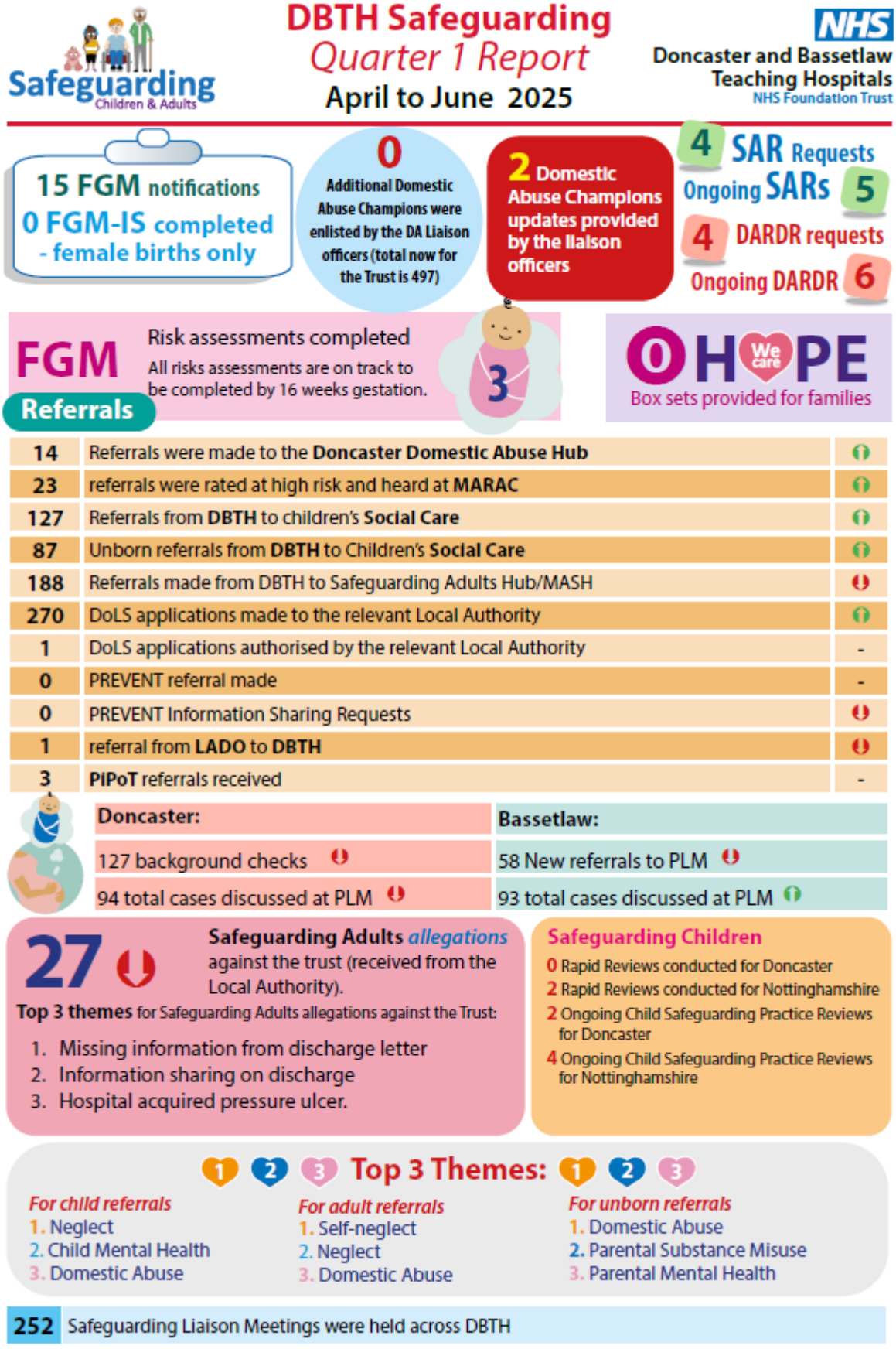
If no response after 21 days, the allegation will be escalated to the Divisional Nurse. Please ensure Head of Safeguarding/Deputy Head of Safeguarding is included at this point. The team will require a response within 7 days. The allegations that exceed 21 days should be taken to the Safeguarding Strategic Group via Divisional Highlight Reports, for wider discussion. Monthly allegation reports will be shared with Divisional & Deputy Divisional Nurses for ongoing oversight.

↓

When the investigator responds to a DATIX the 'Allegations against the Trust template' should be used. This is located in the documents and templates section in the DATIX. Please attach the completed template to the allocated DATIX.

For any support please contact the safeguarding team on 01302 642437
Or email dbh-tr.safeguarding@nhs.net

Appendix 5 – Safeguarding Quarterly reports 2025 - 2026



DBTH Safeguarding Training	Trust compliance	Increase or Decrease?
Safeguarding Adults Level 1 (via SET)	94.87%	↓
Safeguarding Adults Level 2	93.81%	↑
Safeguarding Children Level 1 (via SET)	94.86%	↓
Safeguarding Children Level 2	93.28%	↓
Safeguarding Children Level 3	84.22%	↓
Basic PREVENT awareness (via SET)	96.36%	↑

Key Achievements:	
✓	Collaboration between SG team members and maternity regarding Sterilisation protocol to ensure Mental Capacity is considered
✓	Attendance at Bassetlaw ED Governance
✓	Finalisation and update of the weekly Safeguarding assessment on nerve centre
✓	Exploitation alerts now live on Symphony – for Doncaster
✓	Safeguarding collaboration with the quality work regarding discharge planning (checklist and passport development)
✓	Completion of the annual safeguarding self-assessment
✓	Welcomed DA liaison officer Samantha Caudwell who commenced in post April 2025
✓	Publication of the 'Use of Chaperones – Guidance and Framework for Clinical and Support Staff
✓	Completed audits on the quality of adult safeguarding referrals
✓	Completed audits on the quality of unborn / child safeguarding referrals
✓	Review and publication of Domestic Abuse Policy
✓	Streamlining of the Pregnancy Liaison Meetings
✓	Review of the completion of the Mental Capacity act audit
✓	Slavery Exploitation Risk Assessment Conference SOP

Looking forward priorities:

1 Safeguarding Training and Supervision compliance	2 Embedding PiPoT/LADO processes
3 Continuing visibility of the Safeguarding Team	4 Embedding CP-IS across DBTH
5 Engagement of Medical colleagues in use and documentation of MCA principles	

Safeguarding Documents:

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DARDR - Domestic Abuse Related Death Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS - Child protection information sharing
PLM - Pregnancy Liaison Meeting	

DBTH Safeguarding Quarter 2 Report

July to September 2025

Safeguarding Children & Adults

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

13 FGM notifications
0 FGM-IS completed - female births only

4 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers (total now for the Trust is 503)

3 Domestic Abuse Champions updates provided by the liaison officers

4 SAR Requests

Ongoing SARs **5**

1 DARDR requests

Ongoing DARDR **7**

FGM Referrals

Risk assessments completed

All risks assessments are on track to be completed by 16 weeks gestation.

5

3 HOPE

We care

Box sets provided for families

6	Referrals were made to the **Doncaster Domestic Abuse Hub**	↓
3	Referrals were made to the Bassetlaw women's aid	-
32	Referrals were rated at high risk and referred to Doncaster **MARAC**	↑
5	Referrals were rated at high risk and referred to Nottinghamshire **MARAC**	-
135	DBTH Children's Social Care Referrals	↑
41	DBTH Unborn Social Care Referrals	↓
198	Referrals made to DBTH Safeguarding Adults Hub/MASH	↑
261	DoLs applications made to the relevant Local Authority	↓
4	DoLs applications granted by the relevant Local Authority	↑
0	PREVENT referrals made	-
6	PREVENT Information Sharing Requests	↑
0	LADO referrals completed	↓
11	PiPoT referrals received	↑
4	Sexual safety incidents	-

Doncaster PLM Referrals:	Bassetlaw PLM Referrals:	Out of Area PLM Referrals:
206 New referrals to PLM	34 New referrals to PLM	Start September - end September 8
July - 53 / Aug - 57 / Sept - 96	July - 8 / Aug - 15 / Sept - 11	

30 ↑ **Safeguarding Adults** *allegations* against the trust (received from the Local Authority).

Top 3 themes for Safeguarding Adults allegations against the Trust:

1. Discharge – No Care provision on discharge
2. Discharge - Information sharing
3. Care Received at DBTH

Safeguarding Children

0 Rapid Reviews conducted for Doncaster
0 Rapid Reviews conducted for Nottinghamshire
2 Ongoing Child Safeguarding Practice Reviews for Doncaster
5 Ongoing Child Safeguarding Practice Reviews for Nottinghamshire

Top 3 Themes:

For child referrals	*For adult referrals*	*For unborn referrals*
1. Neglect	1. Self-neglect	1. Female Genital Mutilation
2. Child Mental Health	2. Financial	**2. Previous social care**
3. Domestic Abuse	3. Neglect	3. Domestic Abuse

325 Safeguarding Liaison Meetings were held across DBTH

DBTH Safeguarding Training	Current Trust compliance	Increase or Decrease from previous quarter?
Safeguarding Adults Level 1 (via SET)	93.49%	↓
Safeguarding Adults Level 2	92.70%	↓
Safeguarding Children Level 1 (via SET)	93.44%	↓
Safeguarding Children Level 2	92.37%	↓
Safeguarding Children Level 3	82.08%	↓
Safeguarding Adults Level 3	6.35%	N/A
Basic PREVENT awareness (via SET)	94.89%	↓
Mental Capacity Training	84.34%	N/A
Safeguarding Supervision	16.64%	N/A
Understanding Sexual misconduct	93.77%	N/A

Key Achievements:

- ✓ Safeguarding Level 3 Adults training commenced
- ✓ Safeguarding Star Award Nomination
- ✓ Pilot for Exploitation Alerts (Notts) agreed
- ✓ Commenced Divisional allegation report
- ✓ FII policy
- ✓ Supervision compliance now live on Derick
- ✓ Trust responses to Fuller report in place
- ✓ Victoria Oluwatosin commenced in role as Safeguarding Adult Specialist Nurse

Looking forward priorities:

1. Safeguarding Training and Supervision compliance
2. Embedding PiPoT/LADO processes
3. Continuing visibility of the Safeguarding Team
4. Embedding CP-IS across DBTH
5. Engagement of Medical colleagues in use and documentation of MCA principles

Safeguarding Documents:

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DARDR - Domestic Abuse Related Death Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS - Child protection information sharing
PLM - Pregnancy Liaison Meeting	PiPoT - Person in Position of Trust

DBTH Safeguarding Quarter 3 Report

October to December 2025

Safeguarding Children & Adults

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

18 FGM notifications
10 FGM-IS completed - female births only

5 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers (total now for the Trust is 401)

2 Domestic Abuse Champions updates provided by the liaison officers

5 SAR Requests

Ongoing SARs **6**

5 DARDR requests

Ongoing DARDR **9**

FGM

Risk assessments completed

All risks assessments are on track to be completed by 16 weeks gestation.



7 HOPE We care

Box sets provided for families

Referrals

7	Referrals were made to the **Doncaster Domestic Abuse Hub**
0	Referrals were made to the Bassetlaw women's aid
1	Referral was made to out of area DA services
11	Referrals were rated at high risk and referred to Doncaster **MARAC**
6	Referrals were rated at high risk and referred to Nottinghamshire **MARAC**
2	Referrals were rated high risk and referred to an out of area MARAC
109	DBTH Children's Social Care Referrals
85	DBTH Unborn Social Care Referrals
159	Referrals made to DBTH Safeguarding Adults Hub/MASH
272	DoLs applications made to the relevant Local Authority
1	DoLs applications granted by the relevant Local Authority
1	PREVENT referrals made
7	PREVENT Information Sharing Requests
0	LADO referrals completed
3	PiPoT referrals received
2	Sexual safety incidents

Doncaster PLM Referrals:

170 New referrals to PLM
Oct 35 /Nov 73 / December 62

Bassetlaw PLM Referrals:

39 New referrals to PLM
Oct 10 / Nov 16 / December 13

Out of Area PLM Referrals:

Out of area referrals = 5
October 2 / November 0 / December 3

35 **Safeguarding Adults *allegations***

against the trust (received from the Local Authority)

Top 3 themes

for Safeguarding Adults allegations against the Trust:

1. Discharge – No Care provision on discharge
2. Discharge - Information sharing
3. Care Received at DBTH

Safeguarding Children

1 Serious Incident Notification for Doncaster
1 Serious Incident Notification for Nottinghamshire
1 Rapid Reviews conducted for Doncaster
1 Rapid Review conducted for Nottinghamshire
2 Ongoing Child Safeguarding Practice Reviews for Doncaster
3 Ongoing Child Safeguarding Practice Reviews for Notts

Top 3 Themes:

For child referrals	*For adult referrals*	*For unborn referrals*
1. Neglect	1. Self-neglect	1. **Previous social care**
2. Domestic Abuse	2. Financial	2. Domestic Abuse
3. Child Mental Health	3. Neglect	3. Parental Substance Misuse

557 Safeguarding Liaison Meetings were held across DBTH

DBTH Safeguarding Training	Current Trust compliance	Increase or Decrease from previous quarter?
Safeguarding Adults Level 1 (via SET)	93.07%	↓
Safeguarding Adults Level 2	93.04%	↑
Safeguarding Children Level 1 (via SET)	93.01%	↓
Safeguarding Children Level 2	92.71%	↑
Safeguarding Children Level 3	83.25%	↑
Safeguarding Adults Level 3	12.17%	↑
Basic PREVENT awareness (via SET)	95.18%	↑
Mental Capacity Training	85.74%	↑
Safeguarding Supervision	30.22%	↑
Understanding Sexual misconduct	94.57%	↑

Key Achievements:	
✓	Two presentations at the Trust Grand Rounds. Subjects covered Domestic Abuse and MCA.
✓	MCA Forms 1 and 2 live on Nerve centre
✓	Links established with Prison leads in Doncaster
✓	Contribution to Abduction policy
✓	Mental Capacity QR code on the home screen to link to HIVE resources
✓	Pathway with Notts local authority to implement alerts to records of young people assessed as 'at risk' of exploitation for Nottingham – DBTH are the first health organisation to embed this (process already in place for Doncaster young people).
✓	Sexual Safety Assurance review completed

Looking forward priorities:

❶ Safeguarding Training and Supervision compliance	❷ Embedding PiPoT/LADO processes
❸ Continuing visibility of the Safeguarding Team	❹ Embedding CP-IS across DBTH
❺ Engagement of Medical colleagues in use and documentation of MCA principles	

Safeguarding Documents:

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DARDR - Domestic Abuse Related Death Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS - Child protection information sharing
PLM - Pregnancy Liaison Meeting	PiPoT - Person in Position of Trust

DBTH Safeguarding Quarter 4 Report

January - March 2026

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

14 FGM notifications
6 FGM-IS completed female births only

4 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers (total now for the Trust is 399)

3 Domestic Abuse Champions updates provided by the liaison officers

5 SAR requests

7 Ongoing SARs **2** NOTTS SARS non mandatory and not known to DBTH.

2 DARDR requests

10 DARDRs Ongoing

FGM

Risk assessments completed

All risks assessments are on track to be completed by 16 weeks gestation.



2 HOPE We care

Box sets provided for families

Referrals

18	Referrals were made to the Doncaster Domestic Abuse Hub (Domestic Abuse - standard/medium risk referrals to community services)	↑
4	Domestic Abuse Nottinghamshire	↑
1	Domestic Abuse Out of Area	-
34	Referrals were rated at high risk and heard at **MARAC** Doncaster **25** / Bassetlaw **7** / Out of Area **2**	↑
137	Referrals from **DBTH** to children's **Social Care**	↑
77	Unborn referrals from **DBTH** to Children's **Social Care**	↓
212	Referrals made from DBTH to Safeguarding Adults Hub/MASH	↑
299	DoLS applications made to the relevant Local Authority	↑
1	DoLS applications authorised by the relevant Local Authority	-
0	PREVENT referral made	↓
2	PREVENT Information Sharing Requests	↓
0	Referral from **LADO** to **DBTH**	-
7	**PiPoT** referrals completed	↑
6	Sexual safety incidents reported by Datix	↑

Doncaster:	Bassetlaw:	Out of Area:
193 New referrals to PLM ↑	**56** New referrals to PLM ↑	**12** Out of area referrals to PLM ↑
Jan **60** /Feb **72** / March **61**	Jan **22** / Feb **15** / March **19**	

30 ↓ **Safeguarding Adults** *allegations* against the trust (received from the Local Authority).

Top 3 themes for Safeguarding Adults allegations against the Trust:

1. Discharge - equipment and information sharing concerns
2. Communication – changes to care/medications
3. Neglect – Practice concerns

Safeguarding Children

0 Serious Incident Notification for Doncaster
2 Serious Incident Notification for Nottinghamshire
0 Rapid Reviews conducted for Doncaster
2 Rapid Review conducted for Nottinghamshire
2 Ongoing Child Safeguarding Practice Reviews for Doncaster
3 Ongoing Child Safeguarding Practice Reviews for Nottinghamshire

Top 3 Themes:

For child referrals
1. Neglect
2. Domestic Abuse
3. Child Mental Health

For adult referrals
1. Self-neglect
2. Neglect
3. Physical Abuse

For unborn referrals
1. Domestic Abuse
2. Previous/Current Social Services
3. Neglect

889 Safeguarding Liaison Meetings were held across DBTH

Adult - DRI **388** BDGH **63** MMH **43** **Children's** - DRI **291**, BDGH **104**

DBTH Safeguarding Training	Current Trust Compliance	Increase or Decrease from previous quarter?
Safeguarding Adults Level 1	86.75%	↓
Safeguarding Adults Level 2	91.90%	↓
Safeguarding Children Level 1	86.92%	↓
Safeguarding Children Level 2	91.93%	↓
Safeguarding Children Level 3	81.58%	↓
Safeguarding Adults Level 3	28.79%	↑
Basic PREVENT awareness (via SET)	90.44%	↓
Mental Capacity Training	87.42%	↑
Safeguarding Supervision	39.25%	↑
Understanding sexual misconduct	95.37%	↑

Key Achievements:

- ✓ Healthcare People Management Association Sexual Safety National Presentation
- ✓ Digital FGM Form
- ✓ Domestic Abuse Grab Packs launched in DRI ED on 25.03.2026
- ✓ Adhoc Adult Case review sessions with Ward 19 now complete – positive feedback received
- ✓ Positive Feedback from Domestic Abuse Survey
- ✓ Mental Capacity risk rating reduction
- ✓ Bespoke Safeguarding Children training delivered to Junior Doctors in ED

Looking forward priorities:

1. Safeguarding Training and Supervision compliance
2. Embedding PiPoT/LADO processes
3. Continuing visibility of the Safeguarding Team
4. Embedding CP-IS across DBTH
5. Engagement of Medical colleagues in use and documentation of MCA principles

Safeguarding Documents: Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List

FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DARDR - Domestic Abuse Related Death Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS - Child protection information sharing
PLM - Pregnancy Liaison Meeting	

Appendix 6 – Sexual Safety Assurance Framework summary

Sexual Safety Assurance – DBTH – 2025		
Principle statement	**RAG**	**Outstanding requirements**
1. We will actively work to eradicate sexual harassment and abuse in the workplace.		
2. We will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.		
3. We will take an intersectional approach to the sexual safety of our workforce wo experience unwanted, inappropriate and/or harmful sexual behaviours.		**Requirement needed to RAG as Green:** - Feedback mechanism from EDI groups to working group to be confirmed.
4. We will provide appropriate support for those in our workforce who experience unwanted inappropriate and/or harmful sexual behaviours.		
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour		
6. We will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators.		
7. We will ensure appropriate, specific, clear training is in place		**Requirement needed to RAG as Green:** - Evidence of awareness raising sessions
8. We will ensure appropriate reporting mechanisms are in place.		**Requirement needed to RAG as Green:** -Clarity on reporting mechanisms for EDI themes and Learners
9. We will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases.		
10. We will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct		

- **TOR completed and will report to SSG.**
- **Proposed twice yearly update – will be added to forward schedule for SSG.**

2609 - J INTEGRATED ASSURANCE

12:50

2609 - J1 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

Decision Item | Brenda Thomas, Interim Company Secretary | 12:50

Executive Directors

10 minutes

REFERENCES

Only PDFs are attached

J1 -Board Assurance Framework and Risk Register.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 September 2026
Report Title/ Ref:	**Board Assurance Framework Compliance and Risk Register**			
Sponsor:	Zara Jones, Acting Chief Executive			
Authors:	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.			
For decision papers only: Is this in line with Current risk appetite NO	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested			

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 30 July 2026, according to the review schedule. 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 (BAF) brings together the Trust's strategic objectives and the principal risks to their delivery. It is aligned to the Trust's four priorities: Patients, People, Partnerships and Pounds, and is informed by the Trust Risk Register to support effective oversight of emerging internal and external risks.

The BAF summarises the controls, assurances and further actions in place to manage strategic risks, using the three lines of defence and the agreed risk appetite. It supports the Board in monitoring risk exposure, control effectiveness and any gaps in assurance.

Regular reporting of the BAF supports compliance with the NHS Code of Governance 2023, including the Board's responsibility to assess emerging and principal risks and to monitor the effectiveness of risk management and internal control systems.

This reporting is also aligned to the Trust's Risk Management Policy and is subject to ongoing oversight through the Audit and Risk Committee and the relevant lead committees.

The BAF remains a live document and reflects ongoing updates to the Trust's strategic risks, controls, assurances and action plans. Executive leads and directors continue to review their respective risks through the appropriate committee governance routes.

A clean version of the BAF is included at Appendix 2 for Board review, discussion and approval of the recommendations made through the relevant committees. The BAF will continue to evolve as risk profiles change and in response to internal audit recommendations and best practice.

The significant corporate risk previously associated with archived BAF Risk 6 has now transferred to BAF Risk 2.

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:

- **BAF 1** – Updated to reflect new assurance gaps, strengthened CQC 29A/UEC oversight, fortnightly executive assurance visits and progress on clinical policy management, including reduced overdue policies and recruitment to support policy compliance.
- **BAF 2** – Updated to reflect stronger controls and assurance through the Reset Programme, People metrics, data triangulation and partnership reporting. Progress is noted across workforce, leadership and culture work, with a new gap around system-wide workforce and learning pipeline plans.
- **BAF 3** – Updated to reflect partner-dependent discharge capacity, system demand and capacity planning, and mutual aid arrangements. Completed actions have been archived, with new assurance gaps added for access recovery plans and patient flow audit actions.
- **BAF 4** – Updated to reflect estates capital planning progress, including the £100m Estates Safety Fund commitment, successful funding bids, strengthened assurance routes and ongoing actions linked to backlog, maintenance capacity and site development.
- **BAF 5** – Updated to align finance risks directly to the strategic risk, with added focus on medium-term planning, system assumptions, contract management, financial recovery actions and a review of partner assumptions by September 2026.
- **BAF 7** – Updated to include interoperability dependencies with system partners and suppliers, including EPR interfaces and cyber resilience. New controls, assurance sources, gaps and actions have been added for supplier assurance and clinical safety of interfaces.

Trust Risk Register (Appendix 1)

Summary of data extracted from Datix Risk Management System 10 August 2026
Author: Tracy Evans-Phillips, Trust Risk Manager.

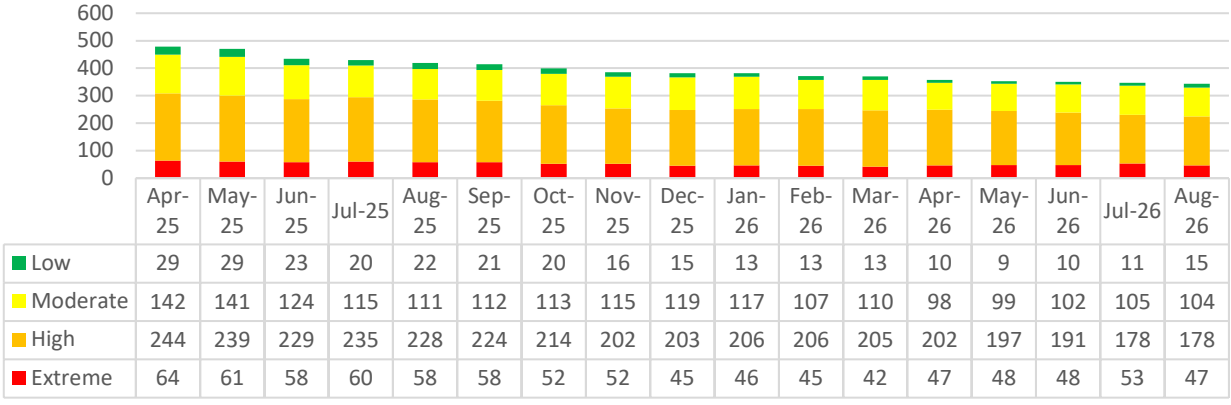
Introduction
This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the continued efforts of the Risk Management Group to assess and moderate risks, including escalations and any new developments in risk management practices.

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

Risk Activity June 2026 to August 2026

From June 2026 to August 2026, the risk register declined from 351 to 344 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 archiving or downgrading of risks that had met their target threshold.

Between April 2026 and August 2026, the overall risk profile has remained broadly stable, with limited movement in the total number of recorded risks and a return to 47 Extreme risks. There is a greater proportion of higher-rated risks, which will continue to be monitored through the Trust's risk management and assurance processes.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Low	29	29	23	20	22	21	20	16	15	13	13	13	10	9	10	11	15
Moderate	142	141	124	115	111	112	113	115	119	117	107	110	98	99	102	105	104
High	244	239	229	235	228	224	214	202	203	206	206	205	202	197	191	178	178
Extreme	64	61	58	60	58	58	52	52	45	46	45	42	47	48	48	53	47

Overview of Risk Numbers and Changes (June 2026 to August 2026)

- Risks archived: 28
- New risks added: 20
- Risks escalated (risk rating increased): 0
- Risks downgraded (risk rating decreased): 20
- Risks with no change in rating: 303

During June to August 2026, risk register activity demonstrates continued grip and oversight, with 20 risks reduced in rating, no upward rating movements, 20 new risks recorded and 28 risks closed or archived. This indicates active review and maintenance of the register, supported by ongoing mitigation and closure of risks where controls and actions have sufficiently progressed. RMG continues to provide regular challenge and moderation, using risk data to test the effectiveness of reviews, controls, assurance and action delivery.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	**8**	
Moderate	**16**	
High	**14**	Finance over-contract activity payments, improved Dermatology staffing
Extreme	**1**	Overarching audiology risks
Total	**39**	

Risk Management Group (RMG) Update

RMG oversight and assurance

RMG has maintained active oversight of the Trust's risk profile, with continued emphasis on the quality of risk descriptions, consistency of scoring, delivery of agreed actions, strength of assurance, and evidence-based escalation or de-escalation decisions.

In July 2026, the overall number of risks reduced further from 351 to 347 and overdue risks improved significantly, returning within the Trust target. Whilst performance improved, the proportion of Extreme risks increased and remains an area requiring enhanced oversight. RMG continued to scrutinise long-standing risks, review assurance ratings, and challenge whether controls are delivering measurable improvements in risk exposure.

Performance highlights

Improved risk review compliance

Overdue risks reduced from 22 to 15, bringing overall overdue risk performance back within target. Action plan compliance for risks rated 15+ remains below target, however focused oversight continues to support improvement and monitoring of gaps in mitigation and action planning.

Continued improvement in risk management capability

Risk management e-learning compliance increased further to 88.45%, continuing the positive trajectory seen across the organisation. RMG also maintained oversight of thematic learning, long-standing risks, and digital transformation risks, ensuring lessons learned are translated into improvements in risk management practice.

Enhanced assurance deep dives

Deep dives into Chief Nursing Officer and Clinical Specialist Services divisional risks continued the enhanced assurance approach, with a stronger focus on testing the effectiveness of controls, identifying assurance gaps, and challenging whether target ratings remain realistic and achievable.

Key evidence from the deep dives

- assessment of whether controls are delivering demonstrable improvement rather than simply existing on paper;
- explicit consideration of assurance strength, including where evidence remains insufficient to support risk reduction;
- identification of ongoing risks associated with workforce capacity, specialist service provision and operational pressures;

- challenge of long-standing risks to determine whether ratings remain appropriate and whether further action is required; and
- improved visibility of barriers to risk reduction, including funding constraints, external dependencies, infrastructure limitations and system integration challenges.

Overall impact

The enhanced assurance process continues to provide a stronger line of sight between risks, controls, evidence and Board assurance. July's deep dives demonstrated that governance arrangements are generally robust and that risks are well understood, while also identifying areas where further evidence, capacity or system improvements are required before assurance can be strengthened or risks reduced.

Risks escalated to Hospital Leadership Team (HLT)

HLT escalation and further review

No risks were escalated to HLT for additional scrutiny or direction during this period.

Further review was requested for the following risks through divisional governance processes:

- Lack of acute CT and MRI imaging capacity causing delays within patient pathways;
- Emergency Department senior medical workforce availability (Tier 4/Tier 5 cover); and
- Trauma equipment storage arrangements within the Emergency Department resuscitation area.

Appendix 1 Trust Risk Register

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

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

BAF	Risk ID	Risk Owner	Title	Review date	Regular Review	Rating (current)	Rating (Target)	Risk score requires review	Time at current risk rating (months)	Duration requires review	Number of Dependent Extreme Risks	Action Status
BAF 1	1517	Chief Pharmacist	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	30/09/2026	✓	15	6	No	25 Months	RMG Deep Dive ✓	0	✓
BAF 1	3209	Chief Operating Officer	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	30/11/2026	✓	8	8	No	13 Months	No	0	✓
BAF 1	3246	Deputy Chief Nurse	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	30/09/2026	✓	12	9	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 1	3290	Chief Nursing Officer	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	01/12/2026	✓	10	6	No	37 Months	RMG Deep Dive ✓	0	✓
BAF 1	3454	Chief Medical Officer	Insufficient governance and service gaps risk failure to meet guidance, leading to harm, regulatory action, and reputational damage	18/09/2026	✓	16	8	No	28 Months	RMG Deep Dive ✓	4	✓
BAF 1	3883	Chief Operating Officer	Incomplete Emergency Response Plans Risk EPRR Non-Compliance and Delayed Incident Response (Domain 3)	31/10/2026	✓	12	3	No	4 Months	No	0	✓
BAF 1	3884	Chief Operating Officer	Insufficient On-Call Training Risks Delayed Incident Command and Non-Compliance with EPRR Standards (Domain 4)	30/09/2026	✓	12	3	No	4 Months	No	0	✓

BAF 1	3885	Chief Operating Officer	Lack of EPRR Training and Exercising Risks Delayed Incident Response and Non-Compliance with Statutory Duties (Domain 5)	30/09/2026	✓	12	3	No	4 Months	No	0	✓
BAF 1	3887	Chief Operating Officer	Insufficient HAZMAT/CBRN Capability Risks Unsafe Incident Response and Non-Compliance with EPRR Standards (Domain 10)	31/10/2026	✓	12	3	No	4 Months	No	0	✓
BAF 2	16	Chief People Officer	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	31/08/2026	✓	9	6	No	11 Months	No	0	✓
BAF 2	19	Chief People Officer	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	30/10/2026	✓	9	6	No	6 Months	RMG Deep Dive ✓	0	✓
BAF 2	3507	Director of Education and Research	Failure to meet MHRA research inspection standards	08/12/2026	✓	12	4	No	24 Months	RMG Deep Dive ✓	0	✓
BAF 3	3890	Deputy Chief Operating Officer	Timely access to diagnostic services - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	4 Months	No	2	✓
BAF 3	3891	Deputy Chief Operating Officer	Timely access to elective care - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	4 Months	No	0	✓
BAF 3	3892	Head of Cancer Nursing	Timely access to cancer services - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	4 Months	No	1	✓
BAF 3	3893	Deputy Chief Operating Officer	Timely access to emergency care - Demand, Capacity & Flow	30/10/2026	✓	16	12	RMG	4 Months	No	0	✓
BAF 4	12	Director of Infrastructure	Failure to maintain estates to standards may cause compliance breaches, service disruption, and reputational harm.	30/11/2026	✓	25	10	No	16 Months	RMG Deep Dive ✓	9	✓
BAF 4	1083	Operational Director of Estates and Facilities	Non-compliant, aging electrical systems may fail, increasing risk of incidents and reducing operational resilience.	02/11/2026	✓	15	10	No	96 Months	RMG Deep Dive ✓	1 RMG Deep Dive ✓	✓
BAF 4	1412	Deputy Director of Estates and Facilities	Failure to maintain estates to fire safety standards may lead to enforcement, service disruption, and reputational harm.	31/12/2026	✓	15	10	No	64 Months	RMG Deep Dive ✓	7 RMG Deep Dive ✓	✓
BAF 4	1807	Operational Director of Estates and Facilities	Aged lifts may fail beyond repair, reducing patient transfer capacity and impacting safety and care.	31/12/2026	✓	16	8	No	16 Months	RMG Deep Dive ✓	3	✓
BAF 4	3348	Chief Medical Officer	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/10/2026	✓	12	8	No	21 Months	RMG Deep Dive ✓	1	✓
BAF 5	3880	Chief Finance Officer	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust	01/07/2026	✘	9	9	Yes	4 Months	RMG Deep Dive ✓	0	✓
BAF 5	3895	Chief Finance Officer	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3896	Chief Finance Officer	Failure to redesign services leads to failure to improve implied productivity at the required rate	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3897	Chief Finance Officer	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate	15/06/2026	✘	16	6	Yes	4 Months	No	0	✘ Missing
BAF 5	3898	Chief Finance Officer	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3899	Chief Finance Officer	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3900	Chief Finance Officer	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3901	Chief Finance Officer	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3902	Chief Finance Officer	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3903	Chief Finance Officer	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow	21/08/2026	✓	16	6	No	4 Months	No	0	✓
BAF 5	3920	Chief Finance Officer	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm	01/09/2026	✓	9	9	No	3 Month	RMG Deep Dive ✓	0	✓
BAF 7	1410	Head of Digital Operations and Cyber Security	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	30/10/2026	✓	10	10	No	12 Months	RMG Deep Dive ✓	0	✓

BAF 7	1663	Chief Information Officer	Failure of the HSCN, Internet, or VOIP telephony external network connections	31/09/2026	✓	8	4	No	19 Months	No	0	✓
BAF 7	2638	UEC – Divisional Nurse Manager	Prescribing medicines in ED for patients waiting for admission to hospital - failure to give or duplication of administration	12/01/2027	✓	15	3	No	30 Months	RMG Deep Dive ✓	0	✓
BAF 7	2727	Digital Infrastructure Manager	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	30/06/2026	✖	9	3	Yes	26 Months	RMG Deep Dive ✓	0	✓
BAF 7	2736	Head of Digital Operations and Cyber Security	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & DR	30/09/2026	✓	9	6	No	51 Months	RMG Deep Dive ✓	0	✖ No Active Action
BAF 7	3184	Chief Information Officer	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	30/09/2026	✓	8	4	No	19 Months	RMG Deep Dive ✓	0	✓
BAF 7	3384	Chief Information Officer	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	17/09/2026	✓	8	4	No	4 Months	No	0	✓

BAF Linked operational risks

BAF No.	Risk Title	Rating
Patients	Quality Committee Oversight	
BAF 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.**	**16**
RISK 1517	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	15
RISK 3209	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	8
RISK 3246	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	12
RISK 3290	Risk of harm to patient due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	10
RISK 3454	Insufficient governance & service gaps risk failure to meet guidance, leading to harm, regulatory action, & reputational damage	16
RISK 3883	Incomplete Emergency Response Plans Risk EPRR Non-Compliance and Delayed Incident Response (Domain 3)	12
RISK 3884	Insufficient On-Call Training Risks Delayed Incident Command and Non-Compliance with EPRR Standards (Domain 4)	12
RISK 3885	Lack of EPRR Training and Exercising Risks Delayed Incident Response and Non-Compliance with Statutory Duties (Domain 5)	12
RISK 3887	Insufficient HAZMAT/CBRN Capability Risks Unsafe Incident Response and Non-Compliance with EPRR Standards (Domain 10)	12
People	People Committee Oversight	
BAF 2	**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.**	**16**
RISK 16	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	9
RISK 19	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	9
RISK 3507	Failure to meet MHRA research inspection standards	12
Patients	Finance and Performance Committee Oversight	
BAF 3	**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**	**16**
RISK 3890	Timely access to diagnostic services - Demand, Capacity & Flow	12
RISK 3891	Timely access to elective care - Demand, Capacity & Flow	12
RISK 3892	Timely access to cancer services - Demand, Capacity & Flow	12
RISK 3893	Timely access to emergency care - Demand, Capacity & Flow	16
Patients & People	Finance and Performance Committee Oversight	
BAF 4	**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.**	**20**
RISK 12	Failure to maintain estates to standards may cause compliance breaches, service disruption, and reputational harm.	25
RISK 1083	Non-compliant, aging electrical systems may fail, increasing risk of incidents and reducing operational resilience.	15
RISK 1412	Failure to maintain estates to fire safety standards may lead to enforcement, service disruption, and reputational harm.	15
RISK 1807	Aged lifts may fail beyond repair, reducing patient transfer capacity and impacting safety and care.	16
RISK 3348	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	12
Pounds	Finance and Performance Committee Oversight	
BAF 5	**If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.**	**16**
RISK 3880	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust	9
RISK 3895	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate	16
RISK 3896	Failure to redesign services leads to failure to improve implied productivity at the required rate	16
RISK 3897	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate	16
RISK 3898	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity	16
RISK 3899	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels	16
RISK 3900	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan	16
RISK 3901	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings	16
RISK 3902	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme	16
RISK 3903	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow	16
RISK 3920	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm	9
Patients & People	Finance and Performance Committee Oversight	
BAF 7	**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.**	**15**
RISK 1410	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	10
RISK 1663	Failure of the HSCN, Internet, or VOIP telephony external network connections	8
RISK 2638	Prescribing medicines in ED for patients waiting for admission to hospital - failure to give or duplication of administration	15
RISK 2727	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	9
RISK 2736	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & Disaster Recovery	9
RISK 3184	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	8
RISK 3384	Failure to update software/hardware may lead to increase cyber-attack exposure and general failure of digital services	8

Appendix 2: Board Assurance Framework

BAF Risk Summary

Introduction:

The Board Assurance Framework (BAF) enables the Board to identify and understand the principal risks to achieving its strategic objectives. Our 'Healthier Together – Delivering Exceptional Care for All' Strategy is structured around four key priorities and these are mapped against each of the risks on the BAF.



Aligning Controls and assurances

The BAF Template format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and assurances are required and what actions we need to include.

Three lines of assurance model

The Trust uses the three lines of assurance model. The assurance provided on the BAF is split by each of the three lines so that we can be clear which part of the organisation is providing assurance and undertaking mitigating action. This also helps us to identify and rectify any gaps

Cause Risk and Consequences

The cause, risk and effect format allows us to see controls, assurances and actions by the cause and effect of each risk, so that we can be sighted on how we are reducing the likelihood and the consequence. Risk descriptors are written using the cause, risk, and effect model to help shape the way we present risk on the BAF.

Clarity over scoring stages and methodology

Scoring terminology is defined as;

- **Inherent Score**. This is the score of a risk based on there being no controls in place. This would apply if the BAF were to identify that current controls are not working effectively.
- **Current score.** This is the score considering the controls currently in place, assuming that they are working. This can also be termed as residual risk by some organisations, due to this, we are avoiding the use of this term.
- **Target score**. This is the score once any new mitigating controls have been put in place; this will need to be within our target appetite or will need to be tolerated and justified as such in the covering risk report.

The Trust uses the 5 x 5 multiplication scoring method of likelihood x consequences/impact

BAF 1

Strategic Risk 1	***If 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	1517, 3209; 3246; 3290; 3454; ~~3769~~, 3883; 3884; 3885; 3887,
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Last reviewed (by on behalf of Lead Directors)	July 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) *Planned Internal Audit Plan 2026-27 Q3/4 - Learning from deaths* *Planned Internal Audit Plan 2026-27 Q1/2 - Mortality data quality assurance*	**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) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3) (Significant Assurance)	
• Listening to patients (Patient forum) Primary listening forums: Citizens Panel Digital Stories Patient Surveys FFT Range of engagement forums	**GC11)** Ockenden and Amos reports to be fully reviewed internally alongside current programmes of work	Caring Assurance group reports (1) Quality Committee (2) Patient Experience Annual Report (1)	
Preventing avoidable harm and poor patient outcomes			
Compliance with Developing workforce safeguards including use of Safer Nursing Care Tool and biannual workforce reviews (BR+ for Midwifery) Establishment changes via Chief Nurse approval.		Biannual establishment review reporting for Nursing to People Committee (2) Trust wide safe staffing meetings (1) Established use of safe care (1) Evidence of escalation in incident reporting (1) Monthly compliance with safe staffing care hours per patient day reporting via unify (2) AHP Biannual workforce report presented to People Committee (2) Biannual Midwifery Workforce report to Trust Board of Directors (2)	
Ensuring regulatory compliance and sustainable quality			
Clinical policies, processes and clinical guidelines	**GC9:** Significant numbers of Clinical policies are out of date **GC10:** CQC 29a notice issued which outlines regulatory breaches	Infection Prevention Control Steering Group (1) Risk Management Group (1) Risk Management Group assesses and moderates significant risks and presence of valid action plans monthly (2) CQC unannounced visit to DRI ED (3) Planned Internal Audit 2026-27 Q1/2 – Medical Devices Management (+ BAF 4 and BAF 7)	
Clinical Audit Programme and monitoring.		Report to Quality Committee (2) Monday.com dashboards outputs reviewed at Audit and effectiveness forum (1)	
Clinical Negligence Scheme for Trusts monitoring and oversight (maternity and neonates)		LMNS-Local maternity and neonatal Annual system check & challenge, feedback received and shared at QC (3) CNST divisional oversight group highlight reports (1) Maternity, Neonatal Quality and safety Group (2) Maternity safety champions visits and meeting (2) Maternity and Neonatal report to QC (3)	
The shape of DBTH Programme Pillar		Progress reporting to Quality Committee (2) Reset Board (1) Board of Directors (2) QPIA's to Quality committee (where criteria met) (2)	

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions	**Timescale**	**Lead**	**Progress update**
GA1) SHMI review of the data quality reporting and individual cases	July 2026	CMO	Currently, Bassetlaw SDEC activity is not coded within the admitted dataset, as per national guidance. Work has commenced to rectify this position to gain parity with Doncaster SDEC recording and further improve Trust-wide clinical coding quality.
GC4) SJR plan in place to address current gaps	July 2026	CMO	Q1 25-26 reported 7% SJR completion, raising to 14% in Q4 25-26. Best practice guidance is 15 – 20% completion which is expected to be attained by the end of Q1 26-27
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	September 2026	Company Secretary	Recruitment to support with the policy role is now in place to provide management and monitoring internally against review dates and the APD process. Report taken through to the Hospital Leadership Team evidencing reduction in overdue policies (14) with plans in place for all these to be reviewed and or signed off before September 2026. Once in place – propose to close.
GC10) Action plan to address the CQC 29A Notice and CQC final report of UEC.	March 2027	CN	Monthly updates via executive team and HLT with oversight at the quality committee. Programme of unannounced executive assurance visits fortnightly to check on embedding of the improvements outlined in the plan.
GC11) Ockenden and Amos review	September 2026	CN & CMO	Awaiting national Gap analysis tool and review against the 10-point action plan from NHSE prior to oversight at Board.

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.

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

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance (**Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**
Waiting time standards Access Policy Cancer Access policy Capacity and flow policy Trust validation Programme Patient Tracking List management Consistent across all Trust services Cancer Patient Tracking List management Clinical Prioritisation Access and Flow Rest Programme Pillar		Performance Review Meetings monthly report (1) National Data Submission of Trust performance (2) Access Standards Reports to F&P Committee (2) IQPR report to Board (2) Doncaster Place UEC board (monthly) (3) NHSE / ICB / Place Tier 2 meeting (fortnightly) (3) Model Health reporting system (3) SYB Cancer performance meeting (3) Operational Delivery & Improvement Group (monthly) now in progress (2) Internal Audit of Data Quality, Cancer metrics 25/26 Plan (3) (limited Assurance) External review of PTL arrangements by GIRFT Elective (3) System discharge / flow partnership oversight reporting (3) Internal Audit Report 25/26: Patient flow: focus on discharge (limited assurance) Progress reporting to F&P Committee (2) Reset Board (1) Board of Directors (2) Trust Access Group: Elective (2) Trust Access Group: UEC & Patient Flow (2)	GA7) Limited assurance on partner-delivered elements of access recovery plans (e.g., community and social care capacity, diagnostic network capacity) and the impact of mutual aid **GA8)** Implementation of Internal Audit recommendations from the Patient flow Audit (Limited Assurance)
Demand management Doncaster Place UEC improvement programme	**GC9)** Implement Urgent Treatment Centre First model	Performance Review Meetings monthly report (1	

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 25th November 2025 following approval at F&P and BoD (3) Department of Critical Care (DCC) relocation project due to complete Jan 2027, this project is an enabling project to the full East Ward Block refurbishment project (2) Bids submitted to NHSE on 13th January for funding via Return to Constitutional Standards (RtCS) which includes at large £25m project to Co-located UEC/UTC/SDEC at DRI (3) Bids have also been submitted against the Estates Safety Fund (ESF) in January for schemes to the value of £24m over 4 years, £6m each year, in addition to a two £25m main theatre bids to first expand by two theatres and then to refurbish the 8 existing theatres (3) Board Development Session BAF 4 & DRI Development Master Plan and accompanying bids to accelerate Backlog and Critical Infrastructure Risk eradication at DRI on 3rd February (3)	
Planned Preventative Maintenance (PPM) program.	**GC1**: The Trust's current maintenance strategy focuses on statutory compliance and minimum essential maintenance requirements. An estates maintenance review indicates that circa £1m of additional resource (the majority at DRI) is required (£690kpay/£317k non-pay) to deliver an effective maintenance strategy that	Report to F&P Committee (2) Ongoing monitoring of maintenance reactive Programme of external audit for Authorising Engineers (AE) and enforcing authorities. (3) PAM Assurance Model Self-Assessment (1)	

	aims to improve preventative maintenance measures in line with industry guidance as a control against estates infrastructure risks.		
Doncaster Royal Infirmary Site Evacuation Plans	**GC2**: Work is currently in progress to establish effective site evacuation plans for DRI, supported by a System response.	EPRR response approved by Board of Directors (2) Review through Capital Monitoring Committee (2) 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 and tackle it's underlying deficit over a reasonable timeframe 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)	August 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	**GC9**: £6.5m full year income misalignment with South Yorkshire ICB with a process agreed to seek to resolve that through an agreed side letter to the contract	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 within Reset Programme and Local Savings target system efficiency schemes (e.g., collaborative procurement, shared pathways and demand management) with named SROs and delivery governance	**GC2:** At the month 3 reporting point the risk adjusted savings forecast is: - £22.7M of recurrent FYE savings vs £48.8M plan, leaving a £26.1M (53.5%) gap - £27.7M of in-year savings vs £46.3M plan, leaving a £18.6M (40.2%) gap **GC5**: Embedding of Medical rostering	Reset Programme reporting to Board and F&P committee (2) HFMA Checklist Action Plan complete in April 2023. (3) Local savings 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 Getting the Basics Right and NHSE Strengthening Financial Management 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.	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 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)	

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**
GC2: Continue to drive each pillar of the reset programme to maximise savings delivery over the medium-term plan horizon.	March 2029	DCEO/ Reset Director	Reset Board reporting now implemented. New PMO tool (Neon) procured that will allow us to correlate scheme actions to savings. Implementation with effect form 19th August Rest Board.
GC2: Divisions and directorates to produce local savings plans and pipelines, to be managed through PRM escalation process.	September 2026	Divisional and directorate management teams	Latest plans reviewed at in person meetings with Rest director and Executive team on 29th July. Plans being checked to reallocate any savings associated with Reset programme currently. Updated plans and pipelines to be reviewed at each PRM meeting going forward.
GC2: Executive Team to consider contingency options (difficult choices) and alternative benchmarking data to find further opportunity	September 2026	Rest director and Executive Team	HLT briefed on 5th August including some ideas for difficult choices. Initial Executive discussion scheduled for 12th August in order to feedback to Rest Board on 19th August.
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~~ September 2026	CFO	Invest to save business case approved by CIG in November 2025. Finance team structure approved by Executive Team in December 2025. Consultation with staff began in July 2026 and implementation of the approved business case will follow the end of the consultation.
GC9: Implement the process agreed in the side letter to the contract to seek to resolve the £6.5m contract misalignment with South Yorkshire ICB	September 2026	CFO	The block contract review and rebasing exercise was completed and the analysis provided to the ICB in line with the agreed timeframe (end of May). However appropriate adjustments to the contract in light of that were not agreed by the end Q1 deadline when the then ICB CFO retired. The Trust is working with the new ICB CFO and her team on this matter, and a revised contract offer is expected in early September.

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	Digital Maturity Assessment (3)	

	dependencies (including EPR interfaces) is not yet fully in place		
Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware) 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		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) 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

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.	

2609 - J2 TRIANGULATION OF INFORMATION TO IDENTIFY AGENDA ITEM THEMES

Discussion Item | Mark Bailey, Interim Chair | 13:00

5 minutes

2609 - J3 BOARD EFFECTIVENESS & DEMONSTRATING THE DBTH WAY

Discussion Item | Mark Bailey, Interim Chair | 13:05

- 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

2609 - K CLOSING ITEMS

13:10

2609 - K1 MINUTES OF THE MEETING HELD ON 7 JULY 2026

Decision Item | Mark Bailey, Interim Chair | 13:10

5 minutes

REFERENCES

Only PDFs are attached

K1 - Board of Directors Draft Minutes - 7 July 2026.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the Board of Directors held in public on
Tuesday 7 July 2026 at 9:30am
in the Boardroom at Bassetlaw Hospital

Present:	Mark Bailey - Interim Chair (Chair) Helen Best - Non-executive Director Jo Gander - Non-executive Director 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 Simon Brown - Deputy Chief Nurse Professor Sam Debbage - Director of Education & Research (agenda item D1) Dr Jane Fearnside - Head of Research (agenda item D1) Paula Hill - Freedom to Speak Up Guardian (agenda item E2) Mohammad Khan - Guardian of Safe Working Hours (agenda item E1) Lois Mellor - Director of Midwifery (agenda item F1) Angela O'Mara - Deputy Company Secretary (minutes) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Hannah Beardmore - Staff Side
Apologies:	Karen Jessop - Chief Nurse

ACTION

P26/07/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.

The Chair recognised the extraordinary work undertaken each and every day to deliver services and encouraged colleagues to reflect on that work as part of today's meeting.

P26/07/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 3 - Speaking Up Reports - the report was included on today's agenda, the frequency of reporting would remain as per current practice. Action closed.

Action 5 - Risk Appetite Statement – the risk appetite statements had been reviewed and were included on today's agenda for ratification. Action closed.

P26/07/B1 **Chair's Report including Partnership Update (Enclosure B1)**

The Board received and noted the Chair's report, which reflected on the Trust's role in the community as a healthcare provider, employer and anchor institution.

Since the last Board meeting, the Chair had spent time with colleagues on the Frailty Assessment Unit, where he had observed a multidisciplinary meeting. He shared with the Board, the care, compassion and professionalism shown by colleagues and their focus on person-centred care, promoting independence, and where safe to do so, to return patients to their home.

The Chair acknowledged the retirement of Chief Executive, Richard Parker, announced last month, and he placed on record his personal appreciation and that of the Board for Richard's significant contribution to the organisation and the wider NHS.

Non-executive Director, Helen Best enquired of opportunities for non-executive directors to become involved in external engagement and the Chair suggested links with partners, including Doncaster Chamber and broader opportunities around the development of the city centre, drawing on individuals areas of expertise, as required.

Non-executive Director, Stephen Radford also suggested the potential for Place, system and community partners to be invited to Board meetings.

The Board:

- ***Noted the Chair's Report***

P26/07/B2 **Chief Executive's Report (Enclosure B2)**

The Acting Chief Executive highlighted the alignment of the Trust's plans to national priorities; prevention, neighbourhood health, digital transformation and an overriding need for financial sustainability.

Consistent cultural, leadership and psychological safety themes seen in Lord Mann, Donna Ockenden and Baroness Amos' reports resonate with ongoing improvement work at the Trust with a focus on behaviours, accountability and organisational culture. Board members were challenged to seek evidence, rather than reassurance and look for signals in controls and governance arrangements that may identify an issue.

Progress was reported against the Trust's strategic priorities and key risks were outlined.

The Acting Chief Executive also acknowledged the Chief Executive's retirement and placed on record her thanks and those of colleagues across the organisation. Richard

had served the NHS for 44 years and had been the Trust's Chief Executive for nearly ten years; his contribution throughout that time was recognised.

Today was also the last meeting of Rebecca Allen, Associate Director of Strategy, Partnerships & Governance who had been instrumental in progressing corporate governance during her time at the Trust.

Zoe Lintin, Chief People Officer would leave the Trust at the end of December 2026, and the Chair congratulated the Acting Chief Executive on her appointment as Chief Executive at East Cheshire NHS Trust.

Non-executive Director, Lucy Nickson enquired if there was an opportunity to consider how the Board received more information on patient experience. The Deputy Chief Nurse confirmed that the Trust was working with a trust in the North-East to understand how they captured real time patient feedback. The intention was to share this with the Quality Committee for feedback to the Board.

Non-executive Director, Kath Smart Kath recognised the national recognition of the Trust's Line in the Sand initiative and enquired what internal feedback had been received and what differences were being seen. The Acting Chief Executive confirmed the approach had generated lots of internal conversations, empowering colleagues to speak up about behaviours which did not align with the Trust's values and enabling earlier interventions. There had also been external interest, from the media and other professional groups, including Freedom to Speak Up colleagues. It was recognised that Trust wide engagement from all colleagues and professional groups was required to ensure its success. In terms of the impact, the Chief People Officer confirmed this could be assessed through casework, Staff Side interactions and Freedom to Speak cases, recognising there may be a resultant increase in activity.

Non-executive Director, Kath Smart, reflected on the national publications and enquired, from an accountability perspective, what the assurance loop would be. The Acting Chief Executive recognised the volume of information which flowed into the organisation, received via executive leads and considered and cascaded via the Executive Team into the relevant governance routes. In terms of oversight of the publications the Deputy Chief Executive agreed to give some thought as to how this could be achieved.

The Board:

- ***Noted the Chief Executive's Report***

P26/07/B3 **<u>Reset Programme Update (Enclosure B3)</u>**

The Acting Chief Executive confirmed that the Reset Programme had been fully mobilised as the single delivery mechanism for the Medium-Term Plan, with established governance arrangements in place.

Good progress was reported against the five pillars, and at month two delivery of the financial plan was on track. Key risks were identified as conversion of early in-year benefit to recurrent savings, capacity and pace to deliver workforce and cultural

change, and clinical engagement and partner decision making to support service redesign. Mitigating actions were being taken to strengthen capacity.

Non-executive Director, Stephen Radford, welcomed the update. To support Board oversight, he suggested it would be helpful to provide a plan on a page to show delivery to date and provide a clear line of sight. With a risk adjusted position and remedial actions clearly articulated.

Non-executive Director, Kath Smart, recognised fortuitous savings had supported the on plan year to date position and enquired what assurance could be provided in respect of securing recurrent savings. The Chief Finance Officer confirmed not all schemes within the rest pillars were capable of delivery recurrent savings.

In response to an observation by Non-executive Director, Kath Smart, the Deputy Chief Executive confirmed that Reset Programme reporting was still in development and was not intended to duplicate what was received at an operational or committee level meeting. Although it was noted that there was an opportunity via the Board Committee Chair's assurance log to receive additional information. The Chief Operating Officer was working with the performance team to redesign reporting in line with the Medium-Term Plan, National Oversight Framework and NHS Standard Contract.

The Chair welcomed colleagues' feedback to enhance reporting, including a forward trajectory for Board oversight.

The Board:

- ***Noted the Reset Programme Update***

P26/07/C1 **Integrated Performance Report including Finance Report (Enclosure C1)**

The Integrated Performance Report (IPR) provided key performance and safety measures relating to cancer standards for April 2026 and remaining access, quality, and workforce standards for May 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 the Integrated Performance Report would be further developed to reflect the metrics across the National Oversight Framework, Medium-Term Plan and NHS Standard Contract, performance would be reported against plan and include benchmarking, where available.

12 hour waits in the Emergency Department, average ambulance handover times, 31-day decision to treatment and 62-day referral to treatment for cancer patients were all ahead of plan.

4-hour waits in the Emergency Department were behind plan, driven by high demand and timely access to care. Referral to treatment, was behind plan, with a delivery plan in place across all specialities and an elective recovery action plan for Trauma & Orthopaedics.

An improved performance in the cancer Faster Diagnosis Standard was expected next month, following resolution of capacity constraints in the breast pathway.

The Chief Medical Officer reported the Summary Hospital-level Mortality Indicator (SHMI) remained within expected range, with green shoot improvements seen in local data collection. A deep dive into sepsis management had been conducted and actions progressed.

The Deputy Chief Nurse confirmed quality key performance indicators remained on track, confirmation of the C. difficile threshold was awaited, currently levels were below the same reference period last year. Targeted improvement work was ongoing in respect of E. coli to reinforce best practice.

The Chief People Officer confirmed a soft launch of the refreshed sickness absence management policy was planned to support attendance at work and shared a recent opportunity for the Trust to share good practice in absence management at a national workshop. Work continued to align with the national Statutory and Mandatory Programme, a Mandatory Learning Oversight Group had been established, and the Trust was responding to actions arising from an internal audit report commissioned in respect of statutory training.

The Chief Finance Officer reported that the underlying deficit exiting 2026/27 was on track year to date. Financial risks had been updated since the plan submission and the main risk centred on delivery of the efficiency programme. Year to date efficiency savings were on plan.

In month two bank and agency spend was above plan, and an increase had been seen from the previous month. The Trust benchmarked well on bank spend but poorly on agency.

The cash balance stood at £18.m, £8.1m behind plan, this was due to non-receipt of deficit support funding.

The latest published data showed a 10.7% improvement in implied workforce productivity and a 10.1% improvement in implied productivity per £, which placed the Trust in the top quartile nationally.

In response to a question from Non-executive Director, Jo Gander, the Chief Finance Officer confirmed that the 2025/26 National Cost Collection would highlight productivity concerns at a speciality level, this was expected to be received in September 2026.

Non-executive Director, Kath Smart, welcomed the supporting narrative on the cover sheet. In terms of external assurance, she highlighted internal audits in respect of sepsis management, patient flow, statutory and essential training and mortality.

Non-executive Director, Stephen Radford, noted a reduction in statutory and essential training compliance and enquired of the reasons for this, and the plan to recover the position. The Chief People Officer confirmed that the main challenge affecting completion was the ability to release colleagues due to operational pressures. Plans to target by area and topic were to be enacted to consider alternative ways of delivering

training. The Trust was also supportive of engaging in a collaborative approach, explored previously for Oliver McGowan training.

The Chief Medical Officer confirmed discussions were ongoing with the British Medical Association in respect of medic's training compliance.

As Chair of the People Committee, Non-executive Director, Lucy Nickson recognised the impact on compliance of national changes and reassured the Board that education and training was subject to scrutiny and focused discussion at the committee.

The Chair acknowledged the challenges, which were also reported in the perinatal safety and quality reporting, a requirement of the Maternity Incentive Scheme, and confirmed this would remain of interest to the Board through routine reporting.

Non-executive Director, Helen Best, reflected on diagnostics performance and recent discussions arising from the Allied Health Professionals workforce review at the Board's People Committee and enquired what plans were in place to ensure stability in the workforce to deliver the required standards and who was accountable for the delivery of this.

The Chief Operating Officer acknowledged that the report described an overall diagnostic performance and as not all diagnostic standards were behind plan it was confirmed that the narrative should better articulate the position in future reports. The Acting Chief Executive confirmed that divisional performance was considered by the divisional leadership team and executive directors at the Performance Review Meetings, with opportunities to expand thinking across divisions and directorates.

The Board:

- ***Noted and took moderate assurance from the IPR***

P26/07/C1i **Q3 2025/26 Learning from Deaths Report (Enclosure C1i)**

The Chief Medical Officer shared with the Board the Quarter 3 Learning from Deaths report. An improving compliance was reported in respect of Structured Judgement Reviews, with a completion rate of 11% and an improvement trajectory to achieve 15%, in line with national expectations.

Non-executive Director, Stephen Radford, challenged the proposed significant assurance level and enquired of the targeted actions in place to close any gaps. The Chief Medical Officer confirmed this had been extensively debated by the Quality Committee and in view of the improvement trajectory, an improving Summary Hospital-level Mortality Indicator (SHMI) and evidence or good care it was decided this offered significant assurance. The Chair suggested maintaining this level of assurance would be subject to continued delivery. Non-executive Director, Kath Smart, suggested it may have been appropriate for the committee to take a split assurance opinion on outcomes versus process.

The Chief Finance Officer enquired if the national expectation of 15% was reasonable and questioned why the Trust's SHMI differed to that of neighbouring organisations. The Chief Medical Officer highlighted the impact of clinical coding on SHMI and

confirmed that over the last four months inhouse data indicated the actual and expected number of deaths were the same.

In response to a question from Non-executive Director, Lucy Nickson, regarding the number of deaths in the Emergency Department, the Chief Medical Officer confirmed the number of deaths in the department were not of concern and advised the Trust was not an outlier in this area.

Where poor care had been identified, Lucy Nickson noted the reference to "not my patient" mentality, the Chief Medical Officer confirmed this was being addressed through interprofessional standards. On occasions this had occurred between the Emergency Department and the specialty. A shared letter from the Chief Operating Officer, Chief Medical Officer and Divisional Director set out the protocol and the enforcement of this would be critical.

The Board:

- ***Noted and took significant assurance from the Q3 2025/26 Learning from Deaths Report***

P26/07/D1 **Research & Innovation Case Study (Enclosure D1)**

The Chair welcomed the Director of Education & Research and Head of Researach to the meeting to share with the Board a patient case study to highlight the importance of access to research opportunities from a patient, organisation and system level.

The Director of Education & Research reflected on the benefits of the 150 day clinical trial and the opportunities for health inequalities research, widening partnership arrangements and attracting commercial income.

A patient with lupus and myositis had been identified by Dr Yee, Consultant Rheumatologist to take part in the trial due to limited treatment options.

A powerful and emotional statement from the patient described the life changing impact of the condition. The clinical trial allowed the efficacy of the drug to be established compared to a placebo, treatment and monitoring throughout the trial and an extended study to support access to investigational therapies, not available on the NHS.

Non-executive Director, Lucy Nickson, welcomed the opportunity to hear the patient voice and perspectives.

In response to a question from the Chief Finance Officer, the Head of Research confirmed that patients participating in trials received a wealth of information ahead of the trial, with ongoing consultations throughout the trial period.

Non-executive Director, Stephen Radford, noted the potential for participants to receive a placebo as part of a clinical trial, the Head of Research confirmed this was understood by participants who benefited from increased clinical monitoring and oversight and alternative therapies as part of the optional extension to the study.

Non-executive Director, Helen Best, recognised clinical research was dependent upon supporting factors and enquired what support was required to continue to grow and develop in this area. The Director of Education & Research confirmed the continued commitment of the Board to advocate for clinical research.

The Board:

- ***Noted the Research & Innovation Case Study***

P26/07/D2 **2025/26 Quality Accounts (Enclosure D2)**

The Board received and noted the 2025/26 Quality Accounts.

The paper provided assurance that robust governance arrangements were in place to oversee quality, sustain improvement, and address areas requiring continued focus in 2026/27.

In response to a question from Non-executive Director, Kath Smart, regarding lower than expected Friends & Family Test response rates, the Deputy Chief Nurse confirmed plans to recruit to Patient Experience volunteers throughout 2026/27.

The Chief Operating Officer noted the reported increase in urgent and emergency care from the previous year and whilst accurate clarified that an increase had been forecast.

The Board:

- ***Noted the 2025/26 Quality Accounts***

P26/07/E1 **Guardian Of Safe Working Hours Report (Enclosure E1)**

The Chair of the Board welcomed the Guardian of Safe Working Hours to the meeting to present exception reporting for the period 1 February to 31 March 2026.

A total of 190 exception reports had been made during this period, the majority of which were from foundation year or resident doctors, The highest number of exception reports were from General Surgery, Obstetrics and Gynaecology and related to additional hours worked, reflecting the high workload, often compounded by rota gaps, vacancies and seasonal pressures. It was confirmed there had been limited reports in respect of missed educational opportunities.

The data within the report was in line with NHS Employers and the British Medical Association guidance and included exception reports which had been withdrawn or rejected.

Non-executive Director, Stephen Radford, noted the wording in the report which stated the vast majority of resident doctors were able to work safely and enquired what percentage could not work safely. The Chief People Officer confirmed that the language used was that described nationally and related to resident doctors working beyond their contracted hours. Processes to support exception reporting and engagement with resident doctors was established. The Guardian of Safe Working Hours recognised that reporting was based upon an individual's view, often related to pressures arising during the shift linked to sickness or rota gaps.

In terms of actions to address known gaps, the Chief Medical Officer advised that a business case to increase the number of resident doctors in General Surgery was in development.

In response to an observation by Non-executive Director, Kath Smart, regarding reduced attendance at the last Resident Doctors' Forum. The Guardian of Safe Working Hours confirmed the various approaches taken to improve attendance which he felt were impacted by the number of less than full-time resident doctors. The next forum would take place online to support attendance.

Non-executive Director, Lucy Nickson, noted the Trust's compliance with the resident doctors ten-point action plan, overseen by the Board's People Committee and confirmed that feedback from the peer representative indicated a good level of resident doctor engagement.

In response to a question from the Chief Finance Officer regarding enforced use of study leave to maintain statutory and essential training compliance, the Guardian of Safe Working Hours confirmed that no exception reports had submitted in this respect. The Chief People Officer highlighted that the impact of training on resident doctors was considered by the Mandatory Learning Oversight Group.

The Board:

- ***Noted and took significant assurance from the Guardian of Safe Working Hours Report***

P26/07/E2 **Speaking Up 2025/26 Annual Report (Enclosure E2)**

The Chair welcomed the Freedom to Speak Up (FTSU) Guardian to the meeting. The 2025/26 Speaking Up Annual Report had been scrutinised at the Board's People Committee in June 2026, and significant assurance was taken in respect of the systems and processes in place, reflected in the peer view, DBTH Way in Action and wider feedback.

A slight increase in the overall number of cases had been seen from 2024/25, with a more notable increase in individual cases and anonymous reporting, whilst this could be indicative of colleagues' psychological safety, a mechanism to support anonymous reporting had been implemented in year, in line with national guidance and the work of the Trust's Sexual Safety Working Group.

93% of colleagues who had used the FTSU service said they would speak up again, delays in case closure and confidence in Speaking Up continued to impact the overall feedback rate.

The Chief People Officer confirmed that Speaking Up would continue to be reported across the People Committee and the Board of Directors in line with regulatory expectations.

The Acting Chief Executive noted the increase in anonymous reporting and enquired if a reason other than anonymity was known, the FTSU Guardian indicated there was limited insight, however, the form did look to establish if the concern had already been

raised internally or with another SU Partner to understand if the contact was a means of escalation.

The Chief Finance Officer reflected on feedback from the DBTH Way in Action review regarding a perceived lack of confidentiality in the Speaking Up process and asked if this feedback had been seen through other routes. The FTSU Guardian confirmed the peer review had highlighted this aspect of the process as a strength and in line with best practice.

In response to a question from Non-executive Director, Kath Smart, regarding how thematic FTSU learning linked to the Reset Programme, the Chief People Officer confirmed that it formed part of the leadership and culture pillar. Progress against detailed action plans was also shared at the Board's People Committee as part of the Engagement and Leadership report.

Non-executive Director, Kath Smart, enquired of the opportunities to engage with the medical workforce, aside from resident doctors, which had been described earlier. The FTSU Guardian highlighted opportunities where the medical workforce supported learners in the organisation and one to one discussions when visiting clinical areas. In addition, the Chief People Officer highlighted the joint Speaking Up and General Medical Council sessions and the Associate Medical Director for Professional Standards and Revalidation was an active member of the Speaking Up Forum.

The Board:

- ***Noted and took significant assurance from the 2025/26 Speaking Up Annual Report***

P26/07/E3 **<u>Workforce Race & Disability Equality Standards (Enclosure E3)</u>**

The Board received and noted the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data for 2025–2026.

Prior to its submission the data had been considered by the Executive Team and was subsequently received by the Board's People Committee, alongside the 2025/26 Equality, Diversity & Inclusion (EDI) Annual Report.

A copy of the EDI Annual Report was circulated to members of the Board post meeting, at the request of the Chair.

The Chief Finance Officer noted the lack of diversity in members of the Board.

Following the publication of Lord Mann's review into tackling racism and antisemitism in the NHS, the Chief Executive of NHSE had written to all trusts setting out a series of immediate actions. The correspondence had been considered by the Executive Team and follow up actions had been agreed. Where necessary the actions had been incorporated in the EDI Improvement Plan.

The Board:

- ***Noted the 2025/26 Workforce Race & Disability Equality Standards Report***

P26/07/F1 **Perinatal Safety & Quality Interim Report (Enclosure F1)**

The interim Perinatal Safety & Quality Report was shared with the Board and provided concise reporting of the extended report considered by the Board's Quality Committee in June and from a workforce perspective, the bi-annual midwifery workforce report reviewed by the Board's People Committee in June.

The Director of Midwifery highlighted a change in reporting, which would be further refined to include the addition of statistical process control charts and invited colleagues to provide feedback.

The Board's attention was drawn to the assurance summary for the period January to March 2026. This confirmed that perinatal mortality was within the expected range, resulting in zero Maternity Outcomes Signal System (MOSS) alerts, one still birth had occurred, there had been no identified learning from the Perinatal Mortality Review Tool (PMRT) and the Trust quality metrics, and Q4 PMRT report were provided for review and noting.

Training compliance remained an area of ongoing focus to meet the Year 8 Maternity Incentive Scheme standard of 90% compliance at the midpoint reference of August 2026.

The Director of Midwifery confirmed that the Ockenden and Amos independent reviews had now been published, with a 10-point immediate action plan shared for the latter there was a significant amount of work ongoing in maternity and neonatal services related to this.

In view of the recent publications, the Acting Chief Executive checked on colleague morale, the Director of Midwifery recognised the impact on colleagues of continued media focus, particularly when managing complex cases and confirmed an increase in sickness absence had been seen. The Deputy Chief Nurse highlighted the wrap around support available, which included Professional Midwifery Advocates and FTSU safety walkarounds. The support of the leadership team and the need for colleagues to support each other had also been reinforced and for support for patients to be provided at the first point of contact.

Non-executive Director, Lucy Nickson, enquired if there had been any impact on the requests received from expectant mothers. The Director of Midwifery confirmed an increase in requests for home birth had been seen, with the Nest at Doncaster Royal Infirmary being offered as an alternative homely environment as a midwife-led unit. It was also suggested, with the support of the Maternity & Neonatal Voices Partnership. that a carousel be organised to share what to expect when having a baby at the Trust.

The national action plan in response to the Amos report was expected by December 2026, the challenge in meeting these expectations across both sites were recognised and would need to be fully considered.

The Board:

- ***Noted and took significant assurance from the Perinatal Safety & Quality Interim Report and reviewed the Q4 PMRT, Trust Quality Metrics, data measures and the MOSS update.***

P26/07/G1 **2025/26 Estates Return Information Collection**

The mandated annual Estates Return Information Collection had been submitted on 29 June 2026, the national data was expected to be publicly available in October 2026.

An £11m increase in backlog maintain was noted, the net effect of an inflationary increase, a deterioration across the estate, primarily related to electrical and mechanical infrastructure, offset by capital investment.

Non-executive Director, Kath Smart, recognised the deteriorating position despite an increase in capital investment from 2024/25, which signalled that the infrastructure was beyond its economic life.

There was a good grip on risk management across the estate, mitigating actions included the development of the East Ward Block business case. Despite investment there was a significant level of underlying risk due to the ageing estate and backlog maintenance.

The Board:

- ***Noted and took significant assurance* from *the robust processes that are in place to deliver the ERIC return and manage estate performance and supported its submission***

P26/07/G2 **Deficit Support Funding (Enclosure G2)**

The Chief Finance Officer advised the Board that during 2026/27 the Trust had the potential to earn up to £15.7m of Deficit Support Funding (DSF). DSF would be earnt on a quarterly basis, subject to NHSE's expectations in appendix one being met.

Each quarter a Board Assurance Statement would be submitted, the Board's Finance & Performance Committee considered Q1's return at its meeting of 25 June 2026, ahead of sign off by the Chair and Chief Executive. A response was awaited from NHSE.

In response to a question from Non-executive Director, Jo Gander, regarding confidence in the ability to earn DSF, the Chief Finance Officer's noted the reliance on delivery of the plan and whilst risks were being managed, a residual risk remained.

The Board:

- **Noted the conditional receipt of the DSF and required ongoing Board oversight and the submission of the first quarterly Board Assurance statement, following approval by the Finance and Performance committee.**

P26/03/H1 **Chair's Assurance Log – Finance & Performance Committee (Enclosure H1)**

The Board received the Finance & Performance Committee Chair's assurance log from May and June 2026's meetings, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken. Significant assurance had been taken on progress of the Trust's digital and data plans, health and safety arrangements and the committee had recommended to the Board approval of the contract award for the renal satellite managed service.

The Board:

- ***Noted the Chair's Assurance Logs***

P26/07/H2 **Chair's Assurance Log – Quality Committee (Enclosure H2)**

The Board received the Quality Committee Chair's assurance log from June 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken. The Committee Chair highlighted ongoing work in strengthen the Trust's position in the National Early Arthritis Audit (NEIAA) audit and Getting It Right First Time reporting.

The Board:

- ***Noted the Chair's Assurance Log***

P26/07/H3 **Chair's Assurance Log – People Committee (Enclosure H3)**

The Board received the People Committee Chair's assurance log from June 2026's meeting which summarised the assurance taken and decision made.

The Board's attention was drawn to the findings of the Allied Health Professionals workforce review, improvements were noted since the last report, with vacancy levels in therapies below the national benchmark and a reduced reliance on temporary staffing in therapies and radiology. There remained some establishment and demand and capacity gaps, with an improvement plan in place to support more vulnerable professions.

The Committee took significant assurance of the controls in place for Just Culture and moderate assurance on the challenges arising from increased casework, capacity issues and the time taken to achieve an outcome.

The Committee had received its first Healthcare Scientist workforce review, a welcomed and innovative addition. The Chief Medical Officer shared his appreciation with the Lead Healthcare Scientist, Liz Johnson.

The Board:

- ***Noted the Chair's Assurance Log***

P26/07/H4 **Chair's Assurance Log – Audit & Risk Committee (Enclosure H4)**

The Board received the Audit & Risk Committee Chair's assurance log from June 2026's meeting, which summarised the assurance taken, areas of ongoing work, and matters of concern. The Committee had received two internal audit reports, patient flow had received a limited assurance audit opinion and implementation of planned actions would be followed up by the Committee. The statutory and essential training (SET) audit had provided a significant assurance audit opinion.

The year end accounts process and required submission would be considered in the confidential Board meeting.

The Board:

- ***Noted the Chair's Assurance Log***

P26/07/H5 **Governance Documents Review (Enclosure H5)**

The Associate Director of Strategy, Partnerships & Governance shared with the Board a suite of corporate governance documents for ratification following decisions taken at the Board Development Session on 14 April and 2 June 2026.

With the support of the Trust's internal auditors, the Trust's risk appetite was reviewed and revisions agreed to the risk appetite statements.

Levels of assurance were aligned with the Trust's internal auditor's assurance framework, with clear descriptors to provide clarity and consistency of application.

The annual review of committee Terms of Reference had taken place, including explicit references to the requirements of the Reset Programme.

The Chief Operating Officer shared her appreciation of the overarching corporate governance manual, developed by the Associate Director of Strategy, Partnerships & Governance. Plans to produce an executive and divisional governance manual would be progressed.

The Board:

- ***Ratified the governance manual. Trust risk appetite statements, Board Committees and Executive Team Terms of Reference***

P26/07/I1 **Board Assurance Framework including Trust Risk Register (Enclosure I1)**

The updated Board Assurance Framework was received for approval following consideration by the Board's assurance committees. In addition to maintaining the BAF as a live document, strategic risk six (partnerships) had been removed as a standalone risk and integrated into the remainder of the framework to recognise where partnerships could enable or be a barrier to delivery of the Trust's strategic objectives.

Non-executive Director, Kath Smart, noted several clinical polices were out of date and enquired if there was any impact on patient safety. The Chief Medical Officer

confirmed that all overdue clinical policies would be reviewed, and a decision taken whether they were categorised as a policy or standard operating procedures and brought up to date by 30 September 2026.

The Deputy Chief Nurse confirmed there was no evidence of harm related to the overdue policies.

The Board

- ***Approved the current BAF risk content and took significant assurance that this enables the Board to fulfil its duty to monitor its highest strategic risks.***
-

P26/07/I2 **Triangulation of Information to Identify Agenda Item Themes (verbal)**

The importance and impact of organisational culture was a common theme across reports and discussions, including national publications referenced in the Chief Executive's report, psychological safety, anonymous reporting and confidence in Speaking Up in the 2025/26 Freedom to Speak Up Annual Report and the ongoing work defined in the culture and leadership pillar of the Reset Programme reinforcing behavioural expectations.

Triangulation between people and performance were shared as part of the Integrated Performance Report related to training compliance, delivery of operational standards, temporary staffing and financial performance.

Clarity on the level of assurance sought from papers and discussions at Board assurance committees was also explored.

P26/07/I3 **Board Effectiveness & Demonstrating the DBTH Way**

The Board reflected on the volume of business received, which was managed across the allocated time and adjusted where necessary to support remote presentation of individual agenda items.

Opportunities were afforded to expand discussion to enable an appropriate level of understanding, constructive challenge and appreciation of impact.

Discussions were courteous and in line with the DBTH Way.

P26/07/J1 **Minutes of the meeting held on 5 May 2026 (Enclosure J1)**

The Board:

- ***Approved the minutes of 5 May 2026***

P26/07/J2 **Pre-submitted Questions regarding the business of the meeting (verbal)**
No public or governor questions were received.

P26/07/J3 **Board of Directors Work Plan (Enclosure F6)**

The Board:

- ***Noted the Board of Directors work plan***

P26/07/J4 **Any other business (to be agreed with the Chair prior to the meeting)**

There were no items of other business.

P26/07/J5 **Date and time of next meeting (verbal):**

Date: 1 September 2026
Time: 9:30am
Venue: Boardroom, Doncaster Royal Infirmary

P26/07/G5 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

P26/07/K **Close of meeting (Verbal)**

The meeting closed at 12.58

2609 - K2 PRE-SUBMITTED QUESTIONS

Discussion Item | Mark Bailey, Interim Chair | 13:15

10 minutes

2609 - K3 BOARD OF DIRECTORS WORK PLAN

Information Item | Brenda Thomas, Interim Company Secretary | 13:25

REFERENCES

Only PDFs are attached

K3 - Board Work Plan.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE								
				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											
Prev known as Maternity & Neonatal Update (Perinatal Safety & Quality Report)	Director of Midwifery	Every meeting	Sep-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	Sep-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-27				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								
PEOPLE											
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Nov-26		x		x		x	x	x
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-27				x				
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-27				x				
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Jan-27		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-27				x				
DBTH Way in Action & Well-led Review Progress Update	Acting Chief Executive	Alternate	Sep-26			x		x		x	x
PARTNERSHIP											
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	Sep-26			x	x	x		x	
Wider Partnership updates	DCEO	As required	As Req'd								
POUNDS											
Financial Plan	Chief Financial Officer	Annual	TBC		x						
Going Concern	Chief Financial Officer	Annual	May-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	Sep-26					x			
Annual Business Plan	Chief Financial Officer	Annual	Jan-26		x						
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-27				x				
ASSURANCE & GOVERNANCE											
Integrated Quality & Performance Report (**to include financial position wef Janary 2026**)	COO/CN/EMD/CPO	Every Meeting	Sep-26	x	x	x	x	x	x	x	x
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Sep-26	x	x	x	x	x	x	x	x
Board Risk Appetite	Deputy Chief Executive	Annual	May-27				x				
Review of Strategic Risks	Deputy Chief Executive	Annual	May-27				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	Sep-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Sep-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Sep-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Sep-26		x	x	x	x			x
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-26								
Board Work Plan (approval)	AD of Strategy, Partnerships & C	Annual	Jan-27	x							x
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annually	Nov-26	x					x		
Trust Seal	AD of Strategy, Partnerships &	Annually	Nov-26						x		
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & C	Annual	May-27			x					
Board Effectiveness	AD of Strategy, Partnerships & C	Annual	2027								
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - People Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & C	Annual	May-26				x				
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Deputy Chief Executive	As Req'd	As Req'd			x (HI)			x (HI)		
Mortuary Annual Report	Executive Medical Director	Annual	Nov-26						x		
ENABLING STRATEGIES											
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027								
People Strategy 2023/27	Chief People Officer		2027								
Research & Innovation Strategy 2023/28	Chief People Officer		2028								
Speaking Up Strategy 2024/28	Chief People Officer		2028								
Tackling Health Inequalities 2023/28	Director of Recovery,		2028								
Digtal Enabling Plan	Chief Finance Office		2029								
TRUST POLICIES											
CORP/FIN 1 - B Standing Financial Instructions	Chief Finance Officer	Annual	Sep-26					x			
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	Sep-26					x			
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships & C	3 yearly	Mar-28								
INFORMATION											
Work Plan	AD of Strategy, Partnerships & C	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Appointment of External Auditors	Chief Financial Officer	As Req'd	As Req'd								
Appointment of Internal Auditors	Chief Financial Officer	As Req'd	As Req'd								
CLOSING ITEM											
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd	x	x	x	x	x	x	x	x

2609 - K4 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Mark Bailey, Interim Chair | 13:25

10 minutes

2609 - K5 DATE AND TIME OF THE NEXT MEETING

Information Item | Mark Bailey, Interim Chair | 13:35

Date: Tuesday 3 November 2026
Time: 09:30am
Venue: Boardroom, Montagu Hospital

2609- K6 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Mark Bailey, Interim Chair | 13:35

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.