Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual Members Meeting
Agenda
Wednesday 23 September 2026
Venue: Lecture Theatre, Doncaster Royal Infirmary

INFORMAL SESSION

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

FORMAL SESSION

1. **Welcome** **17:30**
   Mark Bailey, Interim Chair

2. **To Approve:** Minutes of the Annual Members Meeting held on 30 September 2025. **17:35**
   Mark Bailey, Interim Chair

3. **To receive:** Annual Report and Accounts 2025/26
   Mark Bailey, Interim Chair

   Copies available via the Trust website - www.dbth.nhs.uk/about-us/how-we-are-run/annual-report/

4. **Chair's Reflections on 2025/26** **17:40**
   Mark Bailey, Interim Chair

5. **Chief Executive's Report** **18:00**
   Richard Jenkins, Interim Chief Executive
   Executive Directors

6. **Chief Finance Officer's Report** **18:30**
   Sam Wilde, Chief Finance Officer

7. **Questions & Answers** **18:40**

8. **Closing Remarks** **18:50**
   Mark Bailey, Interim Chair

Draft
AMM/25/1 – 25/10

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

ANNUAL MEMBERS MEETING

Minutes of the Annual Members Meeting
Tuesday 30 September 2025 at 5:30pm
Education Centre, Doncaster Royal Infirmary

Present:		
Chair and Governors	Suzy Brain England OBE	Chair of the Board
	Debbie Benson	Public Governor (Doncaster)
	Mark Bright	Public Governor (Doncaster)
	Andy Flynn	Public Governor (Doncaster)
	Jackie Hammerton	Public Governor (Rest of England & Wales) (Lead Governor)
	Lynne Logan	Public Governor (Doncaster)
	David Northwood	Public Governor (Doncaster)
	Mandy Tyrrell	Staff Governor (Nursing & Midwifery)
	Sheila Walsh	Public Governor (Bassetlaw)

In attendance:			
Board Members	Mark Bailey, Non-executive Director Hazel Brand, Non-executive Director Jo Gander, Non-executive Director Karen Jessop, Chief Nurse Emyr Jones, Non-executive Director Zoe Lintin, Chief People Officer Lucy Nickson, Non-executive Director Richard Parker OBE, Chief Executive Kath Smart, Non-Executive Director Sam Wilde, Chief Finance Officer		
Staff	Mandy Abbott, DBTH John Brinkley, Physiotherapy Manger Philip Buckley, Clinical Research Development Manager Annabel Coote, Consultant Rheumatologist Jane Fearnside, Head of Research Declan Goodard, Digital Business Administrator Sam Hind, Clinical Research Development Manager Dan Howard, Chief Information Officer Rosie Johnson, Vocational Education David Linacre, Head of Digital Operations Jessica Matthews, Apprentice Angela O'Mara, Deputy Company Secretary (minutes) Toni Peet, Advanced Practitioner Rebecca Pettigrew, Assistant Practitioner Jane Smith, Business Manager Adam Tingle, Senior Communications and Engagement Officer Kelly Turhud, Head of Education (Widening Participation) Daniel Wheater, Physiotherapy Team Leader Kirsty Whiteley, Vocational Education		
Members	Helen Best	Janet McCullough	Cllr Tim Needham
	Laura Brookshaw	David Milnes	Richard Rimmington

Press None in attendance

ACTION

AMM/25/1 Welcome & Apologies for Absence (Verbal)

The Chair welcomed everyone to the 2025 Annual Members Meeting, including governors, members, and partners.

This was the first face to face Annual Members Meeting (AMM) since 2019 and marked the Chair's final AMM ahead of her nine-year term of office drawing to a close on 31 December 2025.

The Chair took the opportunity to share her personal thanks, and those of the Board, for Hazel Brand's contribution as a non-executive director over the last three years. Hazel had a long-standing connection with the Trust as a Bassetlaw public governor and prior to that, as Head of Communications.

During the meeting there would be an opportunity to hear about the Trust's achievements, challenges, and innovations during 2024/25, and consider its ambitions in the year ahead.

The Chair thanked colleagues who had given their time to showcase Trust services for the benefit of those attending today's meeting.

Apologies for absence were received and noted from: Irfan Ahmed, Public Governor (Doncaster), Rebecca Allen, Associate Director of Strategy, Partnerships & Governance, Zara Jones, Deputy Chief Executive and Denise Smith, Chief Operating Officer.

AMM/25/2 Minutes of the Annual Members' Meeting held on 26 September 2024 (Verbal)

The Chair confirmed that the minutes of the Annual Members Meeting on 26 September 2024 had been approved as a true record by the Council of Governors' at its meeting on 7 November 2024 and were available for inspection on the Trust's website.

AMM/25/3 Annual Report & Accounts 2024/25

The Chair presented the Annual Report and Accounts for 2024/2025 to those in attendance. The annual report and accounts was received and noted.

Hard copies were available upon request and further copies could be obtained via the Trust's website *www.dbth.nhs.uk/about-us/how-we-are-run/annual-report/* or via the Trust Board Office @ *dbth.TrustBoardOffice@nhs.net*

AMM/25/4 **Chair's Reflections on 2024/25**

During 2024/25 colleagues had continued to respond to unprecedented demand, with professionalism, compassion and resilience, with more than 18,600 patients seen in urgent and emergency care settings in March 2025.

The Trust had refreshed its vision "Healthier Together: Delivering exceptional care for all" to lay the foundations of a new strategy focused on four strategic priorities: Patients, People, Partnerships and Pounds.

Montagu Elective Orthopaedic Centre of Excellence had celebrated its first anniversary, achieving record levels of planned surgery across South Yorkshire, working collaboratively with Barnsley Hospital and The Rotherham NHS Foundation Trusts.

The Bassetlaw Emergency Village was opened, reintroducing 24/7 paediatric overnight observations for the first time since 2017 and more than £49 million had been invested across our hospital sites, completing the Community Diagnostic Centre at Montagu, launching a new robotic surgery programme, and expanding the use of cutting-edge digital systems.

The Trust had continued to invest in its people, including the development of its health and wellbeing offer, development and leadership opportunities, and embedding the DBTH Way as a framework for an inclusive, compassionate culture.

Despite operating in challenges times, the Trust had delivered its financial plan for the eighth consecutive year, demonstrating strong stewardship and the responsible use of public money.

The Chair thanked colleagues, directors, governors, members, partners, and volunteers for their continued efforts for the people and communities we serve each and every day.

AMM/25/5 **Council of Governors Report including approval of the Trust's Constitution**

Lead Governor, Jackie Hammerton, introduced herself and provided an overview of her connections to the Trust, the wider NHS and contributions to the Council of Governors since 2018, initially as a Partner Governor and more recently as a Public Governor representing the Rest of England and Wales.

The Lead Governor shared with the Annual Members Meeting the work of the Council of Governors throughout the year, which included a review of working arrangements, formation of working parties to drive focused improvements and opportunities to develop relationships with non-executive directors to better understand their role and how they held executive directors to account for performance of the Board.

The Council of Governors had recently reviewed the Trust's Constitution, and a number of changes were proposed, which would see the introduction of co-opted governors, a reduction to the number of governor seats in the public constituency and partner governor representatives. The proposed changes were supported by the Board of Directors, and the Council of Governors and approval was sought by those in attendance.

T***he Annual Members Meeting:***

- ***Supported the proposed changes to the Trust Constitution***

AMM/25/6 **Chief Executive's Report (Presentation)**

The Chief Executive introduced himself and welcomed those in attendance, he recognised the wealth of information within the presentation and confirmed that the slides would be available on the Trust's website following the meeting.

By way of an introduction, an overview of the Trust was shared, which included its turnover, in year capital investment, patient contacts, number of employees, beds, research activity and medical equipment.

An insight was provided into local and national context, with the focus of the 10 Year Health Plan confirmed around three strategic shifts: analogue to digital, hospital to community and sickness to prevention. The reforms impacting NHS England and system partners were also highlighted.

Performance against the four Trust priority statements was confirmed, and a snapshot of the 2024 staff survey results were shared. Whilst a reduction had been seen when compared to 2023 results, the Trust's performance compared favourably to that of its peers.

A significant capital programme had been delivered during 2024/25, with a total of £49m invested across the Trust's sites on new developments, infrastructure upgrades and new medical equipment and digital systems to support safer care and improve productivity.

The impact of deprivation in local communities was noted, and the Trust was committed to tackling health inequalities by raising awareness, progressing targeted actions and embedding the required culture.

The Trust's Green Plan had been refreshed and progress and next steps were shared.

Risks and challenges which had the potential to impact delivery related to financial pressures, sustained high activity levels, risks associated with an aging estate and changes to the environment in which we operated.

In terms of next steps, the Trust was committed to recover performance in urgent and emergency care, cancer and elective waits. Develop a culture focused on well-being, inclusivity and flexibility, invest in estates and digital upgrades, including an Electronic Patient Record and strengthen collaborative working to support sustainable service delivery.

AMM/25/7 **Chief Finance Officer's Report**

The Chief Finance Officer confirmed delivery of the 2024/25 £2.4m deficit financial plan, which had been supported by a record level of cost improvement plans, totalling £21.2m. The cash balance at year end stood at £40.8m and the Trust's external auditors had offered an unqualified opinion on the financial accounts.
In terms of the year ahead, the Trust had committed to delivering a breakeven plan, securing £31.4m of cost efficiency programme and a capital investment programme of £62.2m.

The Trust's priority continued to be the delivery of safe, high quality care, whilst spending every pound wisely.

AMM/25/8 **Question and Answer Session (Verbal)**

The following questions were received prior to the meeting, the response has been provided and will be made available on the Trust's website following the meeting.

Question: Does the Trust still intend to pursue funding for a new hospital in Doncaster?

Response: Unfortunately, Doncaster was not included in the Government's New Hospital Programme. Our focus has therefore pivoted to a phased refurbishment of Doncaster Royal Infirmary, with progress already underway. This includes the new Department of Critical Care and the recently opened Discharge Lounge, alongside ambitious plans for a new hospital block which we hope to progress in the near future. These developments form part of our long-term ambition to ensure Doncaster has modern, fit-for-purpose hospital facilities.

Question: I would like to know what is being done to address bullying at DBTH? And has staff morale slipped in part due to a lack of full confidence in the implementation of Freedom to Speak Up?

Response: These are important questions and require a considered response. The Trust takes allegations of bullying very seriously and fully recognises the impact that inappropriate behaviour can have on colleagues.

Bullying is not acceptable. We have clear policies and processes in place to investigate concerns and to provide support, and we expect everyone at DBTH to act in line with our values and the DBTH Way, alongside their professional responsibilities.

The most comprehensive measure of how colleagues feel is the annual national NHS Staff Survey. At DBTH we had a 62% response rate in the most recent survey (4,570 colleagues). The results show:

- Instances of bullying and harassment from managers and colleagues were reported as lower than the national average.
- Colleagues feeling safe to Speak Up about concerns was rated higher than average.
- Willingness to report bullying, harassment or abuse scored slightly below average, which is an area we are determined to address.
- Encouragingly, the Trust scored higher than average on being "compassionate and inclusive," colleagues feeling "each have a voice that counts," and colleagues feeling "safe and healthy."
- These results suggest a largely positive picture, however they also highlight that there is more to do.

Improving culture and ensuring colleagues feel safe and supported remain key priorities within our People Plan, which sets out several strategic workstreams:

Speaking Up:

- We welcome and encourage colleagues to raise concerns, with transparent processes in place and strong Board-level oversight.
  In addition to operational leadership, there is a non-executive director lead role on Freedom to Speak Up (FTSU), as well as bi-annual reporting at the People

Committee and Trust Board.
We have a Speaking Up strategic plan supported by a planning and reflection tool. Over the last year, we have: Increased the number of trained Speaking Up Champions across all sites; Expanded Guardian capacity within the service; Strengthened and clarified our processes.

Just Culture:

- We are embedding a person-centred approach that focuses on learning from situations and experiences, particularly in how employee relations matters are handled.

Staff Networks:

- Our networks have been strengthened this year with the introduction of executive sponsorship, providing safe spaces for colleagues to share experiences and raise issues.
  We remain committed to our anti-racism work, which continues in collaboration with partners across Doncaster.

Finally, and additionally to the People Plan, we have locally implemented the national Sexual Safety Charter, supported by a working group.

This has included introducing a new policy, awareness campaigns and posters, and launching an online reporting tool to make it simpler and safer to raise concerns about behaviours.

Through these combined actions we are committed to building and sustaining a compassionate, inclusive culture where colleagues feel safe, supported, and confident to raise concerns. While our survey results show positive progress, we are not complacent.

We will continue to listen, learn and take action to address bullying, strengthen confidence in Speaking Up, and ensure DBTH is a place where colleagues feel valued and respected.

Question: In the light of recent advancements in the techniques available for the treatment of prostate cancer has the trust got any ambitions or plans for the introduction of such treatments. For example Hifu, Nano and cryo therapy.

Answer: The Trust does not currently have plans to introduce treatments such as High-Intensity Focused Ultrasound (HIFU), NanoKnife (irreversible electroporation) or cryotherapy. However, we are always exploring advancements in clinical practice and new technologies. For example, we have recently introduced robotic surgery, and we continue to review emerging innovations to ensure our patients benefit from safe, evidence-based developments in care.

Question: Has the re-opening of Doncaster Airport been reviewed for potential impact on Trust resources?

Answer: The Trust is aware of the plans to reopen Doncaster Airport in the coming years and has previous experience of the site being operational.

Our planning for the future takes into account a wide range of factors, both within the Trust and in collaboration with the wider Integrated Care System, to ensure any potential impacts are understood and managed ahead of time.

AMM/25/9 **Looking Ahead**

The Chair advised the meeting of a decision taken by the Council of Governors earlier this month to appoint Non-executive Director, Mark Bailey as Interim Chair with effect from 1 January 2026.

Mark had joined the Trust in February 2020, having served over 30 years at Rolls-Royce and held a wealth of experience in senior leadership and board-level roles in the private sector.

The Chair wished Mark every success in his new role.

Mark thanked the Chair for her leadership and recognised her contribution. He welcomed the opportunity to take on the role, born in Doncaster he had strong family connections to the city and the hospital and was proud to lead the organisation in delivery of its strategic ambitions.

The Chief Executive introduced a montage of photographs and video footage of Suzy's time at the Trust. Suzy demonstrated strong leadership, championed partnership working and advocated for the Trust at a local and national level. She had been both supportive and challenging and her significant contribution and leadership had supported the Trust on its journey over the last nine years.

AMM/19/10 **Meeting Close (Verbal)**

The Chair reflected on her time at the Trust and recognised the change and growth in the organisation and colleagues within it over the nine years. She reflected on challenging times, and the loss of colleagues and patients during the Covid pandemic and the lasting legacy of Kev's Wheels and the Rainbow Garden. She recognised the successful delivery of significant projects and capital investment and the spirit and determination of colleagues which had made the Trust a special place to work and she shared how proud she was to have spent time at DBTH. She would leave the organisation in the safe hands of the Board of Directors and placed on record her sincere thanks for their support.

The meeting closed at 7pm

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts

Financial year 2025/2026

Doncaster and Bassetlaw Teaching Hospitals

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

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

Contents

Performance Report

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

Zara Jones
Acting Chief Executive
16 July 2026

Chair and Chief Executive's statement

Over the past year, our Trust has continued to make important progress despite sustained pressure across the NHS.

Throughout 2025/26, colleagues across our hospitals in Doncaster and Bassetlaw have continued to deliver compassionate, safe and high-quality care for our communities while responding to rising demand across urgent and emergency care, elective services and maternity care.

We remain incredibly proud of the dedication, resilience and commitment shown by our teams every day.

During the year, we delivered a number of significant improvements and investments which are already making a difference for patients and colleagues. We continued reducing the longest waits for treatment across most specialties, with 65-week waits virtually eliminated in all but two areas by the end of the financial year.

Cancer performance also improved, with the Trust consistently achieving the Faster Diagnosis Standard and reducing the number of patients waiting more than 62 days on a cancer pathway.

We also expanded diagnostic and treatment capacity across our hospital sites. This included the installation of a second CT scanner at Bassetlaw Hospital, a new SPECT-CT scanner at Doncaster Royal Infirmary and further development of the Montagu Community Diagnostic Centre.

New and refurbished clinical areas, including Same Day Emergency Care facilities and the relocated Discharge Lounge at Doncaster Royal Infirmary, have also helped improve patient flow and support more timely care.

Alongside this, we continued investing in the long-term future of the organisation. During the year, major progress was made on plans for a future Electronic Patient Record system, estate modernisation and critical infrastructure upgrades. Significant capital investment supported improvements to clinical environments, digital capability, medical equipment and sustainability initiatives across our sites.

There were also important areas of progress beyond operational performance. Our work on tackling health inequalities continued to gain regional and national recognition, including the rollout of innovative training programmes and targeted work to improve access for underserved communities.

We also strengthened our focus on research, education and partnership working, helping position DBTH as a leading teaching hospital within South Yorkshire and North Nottinghamshire.

Whilst we have made significant progress, at the same time, we remain realistic about the scale of the challenge ahead.

Performance remains inconsistent in some areas and too many patients continue to wait longer than we would want for treatment or emergency care.

Workforce pressures, variation between services and sites, and the long-term financial sustainability of the organisation continue to require sustained focus and decisive action.

We are clear that incremental improvement alone will not be enough and that the years ahead will require disciplined delivery, service redesign and consistent leadership across every part of the organisation.

During the year, we strengthened our organisational focus on operational improvement, governance and accountability. We continued improving performance oversight arrangements to provide clearer visibility of risk, earlier intervention where concerns emerge and greater accountability for delivery.

This work has also helped shape the development of our Three-Year Plan and wider organisational Reset Programme, setting out how we will improve operational performance, strengthen organisational culture, redesign services and create a more sustainable future for DBTH.

Financially, the organisation delivered its planned position for the year, supported by significant cost improvement activity and national funding. However, we recognise that longer-term financial sustainability will depend on delivering recurrent productivity improvements, modernising services and ensuring the best possible use of public money.

People remain at the centre of everything we do. Feedback from colleagues through the NHS Staff Survey and wider engagement activity has reinforced both the strengths within our Trust and the need for greater consistency in leadership, behaviours and organisational culture.

In response, we have continued embedding the DBTH Way, increasing leadership visibility and strengthening expectations around accountability, inclusion and compassionate leadership.

Partnership working has also remained central to our approach. We continue to work closely with local authorities, primary care, our Integrated Care Boards and wider partners to improve outcomes for local people and support more joined-up care across our communities.

Building on our vision, Healthier together – Delivering exceptional healthcare for all, our Three-Year Plan provides a clearer long-term direction for our services, workforce and hospital sites, while setting out practical ambitions around improving urgent and emergency care, reducing waiting times, strengthening elective services, expanding care closer to home and restoring long-term financial sustainability.

While significant challenges remain, we believe the organisation now has stronger foundations, greater clarity and a more focused direction for improvement.

We would like to thank our colleagues, volunteers, governors, members, partners and local communities for their continued support and commitment throughout the year. The progress outlined within this report would not have been possible without their hard work, dedication and belief in the future of DBTH.

This Annual Report provides a fair, balanced and accurate account of our performance, progress and challenges during 2025/26. It reflects a year of realism, reset and renewed focus as we continue working towards our vision of delivering exceptional healthcare for all.

Mark Bailey
Interim Chair of the Board
16 July 2026

Zara Jones
Acting Chief Executive
16 July 2026

Who we are and what we do

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

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

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

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

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

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

Our main sites are:

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

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

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

Our strategy, vision, mission, values and objectives

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

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

- **Patients**: 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 community.
- **Pounds**: We are efficient and spend public money wisely.

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

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

- Providing the best care environments.
- Tackling health inequalities.
- Becoming a leading centre for research and education.
- Becoming a digitally enabled and mature organisation.

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

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

Our values and the DBTH Way

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

This stands for:

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

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

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

We are:

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

We show:

- Attentive listening
- Integrity and honesty
- Courage and positivity

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

Performance overview and analysis in 2025/26

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

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

Urgent and Emergency Care

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

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

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

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

Elective Care

Our focus during 2025/26 has been to continue reducing the number of patients experiencing long waits for treatment following the disruption and backlog created by the COVID-19 pandemic.

By March 2026, the number of patients waiting more than 65 weeks for treatment had reduced significantly. At the end of the year, 52 patients were waiting over 65 weeks, compared to 146 patients at the end of March 2025.

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

Diagnostics

During the year, the Trust continued to improve waiting times across a number of diagnostic services, supporting earlier diagnosis and faster access to treatment.

In March 2026, 73.8% of patients received their diagnostic test within six weeks.

Cancer

The number of urgent suspected cancer referrals remained high throughout 2025/26. Despite this sustained demand, the Trust achieved its plan to reduce the number of patients waiting more than 62 days on a cancer pathway by the end of the year.

The Trust also consistently delivered the 28-day Faster Diagnosis Standard, ensuring the majority of patients referred urgently by their GP for suspected cancer either received a diagnosis or had cancer ruled out within 28 days.

In February 2026, 83.3% of patients met the Faster Diagnosis Standard, exceeding the national target of 75%.

2025/26 activity

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

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

Compared to the previous year:

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

Finance, investment and infrastructure

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

Our financial statements have been prepared in accordance with the 2025/26 FT ARM and adhere to International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual, to the extent that these are meaningful and appropriate to NHS Foundation Trusts. Accounting policies are applied consistently to items considered material in relation to the accounts.

These accounts have been prepared on a consolidated 'group' basis, incorporating the Trust's charitable funds and wholly owned subsidiary, Doncaster and Bassetlaw Healthcare Services Ltd, in line with NHS financial reporting guidance.

The commentary below relates to the financial performance of the Foundation Trust. Separate annual reports for both the Charity and the wholly owned subsidiary will be published separately.

2025/26 in Review

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

Clinical Income: The Trust's clinical income increased by £26.1 million in the year, as it received additional funds to support increased clinical activity, and inflationary cost pressures within the sector.

Overall Deficit: The Trust reported an overall deficit of £5.9 million, which includes £5.1 million of impairments resulting from the annual valuation exercise. Excluding these and other technical adjustments, the Reportable Group reported a surplus position of £17k (compared to a £2.4m deficit in 2024/25). The Reportable Group was planned to break even in 2025/26.

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

Working Capital: Cash balances held by the Trust as of 31 March 2026 were £53.4 million (31 March 2025: £40.9 million).

Loan Repayments: The Trust made loan repayments of £0.5 million during the year (2024/25: £0.5 million).

Public Dividend Capital (PDC) Dividend: A charge of 3.5% of average relevant net assets is payable to the Department of Health as a PDC dividend. The dividend payable in 2025/26 was £8.5 million (2024/25: £7.6 million).

Income: The Trust received a total income of £663 million in 2025/26, an increase of £22 million from the previous year.

Revenue Expenditure: Operating expenses for the year totalled £662 million, a £6 million decrease from the previous year. The majority of expenditure was on pay budgets (staffing) at £420.5 million

(increase of £35.3m compared to 2024/25, with nursing and medical staffing being the largest areas of expenditure. The decrease is as a result of a £27m reduction of impairments, offset by operational cost pressures.

Capital Expenditure: Expenditure on larger items with a lifespan of more than one year, such as buildings and equipment, was £49 million, of which £27.8 million was funded by the Department of Health and Social Care, primarily for estate improvements. Major areas of capital expenditure included:

- Digital Transformation linked to Electronic Patient Records project: £16 million.
- Critical Care Department: £10 million.
- Medical Equipment Replacement: £8 million.

Joint Forward Plans and Capital Resource Plans

At the start of the 2025/26 financial year, the Trust agreed on its capital plan with the South Yorkshire Integrated Care Board (ICB) and partners. Throughout the year, the Trust engaged with the ICB and its partners to deliver the jointly agreed capital plans.

Additionally, the Trust's business planning process was conducted in conjunction with Place and ICB-based partners to ensure alignment. This planning included setting out how the system would meet national planning guidance expectations and defining each organisation's role.

The Trust actively participated in developing the One Doncaster Plan, which outlines key priorities at Place for the next five years.

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

Capital investment and estate development

Over the past decade years, the Capital Planning Unit - part of the Directorate of Infrastructure, Estates and Facilities - delivered circa £250m million in estate modernisation projects across DBTH.

In 2025/26, this work continued at pace, with £35.8m invested in capital infrastructure. This included a combination of Operational and Public Dividend Capital (PDC) funding. As noted on the Trust website, we are proud of the capital investments that have directly contributed to improved patient care and the creation of high-quality facilities.

Project highlights from 2025/26

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

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

Doncaster Royal Infirmary

Discharge Lounge: Relocated from the rear of Doncaster Royal Infirmary (DRI) to a newly refurbished space within the West Ward Block, accessed via the Thorne Road entrance. The service welcomed its

first patients on 28 July 2025. This move supports improved patient flow and enabled the relocation of the Department of Critical Care.

Surgical Same Day Emergency Care: Moved into a newly refurbished space, opening to patients on 9 August 2025. This improves patient flow and supports wider site reconfiguration, including enabling the relocation of the Department of Critical Care.

Department of Critical Care: Public Dividend Capital funding has been secured to support relocation from Level 7 of the East Ward Block to a new facility on the lower ground floor, adjacent to the main theatres. Works commenced in 2025/26 and are expected to complete in early 2027.

Clinical Research Hub: Provides a purpose-built, welcoming environment for research participants, improving patient experience while giving clinicians the facilities needed to deliver high-quality studies.

Clinical Research Expansion (Phase Two): Additional funding will expand the initial scheme, increasing capacity and broadening the range of studies to support improved access to innovative treatments and better patient care.

Pharmacy Dispensary Robot: A new purpose-built system has replaced the previous equipment, which had reached the end of its operational life, improving efficiency, accuracy and resilience within pharmacy services.

Diagnostic Scheme: SPECT-CT Scanner: Installed at Doncaster Royal Infirmary in November 2025, replacing an 11-year-old system. The new equipment is faster, increases capacity and allows greater flexibility in scheduling complex examinations.

Diagnostic Scheme - MRI Replacement: Funding has been secured to replace the 12-year-old scanner at Doncaster Royal Infirmary, providing a modern and more reliable facility for inpatient and outpatient imaging. Completion is expected in 2026/27.

Women's and Children's Theatres Refurbishment: Includes modular theatres and recovery areas, alongside improvements to the Gynaecology Ward, addressing fire safety requirements and enhancing the care environment.

Minor Operations Room: Fracture Clinic: Funding has been secured to develop a facility within the Fracture Clinic, enabling suitable procedures to be carried out outside main theatres and increasing overall capacity.

Bassetlaw Hospital

Bassetlaw Hospital Second Computed Tomography Scanner: A second scanner was installed adjacent to the existing facility, with completion in November 2025. This increases resilience and continuity of service for patients in the Bassetlaw area, reducing the need to travel to Doncaster Royal Infirmary during routine maintenance periods.

Bassetlaw Same Day Emergency Care: An overall £2.5 million refurbishment (£1.6m in 2025/26) of the former Accident and Emergency department, following the move to the new Emergency Department, has created a dedicated Minor Injuries and Same Day Emergency Care facility, improving access and patient flow.

Montagu Hospital

Cardiorespiratory Expansion at Montagu Hospital: An expansion scheme to modernise the cardiorespiratory department and adjacent phlebotomy rooms at Montagu Community Diagnostic Centre. This supports increased diagnostic activity, improves patient throughput and contributes to recovery of referral to treatment standards.

Operational capital schemes

During 2025/26, we delivered a programme of operational capital schemes focused on maintaining safe, compliant and efficient environments across Doncaster and Bassetlaw Teaching Hospitals sites.

This included significant investment in fire safety and infrastructure, with £4.8 million of fire precaution works and over £2.3 million in electrical upgrades to improve resilience at Doncaster Royal Infirmary.

We also prioritised essential maintenance and estate improvements, including roofing, window replacement, concrete repairs, boiler replacement and ventilation upgrades, alongside improvements to roads, car parks and general site safety.

Targeted schemes enhanced clinical environments and patient safety, such as the replacement of nurse call systems, theatre air handling units and chillers, and ongoing water safety works.

Further investment supported digital and operational resilience, including upgrades to data cabinets, security systems and closed-circuit television, as well as estate management systems and surveys.

In addition, we delivered a range of smaller-scale and enabling works, including improvements to staff areas, space reconfiguration and divisional infrastructure priorities to support evolving service needs.

Together, these schemes ensure our estate remains safe, compliant and fit for purpose, supporting the delivery of high-quality care.

Sustainability and the Trust's Green Plan

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

As one of the largest employers in Doncaster and Bassetlaw, operating across multiple sites, the Trust recognises the environmental footprint created by our activities, including carbon emissions, air pollution and waste generation.

In support of national net zero ambitions, the Trust refreshed its Green Plan in 2025, aligning it with updated guidelines from NHS England. The plan sets out how the Trust will improve sustainability and reduce emissions, how we will measure progress, and the governance and oversight we have put in place to drive delivery.

Our refreshed Green Plan is available here: https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/

Progress during 2025/26

During 2025/26, the Trust continued to make tangible progress against its Green Plan objectives across multiple areas of focus, supported by strengthened governance and increasing clinical and corporate engagement. Key achievements include:

Clinical sustainability: Significant progress has been made through service-led initiatives, including trials of reusable products, reductions in single use items, changes in practice to reduce emissions, and improved waste segregation. This includes a 24% reduction in clinical waste in surgery as a result of efforts from the Trust's Green Theatres Group.

Digital Transformation: A project to implement a new Electronic Patient Record (EPR) system has commenced, which is expected to deliver wider environmental benefits through reductions in paper use, printing and postage, transportation of medical records, and waste associated with obsolete paper records.

Estates Decarbonisation and Renewable Energy: The Trust successfully secured funding through the Government's Great British Energy (GBE) initiative to expand on-site renewable energy generation at Doncaster Royal Infirmary and Bassetlaw Hospital in 2025/26, delivering both carbon and financial savings.

Further energy efficiency opportunities have also been identified through estate-wide energy saving opportunity surveys, which will continue to inform capital planning and future bids for external funding.

Medicines and Anaesthetic Gases: Nitrous oxide is a potent greenhouse gas with a high global warming potential. The Trust has therefore removed piped nitrous oxide infrastructure across all sites, significantly reducing the risk of leaks and wastage associated with these systems to support the NHS's ambition to reduce emissions from medicines and anaesthetic gases.

Waste Management: In response to new national 'Simpler Recycling' legislation, the Trust successfully piloted enhanced waste segregation at Montagu Hospital, leading to a notable increase

in the amount of waste generated by the Trust being recycled. Following the success of the pilot, the initiative is now being rolled out across all sites.

Green Spaces and Biodiversity: The Trust retained Green Flag Awards at Doncaster Royal Infirmary and Bassetlaw Hospital for a third consecutive year and received a Green Flag Award at Montagu Hospital for the first time. Additional tree planting across Trust sites, supported by the NHS Forest scheme, has helped to enhance biodiversity, improve patient and staff wellbeing, and increased climate resilience.

Strengthened governance and future focus

To maintain a focus on Green Plan delivery, governance arrangements have been strengthened through the establishment of a Green Plan Steering Group, chaired by the Director of Infrastructure, and a Green Plan Delivery Group, chaired by the Trust's Board level Net Zero lead, improving accountability, oversight, and Trust-wide ownership.

The Trust has also adopted NHS England's new Green Plan Support Tool to assess progress against national requirements and direct future improvement efforts.

In summary, the Trust remains committed to reducing its environmental impact, improving resilience, and contributing to a healthier future for the communities it serves, supporting its vision of "Healthier together – delivering exceptional healthcare for all."

Health inequalities

The Trust remains committed to embedding the reduction of health inequalities across all aspects of our work to ensure equitable access, experience and outcomes for the communities we serve.

Tackling health inequalities is one of the four strategic ambitions within our Trust Strategy, Healthier Together, supported through prevention, partnership working, workforce development, research and targeted support for underserved communities. This work is delivered through the Trust's Tackling Health Inequalities Enabling Plan, which focuses on prevention, elective recovery, urgent and emergency care, maternity and best start in life, children and young people, and research and innovation.

During 2025/26, the Trust continued to strengthen education and awareness across the organisation. More than 7,200 colleagues completed Health Inequalities training through Statutory and Essential Training, while over 220 colleagues completed specialist Change Initiator Training, which has now been formally approved through the Role Specific Training Approval Panel. A pilot Health Inequalities Advocate programme was also delivered through the Aspiring Matrons Programme. The Trust's health inequalities training model has since been recognised as best practice by South Yorkshire Integrated Care Board, with interest from organisations nationally.

Alongside workforce development, a number of targeted interventions were progressed using local population health data and evidence-based approaches. This included work to reduce Did Not Attend (DNA) and Was Not Brought (WNB) rates through more equitable and targeted approaches, alongside exploration of the WHaLES (Waiting Healthy - a List Equity Score) tool to support fairer waiting list management across South Yorkshire.

Work also continued to improve access, experience and outcomes for women's and children's services, informed by local data showing significant variation in healthy life expectancy across Doncaster and Bassetlaw communities. In urgent and emergency care, focused work was undertaken to improve support for inclusion health groups, including people experiencing homelessness, sex workers and those experiencing substance misuse issues.

Research and innovation remained an important part of the Trust's approach. During the year, the organisation continued involvement in nationally funded research focused on maternity inequalities and barriers to accessing perinatal mental health services, working alongside university, NHS and research partners to develop new approaches to improving equity of care and outcomes.

Significant progress was also made in strengthening governance, leadership and the use of data. During the year, the Trust established a dedicated Health Inequalities Oversight Group reporting into the Board of Directors, alongside a wider Health Inequalities Forum to support collaboration and shared learning across the organisation and system partners.

The Trust also completed the national Health Inequalities Self-Assessment Tool, identifying strengths in public health capability while recognising further development is needed around data insight and evaluation. In response, the Trust developed a new Equity Index to better understand variation in access and outcomes across deprivation and ethnicity groups. A dedicated health inequalities dashboard focusing on DNA and WNB rates is also being developed to support more targeted improvement work.

Health inequalities considerations are now embedded within Trust business cases and decision-making processes, with impacts and opportunities required to be considered in Board papers and programme development. During the year, all Board members also made personal Health Inequalities pledges to reinforce organisational accountability and leadership.

Other developments included the launch of the DBTH Citizens' Panel to strengthen community voice in Trust decision-making and continued work supporting veterans and armed forces communities through dedicated oversight arrangements, workforce initiatives and partnership working.

At DBTH, we believe factors such as deprivation, ethnicity or place of birth should not determine a person's access to, or experience of, healthcare. While significant challenges remain, the progress made during 2025/26 demonstrates our growing commitment to embedding health inequalities improvement into everyday practice, strengthening data and evidence, improving workforce capability and delivering more equitable care for local people.

Preparation of the Annual Report and Accounts 2025/26

The Trust's Board of Directors is responsible for preparing the Annual Report and Accounts 2025/26. The Accounts have been prepared under the direction issued by NHS England (NHSE) under the National Health Service Act 2006.

The Annual Report and Accounts have been prepared on a Group basis. The Board of Directors consider the Annual Report and Accounts 2025/26, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the performance, business model and strategy of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Going Concern statement

The Board of Directors have a reasonable expectation that the services provided by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future.

For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Accountability Report

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

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

Zara Jones
Acting Chief Executive
16 July 2026

Directors' Report

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

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

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

Composition of the Board

During 2025/26, the following persons were members of the Board of Directors:

Name	Position	Length of service at 31 March 2026	Term of office from	Attendance at Board meetings
Suzy Brain England OBE	Chair of the Board (Term ended on the 31.12.2025)	9 years	1.1 2017	3 of 4
Mark Bailey	Non-Executive Director (Interim Chair of the Board from 01.01.2026)	6 Years 2 months	1.2.2020	6 of 6
Kath Smart	Non-Executive Director	8 years	1.4.2018	6 of 6
Hazel Brand	Non-Executive Director (Term ended on the 30.09.25)	3 years 3 months	1.7.2022	3 of 3
Joanne Gander	Non-Executive Director	3 years 9 months	25.7.2022	6 of 6
Dr Emyr Jones	Non-Executive Director (Term ended on the 19.02.2026)	3 years	20.2.2023	5 of 5
Lucy Nickson	Non-Executive Director (Senior Independent Director)	3 years 1 month	1.3.2023	6 of 6
Stephen Radford	Non-Executive Director	6 months	1.10.2025	2 of 3
Helen Best	Non-executive Director	3 months	1.1.2026	2 of 2
Richard Parker OBE	Chief Executive			4 of 6
Zara Jones	Deputy Chief Executive (Acting Chief Executive from 1.1.26)			6 of 6
Zoe Lintin	Chief People Officer			6 of 6

Karen Jessop	Chief Nurse	6 of 6
Sam Wilde	Chief Finance Officer	5 of 6
Denise Smith	Chief Operating Officer	6 of 6
Dr Tim Noble	Executive Medical Director	0 of 6
Dr Nick Mallaband	Acting Executive Medical Director	5 of 6

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

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

The Interim Chair of the Board also holds a number of external roles, including as a Non-Executive Director at another Trust and healthcare service provider, a volunteer Executive Coach with the NHS Leadership Academy, and visiting fellow at Cranfield University.

In 2023/24, the Trust introduced Scope for Growth, a succession planning tool designed to support inclusive talent development. This approach continued during 2025/26, helping to identify and nurture individuals with the potential to progress into leadership roles. Alongside this, we ran a successful cohort of the Board Delegate Programme, encouraging colleagues from diverse backgrounds to consider and prepare for senior and Board-level positions.

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

Balance of the Board

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

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

Brief details of all Directors who served during 2025/26 are as follows:

Chair of the Board (from 1 April to 31 December 2025)

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

Interim Chair of the Board (as of 1 January 2026)

Mark Bailey joined DBTH as a Non-Executive Director in February 2020. A former Group Director at Rolls-Royce plc, Mark has over 30 years of private sector experience in business growth, digital

transformation, and customer service. He also serves as a Non-Executive Director at Derbyshire Community Health Services NHS FT and is a Visiting Fellow at Cranfield University.

Non-Executive Directors during the year and as of 31 March 2026:

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

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

Hazel Brand is a former Lead Governor and Head of Communications at DBTH. Originally trained as an Occupational Therapist, Hazel moved into health journalism and later communications, supporting the Trust through major changes for nearly two decades. Since retirement, she has served on Bassetlaw District Council and held the Non-Executive lead for Freedom to Speak Up at the Trust, before departing the Trust in September 2025.

Dr Emyr Wyn Jones is a retired Consultant Physician in Diabetes and Endocrinology who worked at Doncaster Royal and Mexborough Hospital NHS Trust for 24 years. He has held senior clinical and executive roles and contributed nationally as a Medical Advisor to the National Audit Office and Clinical Lead at NHS Digital. At DBTH, he was a Clinical Non-Executive Director, Deputy Chair of the Quality Committee, and a Maternity and Neonatal Safety Champion. Emyr departed the Trust in February 2026.

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

Stephen Radford joined DBTH as a Non-Executive Director in October 2025. A qualified accountant, he brings over 30 years of financial and leadership experience across both the private and public sectors in the UK and internationally. He has held senior roles including Group and Divisional Finance Director, Head of Shared Services, Senior Vice President and Partner within global management consultancies. Stephen lives locally in the Penistone area and also serves as a Non-executive Director at Barnsley Hospital.

Helen Best brings extensive experience across health, education and governance. She began her career in the NHS as a diagnostic radiographer before moving into senior leadership roles in university education, where she spent over 20 years at Sheffield Hallam University. Helen holds a Master's in Further and Higher Education and a postgraduate award in Health and Social Care Leadership. She has significant experience in corporate governance through university boards and as a Trustee of Sheffield City Trust. Helen is well connected across South Yorkshire and is committed to

supporting the Board in delivering its strategic ambitions. Helen is the Non-Executive lead for Freedom to Speak Up at the Trust.

Executive Directors (as of 31 March 2026):

Richard Parker OBE, Chief Executive, was appointed in January 2017 after serving as Director of Nursing, Midwifery and Quality. Since qualifying as a nurse in 1985, Richard has held several senior NHS roles including Chief Operating Officer at Sheffield Teaching Hospitals. He holds an MBA in Health and Social Services and was awarded an OBE in 2018 for services to health and social care. In June 2026 they announced their plans for retirement from their CEO role.

Zara Jones, Deputy Chief Executive, was appointed in September 2023. She previously served as Executive Director of Strategy and Planning at Derby and Derbyshire ICB, overseeing acute, community, and mental health portfolios. Zara brings experience in strategic leadership, commissioning and partnership working. Since January 2026 Zara has been the Acting Chief Executive Officer at DBTH.

Dr Tim Noble, Executive Medical Director, joined DBTH in 2006 as a Consultant Respiratory Physician and has held multiple leadership roles including Deputy Medical Director. He was appointed Medical Director in March 2020 and left the organisation in January 2026.

Dr Nick Mallaband, Acting Executive Medical Director, joined DBTH as a Consultant in Acute Medicine in 2011, playing a key role in developing the service across both sites. He has since held senior roles including Divisional Director and Medical Director of Workforce. Appointed to Acting Executive Medical Director in late 2023 and appointed as Chief Medical Officer in May 2026, Nick has a strong interest in acute care, education, and digital transformation.

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

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

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

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

Registers of interests

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

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

Cost allocation and charging

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

Donations

The Trust made no donations to political parties or other political organisations in 2025/26 and no charitable donations in 2025/26.

Better Payments Practice Code

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

Non NHS	Number	Value £'000
Total bills paid in the year	99,495	£343,485
Total bills paid within target	38,075	£284,512
Percentage of total bills paid within target	38.3%	77.0%

NHS	Number	Value £'000
Total bills paid in the year	2,624	£40,382
Total bills paid within target	2,251	£34,857
Percentage of total bills paid within target	85.8%	86.3%

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

Quality Governance

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

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

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

The Board remains proactive in assessing the impact of any proposed changes to services, including cost improvement plans, to ensure that service quality and patient safety are not compromised. These considerations are embedded into all aspects of Board decision-making.
There are no material inconsistencies to report between the Annual Governance Statement, quarterly and annual Board statements, the Board Assurance Framework, the Annual Report, and CQC findings.

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

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

Income disclosures

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

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

Remuneration policy – senior managers

As at 31 March 2026, three senior managers other than the Executive Directors are not remunerated according to Agenda for Change Terms and Conditions of service. This is in compliance with the NHS Very Senior Managers Pay Framework, published by the Department of Health and Social Care and NHS England.

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

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

All other administrative managers are remunerated in accordance with Agenda for Change terms and conditions of service. Approval to pay remuneration outside of Agenda for Change terms and conditions or medical and dental contracts are a decision of the Nomination and Remuneration Committee.

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

The Trust intends to maintain this remuneration policy for 2026/27.

Remuneration policy – Other employees

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

Future Policy Table

Salary/Fees		**Taxable Benefits**	**Annual Performance Related Bonus**	**Long Term Related Bonus**	**Pension Related Benefits**
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	N/A	N/A	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the Trust's objectives
How the component Operates	Paid monthly	None disclosed	N/A	N/A	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	As set out in the Remuneration table. Salaries are determined by the Trust's Remuneration Committee	None disclosed	N/A	N/A	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance	Trust appraisal system	None disclosed	N/A	N/A	N/A
Performance Measures	Based on individual objectives agreed with line manager	None disclosed	N/A	N/A	N/A
Performance period	Concurrent with the financial year	None disclosed	N/A	N/A	N/A
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	None disclosed	N/A	None paid	N/A
Explanation of whether there are any provisions for recovery of sums paid to	Any sums paid in error may be recovered. In addition there is provision for recovery of payments in relation to Mutually	None disclosed	Any sums paid in error may be recovered	None paid	N/A

directors, or provisions for withholding payments	Agreed Resignation Scheme (MARS) payments where individuals are subsequently employed in the NHS				

Nominations and Remuneration Committee of the Board of Directors

The membership of the committee in 2025/26 consisted of the Chair and Non-Executive Directors with attendance by the Chief Executive, and Chief People Officer (both of whom withdraw if their remuneration or appointment is considered) where appropriate.

The committee was convened on six occasions during the year to discuss appointments and the remuneration of Executive Directors.

Name	Role	Attendance
Suzy Brain England OBE	Chair of the Board	3 of 3
Kath Smart	Non-Executive Director (Deputy Chair of the Board)	6 of 6
Joanne Gander	Non-Executive Director	4 of 6
Mark Bailey	Non-Executive Director / Interim Chair w.e.f. 1 January 2026	6 of 6
Helen Best	Non-Executive Director	2 of 3
Hazel Brand	Non-Executive Director	3 of 3
Dr Emyr Jones	Non-Executive Director	3 of 5
Lucy Nickson	Non-Executive Director	6 of 6
Stephen Radford	Non-Executive Director	1 of 3

Fair pay comparison

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

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

	2024/25			**2025/26**		
Percentile	25th	Median	75th	25th	Median	75th
Salary component of pay	£242,500	£242,500	£242,500	£322,500	£322,500	£322,500
Total pay and benefits excluding pension	£27,554	£34,228	£45,611	£36,779	£45,193	£60,418
Pay ratio (excluding temporary staff)	8.80:1	7.08:1	5.32:1	11.71:1	8.71:1	6.70:1
Pay ratio (including temporary staff)				8.77:1 *	7.14:1 *	5.34:1 *

* For the above, the 2025/26 figures marked with an asterisk include temporary staffing. However, due to limitations in the data quality, the 2024/25 figures only relate to substantive members of staff.

We have also disclosed the 2025/26 figures excluding temporary staffing to improve the comparability of the disclosure between financial years.

The banded remuneration of the highest paid Director in the financial year 2025/26 was £320k-£325k (2024/25: £240k-£245k). The increase is as a result of a Director receiving contractual payments in lieu of notice upon leaving the organisation.

This is 3.7 times higher than the salary and allowances of all employees on an annualised basis, divided by the FTE number of employees. (2024/25: 4.6 times).

This was 7.14 times (2024/25: 7.08 times) the median remuneration of the workforce, which is £45.193 (2024/25: £34,228).

For substantive employees of the Trust as a whole, the range of remuneration in 2024/25 was from £29 to £573k (2024/25: £5 to £514k). This increase in the higher end of the range is due to additional medical sessions being performed.

25 substantive employees received remuneration in excess of the highest-paid Director in 2025/26 (2024/25: 23 employees).

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

Expenses

	2024/25 No. in office	2024/25 No. receiving expenses	2024/25 Expenses Paid (£)	2025/26 No. in office	2025/26 No. receiving expenses	2025/26 Expenses Paid (£)
Non-Executive Directors	7	2	£1,074.50	10	4	£4,129.74
Executive Directors	9	4	£849.16	8	6	£2,381.14
Governors	39	0	£0.00	29	1	£91.20

Senior Managers Service Contracts

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

Name	Position	Date of contract (date commenced in post as senior manager)	Unexpired term as at 31 March 2026
Suzy Brain England OBE	Chair of the Board	1.1.2017	Left the Trust 31 December 2025
Kath Smart	Non-Executive Director	1.4.2018	One year
Mark Bailey	(Interim Chair from 1.1.2026)	1.2.2020	Nine months
Hazel Brand	Non-Executive Director	1.7.2022	Left the Trust 30 September 2025
Joanne Gander	Non-Executive Director	25.7.2022	Two years four months
Dr Emyr Jones	Non-Executive Director	20.2.2023	Left the Trust 19 February 2026
Lucy Nickson	Non-Executive Director	1.3.2023	Two years Eleven months
Stephen Radford	Non-Executive Director	1.10.2025	Two years six months
Helen Best	Non-Executive Director	1.1.2026	Two years nine months
Richard Parker OBE	Chief Executive	14.10.2013	N/A

Dr Tim Noble	Executive Medical Director	1.4.2020	Left the Trust Jan 2026
Zoe Lintin	Chief People Officer	1.6.2022	N/A
Karen Jessop	Chief Nurse	10.1.2023	N/A
Denise Smith	Chief Operating Officer	3.1.2023	N/A
Zara Jones	Deputy Chief Executive. Acting Chief Executive from 1.1.26	25.09.2023	N/A
Dr Nick Mallaband	Acting Executive Medical Director	26.9.2023	N/A
Sam Wilde	Chief Financial Officer	31.1.2025	N/A

Directors' Remuneration - subject to audit

Name and Title	2024/25 Salary and fees (bands of £5k)	2024/25 Taxable Benefits (to the nearest £100)	2024/25 Pension Benefit (bands of £2.5k)	2024/25 Total (bands of £5k)	2025/26 Salary and fees (bands of £5k)	2025/26 Taxable Benefits (to the nearest £100)	2025/26 Pension Benefit (bands of £2.5k)	2025/26 total (bands of £5k)
Suzy Brain England OBE – Chair of the Board *	55-60	1 ,100		55-60	40-45	1,700		45-50
Mark Bailey – Non-Executive Director / Chair of the Board	10-15	700		15-20	30-35	1,100		30-35
Kathryn Smart – Non-Executive Director	15-20			15-20	15-20			15-20
Mark Day – Independent Director (4)*	15-20	200		15-20	0-0			0-0
Hazel Brand – Non-Executive Director *	10-15			10-15	5-10			5-10
Joanne Gander – Non-Executive Director	10-15			10-15	15-20			15-20
Dr Emyr Jones – Non-Executive Director *	10-15			10-15	10-15			10-15
Lucy Nickson – Non-Executive Director	10-15	300		10-15	15-20	600		15-20
Helen Best - Non-Executive Director **					0-5			0-5
Stephen Radford - Non-Executive Director **					5-10			5-10
Dr Tim Noble – Executive Medical Director (1) (2) *	180-185		42.5-45	225-230	320-325		677.5-680	1,000-1,005
Richard Parker OBE – Chief Executive	240-245			240-245	250-255			250-255
Sam Wilde - Chief Finance Officer	55-60		2.5-5	60-65	155-160		82.5-85	240-245
Zoe Lintin – Chief People Officer	150-155		27.5-30	180-185	155-160		50-52.5	210-215
Denise Smith – Chief Operating Officer	150-155			150-155	155-160		55-57.5	210-215
Karen Jessop – Chief Nurse	145-150			145-150	150-155		12.5-15	165-170
Zara Jones – Deputy Chief Executive, Acting Chief Executive from 1 Jan 2026	155-160		45-47.5	200-205	165-170		55-57.5	220-225
Dr Nick Mallaband – Acting Executive Medical Director (3)	215-220		55-57.5	275-280	245-250			245-250

(1) Individual left role as substantive Director on 31 January 2025 but remained in employment throughout 2024/25 and part of 2025/26. Salary reflects all periods of employment, as recommended within the Group Accounting Manual although pension movements are prorated for the time spent as Director.

Individual was not a member of the NHS Pension scheme.

(2) Individual left the organisation during the year. Significant increase in year as a result of Clinical Director Responsibility earnings being pensionable in 2025/26. Increase in salary compared to previous year as a result of payment in lieu of notice and payment of accrued annual leave.

(3) Individual receives salary relating to their Executive Director role, as well as their Clinical role. For 2025/26, the remuneration for their Clinical role was in £70k-£75k range.

(4) Individual received expenses in 2025/26 of £200 (to the nearest £100) for expenses incurred in 2024/25.

* Individual left organisation in 2025/26.
** Individual joined organisation in 2025/26.

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

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

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

Pension benefit increase = ((20 x PE) + LSE) - ((20 x PB) + LSB))
PE is the annual rate of pension that would be payable to the director, if they became entitled to it at the end of the financial year.
PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

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

Pension benefits

	Real increase/ (decrease) in Pension age	Real increase/(decrease) in pension related lump sum at pension age	Total accrued pension at pension age at 31 March 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer value at 31 March 2026	Employers contribution to stakeholder pension
	(Bands of £2500)	(Bands of £2500)	(Bands of £5000)	(Bands of £5000)				
	£000k	£000k	£000k	£000k	£000k	£000k	£000k	£000k
Richard Parker (1)	0 - 0	0 - 0	0 - 0	0 - 0	-	-	-	-
Dr Tim Noble (2)	30 - 32.5	72.5 - 75	120 - 125	310 - 315	1,989	757	3,003	-
Dr Nick Mallaband (3)	0 - 0	0 - 0	0 - 0	0 - 0	-	-	-	-
Zoe Lintin	2.5 - 5	0 - 2.5	40 - 45	90 - 95	786	48	868	-
Denise Smith	2.5 - 5	0 - 2.5	50 - 55	125 - 130	1,140	64	1,242	-
Karen Jessop	0 - 2.5	0 - 0	55 - 60	135 - 140	1,143	17	1,197	-
Sam Wilde	5 - 7.5	0 - 0	40 - 45	0 - 0	589	70	689	-
Zara Jones	2.5 - 5	0 - 2.5	45 - 50	110 - 115	830	43	907	-

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

(2) Individual left the organisation during the year. Significant increase in year as a result of Clinical Director Responsibility earnings being pensionable in 2025/26.

(3) Individual opted out of the NHS Pension Scheme during the year, therefore no figures are reportable.

Cash Equivalent Transfer Value (CETV)

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

Real increase in CETV

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

Zara Jones
Acting Chief Executive
16 July 2026

Governance Report

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

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

Board of Directors	Council of Governors
● Set the Trusts overall Strategic direction and oversee the delivery of that strategy ● Lead and direct the Trust ● Operate as a unitary board ● Forward planning ● Receive information on Financial, quality and service performance ● Maintain, and implement the statutory governance documents Ensure effective Risk assurance and governance systems ● Annual report and accounts are produced in line with the regulatory requirements including all disclosures	● Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. ● Appoint, remove and determine the remuneration of the Chair and Non-Executive Directors ● Approve the Boards appointment of the Chief Executive ● Appoint and remove the external auditors ● Represent the interests of the Trusts members as a whole and the interests of the wider public. Approve significant transactions, mergers, acquisitions, separations, dissolutions, and increases in non-NHS income of over 5%. ● Receive the Trusts annual accounts and any auditors report on those accounts and the Trust annual report

Board of Directors

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

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

Performance evaluation of directors

The Chair conducts the performance appraisals of the Chief Executive and Non-Executive Directors. The Senior Independent Director conducted the performance appraisal of the Chair in 2025/26. The Council of Governors feed into the appraisal process of the Chair and the Non-Executive Directors by providing commentary through the Lead governor regarding the performance of the Chair and Non-Executive Directors.

The performance review of Executive Directors is carried out by the Chief Executive.

Performance evaluation of the Board and its committees

Each Board Committee undertook a self-effectiveness review during 2025/26, with outcomes reported back to the respective committees and then to the Audit and Risk Committee (ARC) for oversight at its April 2026 meeting.

Audit and Risk Committee (ARC)

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

- Financial Reporting and Financial Stewardship.
- Governance and Internal Control.
- Management and Risk Assurance Process.
- Emergency Preparedness Resilience and Response.
- Information Governance and Cybersecurity.
- Compliance with law, guidance and codes of conduct.
- Counter fraud activity.

The Committee has Board-approved Terms of Reference, reviewed on at least an annual basis. It has four members – all Non-Executive Directors who chair the other board committees, plus the Chair of the Committee. Two members (the Chair and Finance and Performance Committee Chair) have recent and relevant financial experience and are qualified accountants.

The committee maintains a formal work plan and action log to ensure that areas of concern are followed up and addressed by the Trust. The Committee reviews the effectiveness of both the internal auditors and the external auditors on an annual basis. The external auditor contract was re-tendered in 2025-26 and the new provider approved by the Council of Governors who had oversight of the tender evaluation process.

Name	**Role**	**Meeting attendance**
Kath Smart – Chair	Non-Executive Director	5 of 5
Mark Bailey	Non-Executive Director	4 of 4
Joanne Gander	Non-Executive Director	5 of 5
Lucy Nickson	Non-Executive Director	4 of 5
Stephen Radford	Non-Executive Director	1 of 2

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

organisation's risk management, governance and internal control processes are operating effectively by:

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

ARC undertakes an annual effectiveness review of both the Internal and External Audit provision; this was carried out in October 2025.

For 2025/26, the Group incurred costs of £249k for the audit of the Group, which includes £30k of cost overruns relating to 2024/25, as well as £35k for the audit of the Wholly Owned Subsidiary and £35k for the Charitable Funds Statutory Audit. Also, the audits of WOS and Charity are performed by a different audit firm than the Group audit

Staff Report

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

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

All colleague policies and procedures can be found here: https://www.dbth.nhs.uk/about-us/our-publications/publication-scheme/our-policies-and-procedures/

Keeping our colleagues informed and engaged

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

Here are some of the key platforms we use:

- **The Hive:** Our intranet received over two million page views and five million interactions last year. It features all essential Trust information, including news and updates.
- **All-colleagues emails:** Used sparingly to avoid fatigue, these emails are sent to 7,800 users and help to mark key moments and drive action.
- **DBTH Staff App:** With 7,000 users and around three million interactions last year, the app gives colleagues another way to access The Hive and receive key updates via push notifications.

- **DBTH Buzz, Managers' Brief and Chief Executive blog:** These newsletters provide regular updates to colleagues. In 2025/26, the DBTH Buzz received an average of 3,500 views per issue. The average read time is around five minutes.
- **DBTH Staff Facebook Group:** With 7,300 members, this is one of our most active spaces, with 8,000 posts and over 200,000 interactions last year. On average, 6,800 colleagues check the group daily, with the most popular times being Wednesday and Friday evenings.
- **Trust website:** Our public-facing site has over two million page views and almost six million interactions across the year.
- **Informal channels:** We recognise that many colleagues share updates via informal routes such as WhatsApp. All our communications are designed to be easy to copy, link or screenshot, helping colleagues to cascade updates quickly and effectively within their teams in a method that suits.

Reward and Recognition

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

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

Health and Wellbeing

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

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

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

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

Accolades

- Awarded Gold in the South Yorkshire *Be Well @ Work* awards
- Accredited as a Menopause Friendly Employer
- North West BAME Assembly Anti-Racist Framework

Women's health

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

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

Staff Survey 2025

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

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

Vivup

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

Wellbeing Champions

We're proud to have around 80 Wellbeing Champions across the Trust, promoting support services and encouraging participation in activities. In 2024, we introduced bi-monthly sessions to offer further training and support for Champions in their roles.

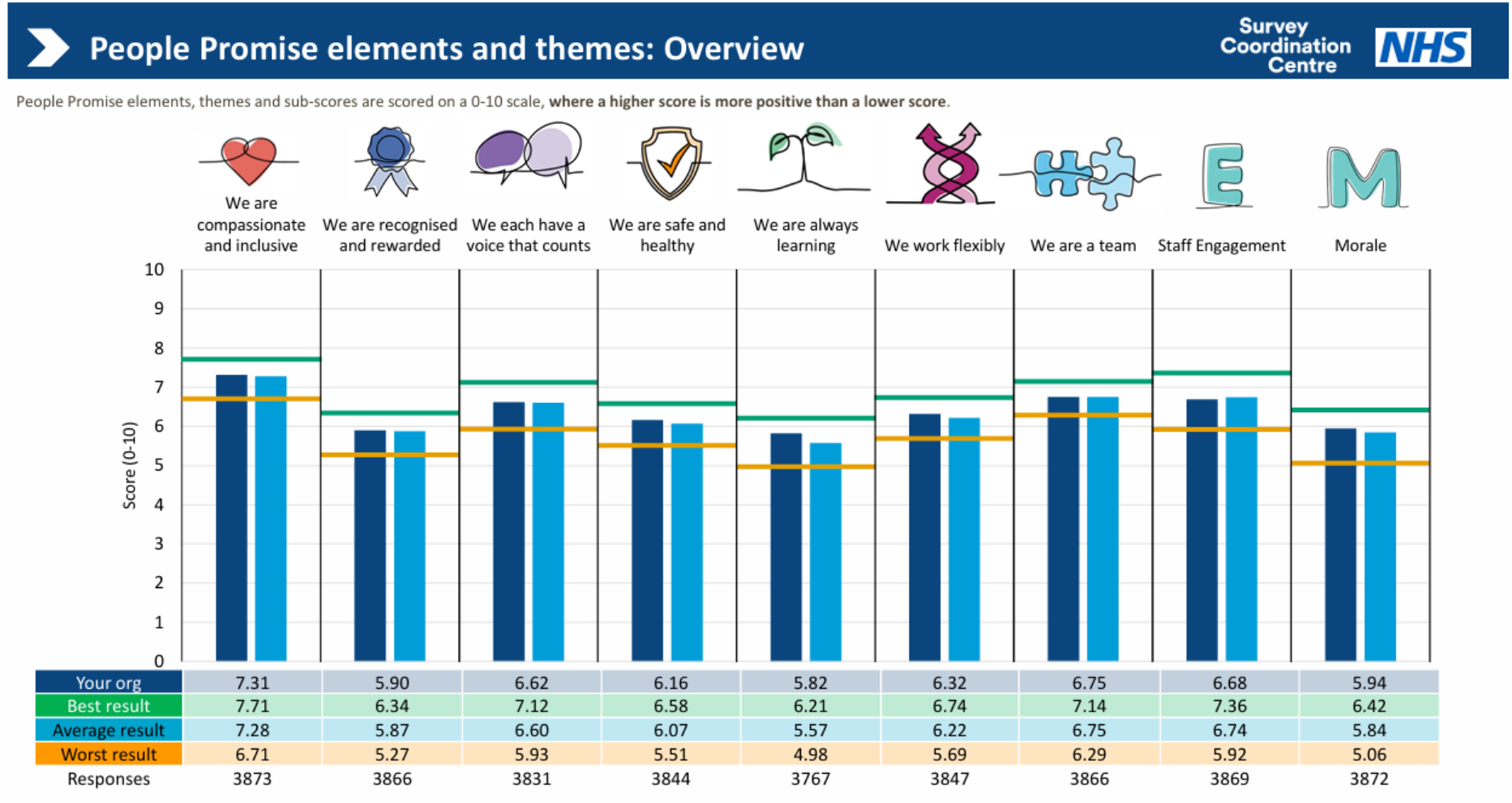
Additional support

Our health and wellbeing offer continues to evolve and currently includes:

- Complementary therapies

- Reiki
- Dr Bike clinics
- Dance sessions
- Visits from therapy dogs
- Wellbeing trolleys
- An annual *Wellbeing Calendar* packed with activities and awareness events
- Healthy weight management

The team work alongside many external organisations, including Talking Therapies, fitness centres and Doncaster Council, to provide colleagues with the best possible health and wellbeing support, resources and opportunities.



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

The NHS Staff Survey is conducted annually and aligns with the NHS People Promise, focusing on the experiences of colleagues across seven themes, alongside the areas of Staff Engagement and Morale. All indicators are scored out of 10, based on the average responses to a series of related questions.
The response rate to the 2025 survey among colleagues at DBTH was 54%, with 3,879 completed questionnaires. This remained above the national median response rate for comparable organisations, which was 47%.

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

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

What we're doing well

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

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

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

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

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

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

Where we need to improve

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

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

Speaking up and involvement: Although results around autonomy and involvement remain broadly positive, scores linked to raising concerns declined slightly this year. We want all colleagues to feel confident that their voice matters and that concerns will be listened to and acted upon.
Workload, burnout and wellbeing: Pressures across the NHS continue to impact colleague wellbeing. Burnout and work pressure scores remain areas of challenge both locally and nationally and we will continue strengthening our wellbeing support and promoting healthy working environments.

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

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

Education

In our continued commitment to providing and securing the highest quality education and training for all colleagues, including all our learners, we have further embedded the DBTH Education Quality Framework, providing a mechanism to triangulate educational data across programmes, professions, and clinical groupings. We have continued to deliver on our People Plan, receiving external validation from NHSE and Higher Education Institute partners that we have met the quality standards outlined in the NHSE education contract.

Our multidisciplinary and inclusive Education Department leads and supports all training areas, including Statutory and Essential Training (SET), Role Specific Training (ReST), upskilling for new roles, and ongoing professional development. Additionally, we have continued to provide high-quality clinical placements for almost 500 pre-registration students from various Higher Education Institutes (HEIs) across South Yorkshire and beyond. These placements cover a wide range of programmes, including Medicine, Nursing, Midwifery, Allied Health Professionals, Healthcare Scientists, and Pharmacy, alongside elective placements and return-to-practice opportunities. We have also continued to support postgraduate doctors in training in collaboration with NHSE, ensuring our clinical service provision aligns with training needs.

Providing clinical placements for both pre-registration and postgraduate learners remains a core aspect of our educational mission. We take pride in our reputation for high-quality clinical education, as reflected in learner feedback and confirmed through annual external assessments, including the Senior Leaders Engagement (SLE) meeting and the University of Sheffield Medical School annual assessment. We remain aligned to national standards and improvement work and continue to embed the Safe Learning Environment Charter across all areas of our organisation.

Our Knowledge and Library Service has continued to deliver services that strengthen evidence-based practice, embed research into practice, share learning and best practice, and support wellbeing. We delivered robust, high-quality evidence searches that inform decision-making across the organisation and ensure colleagues and learners can access and utilise clinical decision support tools such as BMJ Best Practice and DynaMed.

Knowledge dissemination has remained a core priority, with new evidence shared through KnowledgeShare and specialist bulletins, including Learning from Incidents, QI Evidence Update,

Research Funding, and the Sustainability Bulletin. Complementing this, we also provide training to equip colleagues and learners with the skills to find and critically appraise evidence.

Demand for journal club support has grown significantly. These sessions enable health professionals to read and critically appraise the methodology used in research articles, evaluate findings, and consider their application to practice. We also continued to provide access to essential resources including books, eBooks, journals, databases, PCs, and library spaces, while working in partnership with NHS libraries to extend access to resources.

Colleague and learner wellbeing has also been supported through a range of initiatives, including a monthly reading group, access to health and wellbeing resources and dedicated spaces for relaxation and reflection away from ward and office environments.

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

The apprenticeship levy has further enabled us to expand our educational offerings across all workforce areas, from entry-level through to postgraduate study. We remain a leading employer for apprenticeships, with a rolling average of 3.14% of our workforce engaged in apprenticeships during 2025/26. Our continued commitment to 'growing our own' and investing in our people is further supported by significantly low attrition rates among apprentices. We will continue to respond to the new national Skills Bill, ensuring we maximise opportunities for colleagues across our organisation.

Building on our partnerships with local education providers, including schools and Further Education Institutes (FEIs), and recognising our role as an Anchor organisation within our local communities, we have continued to offer a wide range of work experience placements. These include T Level students, clinical attachments, virtual workshops, career events, and bespoke opportunities such as garden design projects with Vinci Buildings and DN Colleges, alongside supporting local events to ensure learners and citizens across Bassetlaw and Doncaster are work-ready.

We remain in Foundation School in Health partnerships with Hall Cross Academy in Doncaster and Retford Oaks Academy in Bassetlaw, hosting a further two 'We Care Into the Future' events, with more than 3,050 Year 8 students attending and exploring the wide range of employment and educational opportunities available within our organisation. This model has gained national interest, with other NHS providers replicating the partnership and event.

Recognised for our forward-looking approach to health and wider care careers, we formalised our partnership with Doncaster College through the Healthcare Education Strategic Alliance and delivered against a breadth of educational performance indicators, including the introduction of new apprenticeships and broader placement opportunities for those undertaking health workforce-related studies, both clinical and non-clinical. Complementing this, members of our Education Senior Leadership Team continue to contribute to a number of Education and Skills groups across South Yorkshire and Doncaster.

Research

We remain committed to becoming a leading centre of research excellence, enhancing both patient care and workforce development. In 2025/26, we successfully delivered against Year 2 of our

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

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

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

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

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

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

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

systems engineering and digital twins to improve the health and wellbeing of people living with multiple long-term conditions.

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

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

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

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

Health and Safety

We are committed to maintaining a safe and secure environment for our patients, colleagues and visitors.

We achieve this by embedding robust systems and processes to ensure health and safety is managed effectively. Our approach includes the proactive identification, management, monitoring, and reporting of risk, supported by effective control measures. We also promote a no- blame culture, encouraging incident reporting through the Trust's electronic reporting system (Datix) to support learning and reflection that reduces the likelihood of future incidents.

This report provides an overview of Health and Safety management across the Trust for the reporting period 2025/26.

The Trust's Health and Safety Committee meets quarterly, providing a formal biannual report to the Finance and Performance Committee. Any areas of concern are then escalated to the Trust Board via the Chair's assurance report.

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

The Trust's electronic incident reporting system (Datix) was used to record incidents that caused, or had the potential to cause, injury to colleagues, visitors, or contractors throughout the reporting period. Those meeting the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) threshold were reported to the Health and Safety Executive (HSE).

Table 1 provides a breakdown of reported incidents by subcategory and site for the period April 2025 to March 2026.

Table 1: Breakdown of incidents into Subcategory and Site April 2025 – March 2026

	Doncaster Royal Infirmary	Bassetlaw Hospital	Montagu Hospital	External to DBH	Total
Accident caused by some other means	41	13	10	0	64
Collisions	15	13	3	0	22
Exposure to electricity, hazardous substance, infection etc	12	11	2	0	25
Injury caused by physical or mental strain	11	2	1	0	13
Moving and Handling Incidents	32	14	2	1	49
Sharps related incident, including knives	96	34	8	0	138
Slips/trips/falls (includes faints)	55	14	6	5	80
Transport related incident	2	1	0	0	3
Total	264	93	31	6	394

The Trust retained a Gold Award from the Royal Society for the Prevention of Accidents (RoSPA) for its approach to health and safety management in 2025. The RoSPA award scheme provides independent external recognition for organisations that are able to demonstrate and evidence effective health and safety management practices within their organisation, and the retention of this award reflects DBTH's ongoing commitment to patient, colleague, and visitor safety.

During the year the Trust also carried out an assessment of its safety culture using the Health and Safety Executive's (HSE) 'Safety Climate Tool', a nationally recognised methodology that provides valuable insights to inform targeted safety improvement initiatives. This process identified areas of good practice, as well as areas requiring further development, and work is now in progress to achieve a fully embedded, strong and consistent safety culture across all services at DBTH.

The Trust has also added a comprehensive review of compliance with NHS Workplace Health and Safety Standards to the workplan of its Health and Safety Committee. The standard outlines requirements that ensure NHS organisations meet their legal duties under health and safety legislation. The Health and Safety Committee receives information regularly describing the Trust's current position against each of the standards, assessing current compliance levels, and obtaining assurance that appropriate action is being taken to close any gaps identified.

A further measure implemented to drive improvement this year is the implementation of a new internal annual Health and Safety Audit, which allows departmental managers to review compliance within their areas of responsibility, informing local improvement plans where necessary. This process is overseen by the Health and Safety Advisor, with regular updates provided to the Health and Safety Committee for assurance.

A network of 'Health and Safety Champions' has also been implemented. Six colleagues from different areas within the Trust completed the Institute of Occupational Safety and Health (IOSH) "Managing Safely" training and now provide local support to their colleagues. The Champions play an important role in making safety part of everyday practice. They help share information with teams, support audits, and raise concerns where needed. This initiative is having a positive impact on safety at DBTH, with champions helping to identify risks, improve awareness, and support local problem- solving.

Health and Safety Champions also meet regularly with the Health and Safety Advisor to share learning, raise concerns, and discuss areas of good practice. Plans are in place to further strengthen this work by linking with the Trust's "Just Culture" and "Speak Up" initiatives.

Finally, the Trust continues to ensure that health and safety information is shared regularly with the Health and Wellbeing Committee. This includes incident data and trends, helping the Trust take a joined- up approach to staff safety and wellbeing, recognising that both are closely connected and equally important.

Fire Safety

The Trust continues to invest significantly in fire safety to protect patients, staff and visitors across all Trust premises.

The Trust's fire safety improvement programme is informed by regular fire risk assessments, risks recorded on the Trust's risk register, and close working with South Yorkshire Fire and Rescue Service and Nottingham Fire and Rescue Service. The programme is approved annually by the Trust Board and is monitored through established governance arrangements to ensure progress is tracked and risks are appropriately managed.

During 2025/26, the approved fire safety capital improvement programme totalled approximately £6.3 million. This funding supports a wide range of fire safety improvements across Trust sites. A significant proportion of the original programme was allocated to fire safety works in clinical areas at Doncaster Royal Infirmary. However, due to delays in providing temporary accommodation required to safely decant services, elements of this work have been rescheduled into 2026/27. The Trust has taken a managed approach to this change, ensuring that available funding continues to be used to deliver fire safety improvements elsewhere while maintaining a clear and agreed plan for future delivery of the deferred works.

In parallel with major capital projects, an ongoing programme of fire safety activity is delivered through a dedicated Fire Task and Finish Group. This includes completing fire risk assessments, undertaking detailed surveys of fire compartmentation, inspecting fire doors, mapping fire safety systems, upgrading fire alarm systems, testing and repairing fire dampers, and improving the quality and accessibility of fire safety records. Together, these actions help ensure that Trust buildings are designed, maintained and operated in a way that reduces fire risk and supports safe evacuation when required.

A comprehensive review of fire risk assessments across all Trust premises is also currently underway. This is being carried out by specialist external fire safety consultants, and the findings of the review will help to inform the future development of fire safety improvement work at DBTH. Independent oversight and assurance is provided through regular engagement with fire and rescue services and external fire safety specialists employed by the Trust.

Task Force on Climate- Related Financial Disclosures (TCFD)

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

These recommendations, as interpreted and adapted for the public sector, were implemented on a phased basis up to the 2025/26 financial year, which represents the final phase of TCFD implementation.

Local NHS bodies are not required to disclose Scope 1, 2, and 3 greenhouse gas emissions under the TCFD framework, as these are calculated nationally by NHS England.

For the 2025/26 financial year, disclosures are required across all four TCFD pillars: governance, strategy, risk management, and metrics and targets. These disclosures are set out below.

Board oversight of climate-related issues

The Chief Finance Officer (CFO) is the designated Board- level Net Zero Lead for the Trust. The Trust's Finance and Performance Committee, a committee of the Board, receives biannual updates on Green Plan delivery. These updates include progress against key objectives set out in the Green Plan, updates on system- wide initiatives and consideration of other climate- related issues, which inform strategic planning at Board level.

Management's role in assessing and managing climate- related issues

The Director of Infrastructure and the Operational Director of Estates and Facilities act as operational sustainability leads for the Trust, reporting to the CFO and overseeing delivery of the Green Plan.

A Green Plan Steering Group meets quarterly to co-ordinate delivery of Green Plan objectives, monitor progress across the organisation, support colleagues, and to assess climate-related issues.

A Climate Change Adaptation Working Group has also been established. Working in line with NHS England's Climate Change Adaptation Framework NHS England » A climate adaptation framework

for NHS organisations in England, this forum adopts a multi-disciplinary approach to identifying risks associated with climate change so that appropriate adaptations may be designed and implemented. This group reports formally to the Emergency Preparedness Resilience and Response (EPRR) Group.

Outputs from these forums inform tactical and strategic decision making on matters related to climate-related issues at DBTH, details of which are reported through established governance routes, including biannual reporting to the Finance and Performance Committee.

Climate- related risks and opportunities

The Trust recognises that climate change presents a range of actual and potential risks to healthcare service delivery, estate resilience, workforce wellbeing, and long- term financial sustainability. These include risks arising directly from extreme weather events, rising energy costs, increased regulatory compliance requirements, and the need to decarbonise infrastructure and services in line with national objectives.

As described in the previous section, a Climate Change Adaptation Working Group has been established to investigate climate-related risks and their impact on Trust services, including rising temperatures, changes to patterns of rainfall, and an increasing number of extreme weather events. The work of this group will assist the development of climate adaptation plans and inform future strategic planning activity.

The Trust also recognises opportunities associated with the transition to a low- carbon health system, including improved energy efficiency, modernisation of the estate, digital transformation and wider health and wellbeing benefits for patients, colleagues, and local communities.

Projects to further expand solar power capacity at Doncaster Royal Infirmary and Bassetlaw Hospital completed in 2025/26 typify these opportunities. Funded by the UK Government's Great British Energy initiative, these projects have expanded on-site renewable energy generation at the Trust, reducing both emissions and cost.

Impact on strategy and financial planning

The Trust's strategic response to climate- related risks and opportunities is primarily delivered through its Green Plan. Spanning nine areas of focus, the Green Plan includes key objectives, delivery milestones, and performance metrics, outlining the Trust's strategy to progress the NHS's ambition to become the world's first national net zero healthcare provider - this can be viewed on our website www.dbth.nhs.uk

Climate-related risks and opportunities also inform estate and capital planning, business case development, and longer- term financial planning, supporting alignment between sustainability objectives, service delivery and financial sustainability.

Identifying and assessing climate- related risks

The Trust's Climate Change Adaptation Working Group is in the process of undertaking a climate change risk assessment, informed by historic incidents and known risks related to the geographical location and profile of each site. Once complete, this assessment will define key climate- related risks and proposed control measures, informing the development of a climate adaptation plan. Identified risks will be recorded on the Trust's risk register and managed in line with established risk

management processes. This work is planned for scheduled for completion during the 2026/27 financial year.

Horizon scanning is also undertaken by the Trust's Green Plan Steering Group to identify emerging climate- related risks, informed by guidance from NHS England and other public bodies.

Managing climate- related risks

The Trust's Green Plan sets out a comprehensive range of objectives aimed at managing and reducing climate- related risks. Green Plan delivery is monitored via the Green Plan Steering Group, with oversight from the Finance and Performance Committee.

Where new or emerging climate- related risks are identified, they are managed through the Trust's risk management framework, ensuring appropriate oversight, mitigation, and assurance. The forthcoming climate adaptation plan will set out further mitigation and control measures aligned to identified risks.

Integration into overall risk management

Processes for identifying, assessing, and managing climate- related risks are integrated into the Trust's wider risk management framework and support both operational and strategic decision making.

Metrics used to assess climate- related risks and opportunities

In line with NHS England guidance, the Trust does not independently calculate or publish a full organisational carbon footprint, as emissions data is reported nationally.

NHS England's Green Plan Support Tool does, however, provide carbon footprint and carbon footprint plus estimates at an organisation level to support planning and progress monitoring. Additionally, NHS England's Greener NHS Dashboard provides detail at Trust level to monitor progress and support future planning. This includes data on energy consumption, waste, water and volatile anaesthetic gas emissions, metered inhaler use, and information collected via quarterly data returns.

Relevant data is also reported annually through the Estates Return Information Collection (ERIC) and published on NHS England platforms, including Model Hospital, supporting benchmarking and trend analysis.

At a local level, the Trust's refreshed Green Plan includes a suite of metrics aligned to NHS England guidance that measure progress against the objectives contained within each of the plan's nine areas of focus.

Statement of compliance (comply or explain)

The Trust has applied the TCFD framework on a comply- or- explain basis in line with NHS England guidance; any limitations in disclosure reflect data availability, proportionality, and the evolving nature of national NHS sustainability reporting arrangements.

Workforce statistics as at 31 March 2026 (not subject to Audit)

In 2025/26, the Trust's staff turnover figure stood at 9.34%. Please note, staff turnover information can be viewed here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

	FTE (Perm)	FTE (Other)	FTE (Total)
Total staff employed as at 31 March 2026	6,385	394	6,679
Medical and dental	733	65	798
Administration and estates	1,739	34	1,773
Nursing, midwifery and health visiting staff	1,964	117	2,081
Scientific, therapeutic and technical staff	699	5	704
Healthcare science staff	50	0	50
Other	1,100	173	1,273

Sickness absence

Metric	2025/26 Actual	2025/26 Target	Benchmarking data
Staff Sickness Absence Rate	5.6%	5%	The Trusts 2024/25 rate was 5.8%. The March 2026 rate was 5.51%. In March 2026 the regional rate was 5.4%.

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital	
Average FTE 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
6,270.01			2,288,571.22	124,533.39

Staff costs (subject to audit)

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

	Total £000	**Permanently employed total £'000**	**Other total £'000**
Salaries and wages	317,790	303,110	14,680
Social security costs	40,740	40,740	-
Apprenticeship Levy	1,542	1,542	
Pension cost – defined contribution plans employer's contributions to NHS Pensions	35,769	35,769	-
Pension cost – defined contribution plans employer's contributions to NHS Pensions paid by NHS England on provider's behalf	23,384	23,384	
Pension cost - other	40	40	-
Temporary staff – external bank	29,040	-	29.040
Total staff costs	448,305	404,585	43,720

Equality, diversity and inclusion (not subject to audit)

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

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

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

On 8 June 2023, NHS England launched its first Equality, Diversity and Inclusion (EDI) Improvement Plan, recognising that a diverse and inclusive workforce leads to better care for patients. In response, we developed our own DBTH EDI Improvement Plan, reviewing all current EDI workstreams and aligning our actions to the six high impact priorities and associated success metrics. As of March 2026, we have now refreshed our EDI Improvement Plan for the second time with new priorities and measurable outcomes for 2026 and 2027, while ensuring all remaining actions remain on track.

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

In 2025, the Trust was a key member of the Doncaster Anti-Racism Steering Group, which brings organisations together to share resources and take a joined-up approach to becoming actively anti-racist as employers and service providers. This work is co-ordinated through the Doncaster Place Strategic Workforce Group. In December 2025, the Trust also achieved Bronze status under the North West Black, Asian & minority Ethnic Assembly's Antiracist framework. The Trust is the first NHS Trust in South Yorkshire and Nottinghamshire to achieve this status. Demonstrating its effort and dedication in becoming an antiracist organisation.

Our efforts are having an impact. The 2025 NHS Staff Survey shows continued improvements in the workplace culture and colleague experience at DBTH since 2021, with results that consistently exceed the national average for acute trusts. While we are proud of the progress made, we remain committed to doing more to ensure fairness, equity and inclusion for every colleague.

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

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

Equality Information as at 31 March 2026 – Executive and Senior Directors

Gender (Directors Only)	Headcount	Headcount %
Female	8	69.95%
Male	3	30.05%

Senior managers

Gender	Headcount	Headcount %
Female	71	59.98%
Male	41	40.02%

Organisational equality information

Gender	Headcount	FTE	Headcount %
Female	6165	5,068.15	82.57%
Male	1301	1,171.56	17.43%
	7466	6,239.71	100%

Age	Headcount	FTE	Headcount %
16 - 20	68	58.23	0.91%
21 - 25	507	450.50	6.79%
26 - 30	828	746.27	11.09%
31 - 35	1029	869.26	13.78%
36 - 40	988	836.89	13.23%
41 - 45	836	723.17	11.20%
46 - 50	691	603.42	9.26%
51 - 55	854	735.34	11.44%
56 - 60	802	635.86	10.74%
61 - 65	654	455.75	8.76%
66 - 70	147	85.66	1.97%
71 & above	62	39.36	0.83%

Ethnicity	Headcount	FTE	Headcount %
Any Other	125	116.5277	1.67%
Asian	761	704.3116	10.19%
Black	390	359.5096	5.22%
Chinese	30	26.84333	0.40%
Mixed	113	98.83365	1.51%
White	5941	4,846.229	79.57%

Not Disclosed	106	87.45499	1.42%
Disability	**Headcount**	**FTE**	**Headcount %**
No	6,640	5,571.50	88.94%
Not Declared	314	252.02	4.21%
Prefer Not To Answer	26	20.40	0.35%
Unspecified	4	2.50	0.05%
Yes	482	393.28	6.46%
Sexual Orientation	**Headcount**	**FTE**	**Headcount %**
Bisexual	88	73.29	1.18%
Gay or Lesbian	110	100.23	1.47%
Heterosexual or straight	6,061	5,089.64	81.18%
Other sexual orientation not listed	13	11.45	0.17%
Undecided	12	9.60	0.16%
Unspecified	0	0.00	0.00%
Not Disclosed	1,182	955.51	15.83%

Gender pay gap

This report examines the gender pay gap within our Trust as of 31 March 2025, showing disparities between male and female employees. The deadline for national submission of our gender pay gap reporting is 31 March 2026. The gender breakdown continues to show that women make up the majority of the workforce at DBTH.

The median gender pay gap stands at 24.35%, improved from 29.4% in 2024, and the mean gender pay gap stands at 34.63%, improved from 37.6% in 2024.

Hourly Pay Gap

- Mean Pay Gap: 34.63% in favour of men.
- Median Pay Gap: 24.35% in favour of men.

This indicates that, on average, men continue to earn significantly more per hour than women, highlighting ongoing systemic issues in pay equity at DBTH. This is reflective of the wider NHS as pay arrangements are determined nationally and the gender breakdown in trusts is often similar to the shape at DBTH.

This position is also linked to the distribution of employees amongst the pay quartiles, with the upper quartile being the one where men are most represented. There has been some improvement compared to 2024, although the gap remains considerable.

Pay Quartiles

- Upper Quartile: 35.48 % men vs. 64.52% women. Men remain more represented in higher-paying.

- roles (e.g., experienced senior consultants), contributing to the overall pay gap.
- Upper Middle Quartile: 14.70% men vs. 85.30% women.
- Lower Middle Quartile: 13.88% men vs. 86.12% women.
- Lower Quartile: 12.22% men vs. 87.78% women.

Women continue to make up a higher percentage of the workforce in the middle and lower pay quartiles, as they are predominantly represented in roles such as Healthcare Assistants, Administrative and Clerical and Support Services. These roles, based on the 2025 DBTH workforce data, are filled by women across a range of job roles and the Agenda for Change pay scales from band 2 upwards to band 6.

The Healthcare Assistant and Support Worker transition project at DBTH has been completed, it supported colleagues transitioning from Band 2 to Band 3 where appropriate to the work undertaken within the required role. This project ensured that pay protection, backdated pay and any required adjustments were applied fairly and accurately and the majority of employees involved were women.

Actions are being added to the DBTH ED&I high-level improvement plan under High-Level Action 3 - Develop and implement an improvement plan to eliminate pay gaps. The Trust continues to progress the flexible working workstream, Scope for Growth career conversation, talent management and leadership development opportunities.

Bonus Pay

The Clinical Excellence Awards (CEA) for consultants remain a key driver of bonus pay disparity. Other allowances or forms of additional income may also be relevant, such as grants or payments linked to academic or research activity.

Proportion Receiving Bonuses:

- Men: 9.61%.
- Women: 0.74%.
- Mean Bonus Gap: 35.96% in favour of men.
- Median Bonus Gap: 96.19% in favour of men.

The significant disparity in bonus pay reflects the higher number of senior male consultants within the Trust. As CEAs are awarded primarily to consultant-level colleagues, and men make up the majority of this group, this drives a wide bonus pay gap. As in previous years, CEAs were distributed equally among consultants who met the criteria. Nationally negotiated changes mean that the current CEA scheme will not continue in its existing form in future years.

Comparison in the Gender Pay Gap

Mean Pay Gap: Highlights the overall difference in earnings between genders, however this can be influenced by a small number of highly paid individuals, such as senior male consultants as evidenced in the 2025 DBTH workforce data.

Median Pay Gap: Reflects the workforce data more accurately and therefore gives a clearer picture of everyday pay disparity.

There has been a reduction in both the mean and median gender pay gaps when compared with the previous reporting year. The mean gender pay gap has reduced from 37.6% in 2024 to 34.63% in 2025, representing a reduction of approximately 3 percentage points. The median gender pay gap has also reduced from 29.4% in March 2024 to 24.35% in March 2025. a reduction of just over 5 percentage points from last year.

Actions to Address the Gender Pay Gap

To address the gender pay gap, the Trust continues to implement strategies aimed at fostering workplace equity. These include:

- Promoting flexible working practices.
- Enhancing support for colleagues experiencing menopause and raising awareness with managers and colleagues.
- Advancing initiatives designed to improve gender diversity in leadership roles.
- Scope for Growth career conversations.
- EDI high-level improvement plan under High-Level Action 3 – Develop and implement an improvement plan to eliminate pay gaps.

These efforts support a more inclusive workplace culture for all colleagues. A key focus of these initiatives is making senior positions more accessible to women. This is achieved through encouraging flexible job arrangements and expanding access to leadership development opportunities open to all colleagues, designed to strengthen leadership capability and support career progression. These include:

- Board Development Delegate Programme – aimed at increasing diversity in leadership.
- Reciprocal Mentoring Programme – where the majority of aspiring leaders are women.
- As of Dec 2025, 36 of the 49 people on leadership & Management apprenticeships are women.

These initiatives are crucial in ensuring that talent and potential are not hindered by structural or cultural barriers. The South Yorkshire Women's Network also provides a space for professional growth, peer support, and increased visibility, while addressing challenges and inequalities faced by women in the workplace.

To drive progress, the Trust has established clear goals, benchmarks and accountability mechanisms, all of which are outlined within the DBTH ED&I high-level improvement plan under High-Level Action 3 - Develop and implement an improvement plan to eliminate pay gaps.

Our Supply Chains

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

Slavery and Human Trafficking Statement 2025/26

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

Our Policies on Slavery and Human Trafficking

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

Due Diligence Processes for Slavery and Human Trafficking

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

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

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

The Supplier warrants and undertakes that it will:

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

Supplier Adherence to Our Values

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

Training

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

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

Countering fraud, bribery and corruption

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

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

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

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

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

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

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

In pursuance of our proactive approach to spotting and disrupting fraud, we have a well-publicised system in place for staff to raise any concerns of suspected fraud. They can do this via our LCFS, or the CFO or via the NHS Fraud and Corruption reporting line on **0800 028 40 60** (online at

https://cfa.nhs.uk/reportfraud). Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels.

Expenditure on consultancy

The Trust incurred consultancy expenditure of £455,000 (2024/25: £174,000).

Included was the cost of specific director recruitment agency fees of £15,000 for the appointment of the Chief medical officer and a non-executive director, whose appointment dates fell into the 2026-27 financial year.

Staff Exit packages for 2025/26 - subject to audit

There was one non contractual payment in lieu of notice, totalling £119k.

High paid and off pay-roll arrangements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	16

Finance and Performance Committee

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

Name	**Role**	**Meeting attendance**
Denise Smith	Chief Operating Officer	10 of 11
Sam Wilde	Chief Finance Officer	10 of 11
Kath Smart	Non-Executive Director	11 of 11
Mark Bailey (Chair from April 2025 - December 2025)	Non-Executive Director	7 of 8
Dr Emyr Jones	Non-Executive Director	9 of 10
Joanne Gander	Non-Executive Director	3 of 3
Stephen Radford (Chair from January 2026)	Non-Executive Director	3 of 6

**Three meetings were rescheduled following changes to the Board of Directors' meeting dates; this impacted on attendance. However, all meetings remained fully quorate.*

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

Provided assurance on:

- Current financial and operational performance.
- Financial forecasts, budgets and plans in the light of trends and operational expectations.
- Any specific risks in the Board Assurance Framework relevant to the committee.
- Reviewed and developed enabling plans in relation to clinical site development, estates and facilities, IT and information and finance.
- Undertaken deep dives into key service areas and cost improvement plans~~,~~
- Reviewed Digital and data Quality arrangements, Infrastructure and Net Zero, and Trust Health, Safety and Fire processes and arrangements.

Quality Committee

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

Name	Role	Meeting attendance
Joanne Gander (Chair)	Non-Executive Director	6 of 6
Dr Emyr Jones	Non-Executive Director	5 of 6
Hazel Brand	Non-Executive Director	3 of 3
Dr Nick Mallaband	Acting Executive Medical Director	4 of 6
Karen Jessop	Chief Nurse	5 of 6
Stephen Radford	Non-Executive Director	2 of 3
Helen Best	Non-Executive Director	1 of 1

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

- The effectiveness of clinical governance, clinical risk management and clinical control
- Compliance with Care Quality Commission standards.
- Patient Safety, experience and outcomes including the monitoring of systems and controls, patient-centred care, compliments and complaints.
- Undertaken strategic discussions and deep dives into quality, governance and workforce related issues.
- Carried out discussions of key risks on the Trust's corporate risk register and board assurance framework.
- Annual Quality Strategy, Plan and Reports, inc. Trust Quality Priorities and Plan, Quality Performance and Equality Impact Assessments.
- Progress on Maternity and Neonatal Year 3 Delivery Plan.
- Review the Clinical Negligence Scheme for Trusts, Maternity Incentive Schemes declaration and compliance against Standards.
- Legislative and Statutory Compliance on Mental Health Act and Safeguarding.
- Compliance on guidance and best practice in respect of its mortality surveillance systems and learning-from-deaths processes.

People Committee

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

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

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

Name	Role	Meeting Attendance
Hazel Brand	Non-Executive Director	2 of 2
Emyr Jones	Non-Executive Director	5 of 5
Lucy Nickson (Chair)	Non-Executive Director	5 of 5
Zoe Lintin	Chief People Officer	5 of 5
Karen Jessop	Chief Nurse	4 of 5
Dr Nick Mallaband	Acting Executive Medical Director	3 of 5
Stephen Radford	Non-Executive Director	1 of 2
Helen Best	Non-Executive Director	1 of 1

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). An additional Segment 5 is used where intensive, tailored support is provided via the Recovery Support Programme where there is also low capability to improve.

A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. An NHS

Foundation Trust will be in segment 3 or 4 where it has been found to be in breach or suspected breach of its licence conditions

Segmentation

NHS England has placed DBTH NHS Foundation Trust in Segment 3. This is the Trust's position as at 26 June 2026, using the most up-to-date information available at the time of preparing this Annual Report.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Statement of Accounting Officer's responsibilities

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust.

The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

Under the NHS Act 2006, NHS England has directed Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Zara Jones
Acting Chief Executive
16 July 2026

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness or stifle clinical innovation. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors has overall responsibility for risk management. This includes the identification and effective management of emerging and principal risks to achievement of the Trust's strategic objectives, supported by Board Committee and governance processes, captured on and managed through the Board Assurance Framework (BAF). The Board is also responsible for ensuring that effective systems and processes for managing risk are in place across the organisation.

As Accounting Officer, I ensure that sufficient resources are invested in managing risk. Responsibility and leadership are delegated through directors in accordance with the Trust's Scheme of Reservation and Delegation. This covers all aspects of governance relating to our service delivery including quality governance, clinical care, CQC and other regulatory and statutory requirements, finance and health and safety. The Chief Medical Officer has delegated responsibility from the Chief Executive for the executive leadership of risk in the Trust and is responsible for devising, implementing and embedding all risk processes throughout the organisation. The Trust Company Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework.

All Directors and divisional managers have a leadership responsibility for risk management within their own areas and are accountable to the Trust Board through regular reporting to the Audit and Risk Committee.

Training and equipping staff to manage risk

The identification, assessment and management of risk is the responsibility of all colleagues who are supported by a range of policies in place which are available on the Trusts intranet. These describe the roles and responsibilities in relation to the identification, management and control of risk.

The Trust's mandatory training programme, which forms part of the staff induction, includes guidance on how to report risks and information via the DatixWeb© integrated risk management system, the system through which these are managed. Individual training is provided to staff across the Trust according to their role specific responsibilities. Executive Directors and senior managers receive training on strategic risk management, and divisional staff receive training on operational risk management. Compliance with the role specific mandatory training is reported to the Audit and Risk Committee.

Staff are equipped to manage risk based on their responsibilities, through further guidance disseminated via briefing systems, including intranet resources, electronic communications, divisional governance meetings. The Trust has a range of organisation-wide policies and service/division specific procedures which support and align with the Trust's approach to risk management. Staff can contact the Company Secretary and Trust Risk Manager for guidance on applying relevant risk management policies. The Trusts Risk Management Group provides a forum for active check and challenge on the grading of risks, understanding action effectiveness and length of time a risk remains on the risk register, this forum shares best practice across the organisation.

In 2025 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust was shortlisted in the HFMA Awards governance category for developing a more integrated, transparent and responsive governance framework, resulting in stronger operational oversight and better alignment between day-to-day decision-making and longer-term strategic aims.

The risk and control framework

The Trusts Risk Management policy is regularly reviewed in light of current best practice advice to assess whether changes are required and the Risk Management Groups annual work programme is reported through the Audit and Risk Committee. This supports the delivery of the Trust's overarching strategy and determines how risks inherent to, and arising from, DBTH activities are identified, assessed, mitigated or transferred, and controlled. It is supported by a number of enabling strategies and plans and implemented through the risk management policy.

All staff are responsible for identifying risks which may arise from a range of internal and external sources, and record risks on DatixWeb© for review and incorporation in local, divisional, and corporate risk registers as appropriate. Each risk is assessed and scored using our risk scoring matrix, based on consequence and likelihood of realisation, with an initial score, a current score, and a

target score aligned to our risk appetite. This enables the effective prioritisation of resources to address and mitigate risks as appropriate. The Trust follows the following risk management process:

- Identify and evaluate risks: what could stop you achieving your objectives/cause harm? What could help you achieve your objectives?
- Assess and score risks: assessing the risk to determine and prioritise how the risks should be managed.
- Control and manage risks: the selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level.
- Monitor and review risks: the design and operation of integrated, insightful and informative risk monitoring and timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.

The Trust's risk appetite is set annually by the Board with the goal of aligning risk-taking with strategy, statutory and regulatory requirements, clinical quality and safety, and financial planning, and capture changes in the Trust's strategic priorities, operating environment, and risk profile. The Board recognises the importance of a robust, consistent, and embedded approach to ensure all staff are aware of the collective appetite and the reasons for it, to avoid erratic risk taking or an overly cautious approach which may stifle growth and innovation.

Individual risk owners are responsible for regularly reviewing and updating their risks, and additional reviews are undertaken through departmental and divisional governance meetings. These are reviewed via the Trusts Risk Management Group which is responsible for facilitating the appropriate use of risk management processes across the Trust, providing specialist advice, challenge and supporting staff to identify, record, assess, and control risks in accordance with the risk management policy. The Audit and Risk Committee review the internal risk management and oversight processes, both in relation to operational and strategic risks, to ensure that this aspect of the Trust's internal control framework remains robust. Assurance is provided to the full board following each review. The Oversight and management of risk were reviewed as part of the external well-led and cultural review which was commissioned in 2025, with recommendations made on the BAF. The trust received a significant assurance report from Internal Auditors on its BAF in 2025-26 and risk management across the trust is included within the internal audit plan 2026-27.

On 8 May 2026 the Trust received the final CQC report of its unannounced inspection of the Emergency Department at Doncaster Royal Infirmary which rated it as 'requires improvement'.

Significant Risks and Challenges

The Board is responsible for identifying, assessing, and monitoring key strategic risks. Individual strategic risks are recorded on the Board Assurance Framework (BAF) which is regularly reviewed by Executives, at each of the monitoring committees, and at the public Board of Directors. The BAF is reviewed and updated throughout the year as a key working document. In 2025-26 the significant Strategic risks and challenges were identified as:

1. **Quality of Care**: If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH.
2. **Workforce:** If DBTH does not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.
3. **Access to Care**: If demand for clinical services exceeds the capacity available we are unable to deliver timely access to care, resulting in long waiting times and potential patient harm.
4. **The Care Environment**: If DBTH cannot maintain and improve the care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and / or regulatory actions.
5. **Financial sustainability**: If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.
6. **Partnership and collaboration**: Due to insufficient resource, engagement, and governance arrangements, our partnerships do not deliver on the expected benefits, resulting in poor use of resources and inability to transform and enhance services.
7. **Digital and Cyber**: If we fail to develop essential digital, data and technology that prioritises cyber resilience, we will prevent our people from delivering efficient, safe patient care and increase the risk of key system failure and disruption to services.

During the year, there were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHSE ratings or Care Quality Commissions assessments.

The trusts assessment of principle risks, governance controls and mitigating actions have been informed by the external regulatory feedback and there are no material inconsistencies between the Trust's assessment of key risks and those advised by the Care Quality Commission and NHSE

Quality Governance Framework

The quality governance structure was updated during 2024-25 to clearly define the reporting lines and governance arrangements for all aspects of quality governance, and its positive impact has further embedded within 2025-26. This is part of a wider piece of work to realign the executive profiles and ensure responsibilities for oversight, quality assurance and consistency.

As part of the Trust's ongoing commitment to strengthening quality governance, the Patient Safety Incident Response Framework (PSIRF) has been fully implemented, enhancing oversight and learning from patient safety incidents. In alignment with this framework, the Trust has established a Patient Safety Review Group, which supports robust governance, collating information from across the Trust and reporting into the executive-led Patient Safety Assurance Group and Effective Assurance Group. These reports provide assurance on local governance activities and the management of safety

incidents and concerns within each clinical area. The outputs of these operational groups are reviewed by the Quality Committee and contribute directly to the Trust Board's oversight of quality and patient safety.

A culture of continuous quality improvement is embedded in the Trust's overall strategy. The Trust's performance against the quality standards is included in the Integrated Quality Performance Report (IQPR) which is subject to review by the relevant committees and ultimately by the Board of Directors. In line with recommendations from the external well-led review that took place within the year, the IQPR key metrics have been reviewed for greater focus to support board oversight of Trust performance. During 2025-26, the Board continued to receive regular performance information on key quality indicators including patient safety, patient experience and clinical effectiveness.

All staff are trained in incident reporting and are encouraged to report and assess all incidents through the DatixWeb© integrated risk management system, to take learning forward for continuous improvement. Incident investigation training is provided to staff with investigation and management responsibility. Robust escalation and governance processes are in place, from ward to Board, to ensure the appropriate response and prioritisation of all incidents and risks.

Quality impact assessments are undertaken to assess potential impact of service changes on quality and ensure a consistent approach to support quality governance and are a routine part of business case development.

Equality impact assessments are undertaken to assess potential equality risks of service or policy changes, to ensure mitigations are implemented and any potential negative impact removed as part of any service change or business case development.

The Trust has a wide range of formal and informal ways for patients and the public to share their views and concerns about both individual care and services. Patients and relatives may provide formal feedback via the Friends and Family Test, patient surveys, complaints, Patient Advice and Liaison Service (PALS), and online through a feedback form on the Trust's website or NHS choices, and Care Opinion. Informal feedback is often sent through the Trust's social media channels and can be provided directly to our wards and department clinical leaders.

Business Continuity

The Trust has established business continuity arrangements in line with the Civil Contingencies Act 2004, the Health and Social Care Act 2012, and the NHSE Core Standards for Emergency Preparedness, Response, and Recovery, under the oversight of the Chief Operating Officer. A variety of emergency response frameworks are in place to address multiple scenarios, and these are regularly reviewed and tested. Each department is responsible for maintaining integrated business continuity plans, which are also reviewed and validated through live exercises. After any critical incident, the Trust conducts debriefs and applies lessons learned to strengthen future risk mitigation.

Workforce risks

Significant workforce risks are monitored through the Divisional risk registers, corporate risk register, BAF, the Executive Team, Quality and People Committees, and Board. The people strategy sets the Trust's commitment to ensuring staffing processes are safe, sustainable and effective with data presented in the Integrated Quality and Performance Report (IQPR) at the public Board.

The Trust is fully compliant with Developing Workforce Safeguards Standards for nursing and midwifery. We have a number of mechanisms in place for continued assurance around short, medium, and long-term workforce strategies and safe staffing systems, including:

- Use of e-rostering in line with the Developing Workforce Safeguards recommendations;
- Monthly HR performance scorecard, used operationally at ward and divisional level and reported to our People Committee and to the Board;
- Monthly safe staffing dashboard, regular reporting to the Quality Committee reported to Board;
- Six-monthly assurance report on Nursing and Midwifery staffing levels, also reported to Board.

Stakeholder engagement

The Trust recognises that effective risk management relies on a range of contributions, and collaborative work is undertaken with many stakeholders. To support the identification of risk, the Trust directly engages with both Integrated Care Systems in which they have contractual relationships; Nottingham and Nottinghamshire ICB, which became Derbyshire Lincolnshire and Nottinghamshire (DLN) Integrated Care Board during 2025/26, and hosts a Healthcare Risk Management Network which focuses on joint identification and mitigation of system risk, plus the South Yorkshire and Bassetlaw Integrated Care Board. DBTH also works closely with its neighbouring provider trusts, local authorities, Healthwatch, the University of Sheffield, Sheffield Hallam University and University of Lincoln, associated charities, patients and carers. DBTH encourages stakeholders to raise concerns or potential upside risks through engagement and support groups, the patient engagement forums, Council of Governors, complaints and enquiries teams, social media commentary, friends and family tests, and CQC surveys.

The Council of Governors provide a key link to the members and public and the Annual Public/ Members Meeting held September 2025 enabled a range of services to 'showcase' in a public arena that invited feedback. Throughout the year there were a number of Governor briefing sessions, and 'meet and greet' sessions with governors held on hospital sites.

All risks arising from these engagement forums are captured and assessed through our risk management policy framework.

Care Quality Commission (CQC) Standards

There are systems and controls in place to ensure the CQC standards continue to be embedded within the Trust. CQC inspections provide a good level of independent assurance to the Board and Council of Governors that the Trust is safe, effective, caring, responsive, and well-led.

The inspections which were undertaken in 2025-26 were:

Un-announced Visit - Urgent and Emergency Care: December 2025 - Final report received 8 May 2026. The immediate actions requested from the initial feedback following the visit were fully implemented.

On 28 January 2026 the Trust received a Section 29A warning notice from the CQC as a result of their unannounced inspection of the Emergency Department. The final report was received on 8 May 2026 with an overall summary of requires improvement.

Following receipt of the May 2026 CQC Inspection report, the Trust put in place an improvement programme focussed on the outcomes identified. This plan is overseen by the Chief Nurse; it is reviewed within the executive team monthly and reported to the Quality Committee.

Un-announced Visit – Children and Young Persons Services: 22 and 23 April 2026 – Awaiting final report however the initial feedback received on 23 April 2026, which was confirmed in writing on 27 April 2026 did not identify any immediate concerns.

Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust are fully compliant with the registration requirements of the Care Quality Commission and have actions in place to address the recommendations of the CQCs unannounced inspection of the ED. The Trust has an overall Trust rating of 'requires improvement'. The Trust's governance processes are informed by the CQC and NHS England well-led framework, as discussed in the directors' report.

NHS Provider Licence

The Trust has processes and actions in place to maintain its compliance with the NHS Provider licence. Together with the Code of Governance for NHS Providers this is reviewed via self-assessment, and relevant aspects were presented to the Audit and Risk Committee in October 2025 which reported its compliance to the November 2025 Board of Directors. Throughout the year and up to and including submission, there have been a number of key actions to strengthen and improve the governance arrangements across the Trust.

Risks to compliance and their mitigations are detailed:

	Risk	Mitigation and actions
Effective Governance Structures	Ineffective governance structures, non compliance with the Code of Governance for NHS Provider Trusts and accepted standards.	Utilisation of the Code of Governance for NHS Provider Trusts review presented at the Audit and Risk Committee annually. External well-led review in 2025-26 which Identified gaps and has supported ongoing improvement work. This was shared in the Public Board meeting in May 2026. Annual Board and committee effectiveness reviews with learning embedded. Self-assessment of the Code of Governance for NHS Providers reported at the October 2025 Audit and Risk shared as compliant at the November 2025 Board of Directors.
Responsibilities of directors' sub committees	Lack of clarity, duplication or omission of duties, ineffective oversight, monitoring and escalation processes.	Directors' role profiles issued on appointment, statutory roles regularly reviewed. Annual review of the reservation of powers, standing financial instructions, and related schemes of delegation, committee terms of reference and work plans. Continued refinement of the director led meeting structure, Terms of Reference and information flows, to support delivery of portfolio responsibilities and aligned to the strategic priorities.
reporting lines and accountabilities between the board, its subcommittees and the executive team	Lack of clarity and accountability, ineffective escalation processes.	Board committee structure map in place, each committee led by Non-Executive Director and Executive Committees by the CEO, all provide regular reports to the Board. Organisational structure charts regularly reviewed and updated. Updates to the assurance matrix and risk statements linked to the boards risk appetite statements with triangulation explicit within reports

	Risk	Mitigation and actions
Timely and accurate information to assess risks with compliance	Inaccurate assessment of compliance with the provider licence, unidentified gaps	Data capacity and quality regularly monitored through the BAF (risk 7), by the Finance and Performance Committee. Monthly performance report, quality assurance report, HR performance report, and finance report produced, and data triangulated for accurate analysis and identification of gaps.
Board oversight of performance	Reduced assurance of performance, poor patient experience, non-compliance with health care standards, reduced leadership and decision-making ability	Operational performance report reviewed at Executive Team, each Committee, and Board. Formal performance governance structure implemented in 25/26 and structure strengthened around divisional performance review meetings. Quality assurance report, workforce performance report, and finance report also reviewed regularly at Board and/or committees. Cross referral between committees on specific assurance matters and deep dives commissioned on areas requiring greater scrutiny.

Law Regulation and National Guidance

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board is responsible for establishing an effective system of internal control to ensure that resources are used economically, efficiently, and effectively, aided by monitoring and scrutiny through the Audit and Risk Committee and the Finance and Performance Committee.

Controls currently in place to ensure the economic, efficient and effective use of resources include:

- Regular finance and performance reports to Board and its committees;
- Detailed annual review of the reservation of powers, standing financial instructions, and related schemes of delegation by the Audit and Risk Committee and Board, with additional reviews as required;
- Annual governance structure effectiveness reviews to ensure correct levels of delegation, oversight, and financial monitoring are maintained;
- Weekly Executive oversight of the financial position against plan together with capital and cash reserves, pay and non-pay budgetary control systems;
- Vacancy control panel;
- Transparent and robust business case evaluation and benefits realisation process;
- Continuous service and cost improvements supported across the Trust with emphasis on productivity gains.

In relation to the financial statements in 2025-26, external auditors have identified a significant weakness in VFM arrangements regarding how the body monitors and ensures appropriate standards, such as meeting legislative requirements.

Internal Audit

The Trust's internal auditors, 360 Assurance, undertake an annual risk-based audit plan, agreed by the Audit and Risk Committee, aligned with the Trust's principal risks as identified on the Board Assurance Framework. 360 Assurance provide assurance reports on the design and effectiveness of controls and follow up on implementation of recommendations to mitigate risk. For 2025-26, the Head of Internal Audit provided a Moderate opinion on the system of internal control.

The 2025-26 Head of internal Audit Opinion is given below:

I am providing an opinion of **moderate assurance** that there are areas for improvement in the framework of governance, risk management and control and some inconsistent application of controls puts the achievement of the organisation's objectives at risk.

Overall, audit findings from the approved Internal Audit Plan were largely positive, although two reviews received 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 and medium risk actions implemented on time. The scope of this opinion is limited to the work completed during the year and the coverage set out within the Plan.

In forming my opinion, I 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 two 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 Doncaster Royal Infirmary. The service remained rated as "Requires Improvement", and a Section 29A Warning Notice was issued. External Audit has raised a significant weakness in respect of the Trust's Value for Money arrangements, in relation to how the body monitors and ensures 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 internal audit plan produced largely positive findings, consideration of the wider sources of assurance and organisational context has impacted my overall assessment and contributed to the moderate assurance opinion.

External Audit

The Trust's external auditors, Earnst and Young, provide assurance through the Audit and Risk Committee and their annual audit of the Trust's Annual Report and Accounts.

Data Security

The Trust complies with NHS Digital guidance for reporting, managing, and investigating data security risks, and monitors data risks through the Divisional risk registers, Trust risk register, BAF, Information Governance and Cyber Group, through the Finance and Performance Committee, and Board.

Information governance

The information governance yearly workplan is aligned with the Data Security Protection Toolkit (DSPT) annual submission and is continuously monitored by the Information Governance Group chaired by the Head of Information Governance who is the Trust Data Protection Officer and reporting to the Finance and Performance Committee. The 2024/25 DSPT annual submission recorded 'Standards Met' which demonstrated that the Trust is consistently and effectively incorporating the ten National Data Guardian data security standards to comply with data protection and security assurance and Data Protection Legislation, this also incorporated the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and Information Governance assurance. CAF is designed for organisations 'that play a vital role in the day-to day life of the UK' and is used across government and other regulatory sectors. The aim of the CAF is to: set

out broad principles to drive good decision-making over compliance, with better understanding and ownership of information risks at an organisation level to effectively manage the risks and, to support a culture of evaluation and improvement to meet outcomes. Work is progressing with the evidence for the 2025-26 annual DSPT submission and an independent audit is underway with the final DSPT submission due end of June 2026.

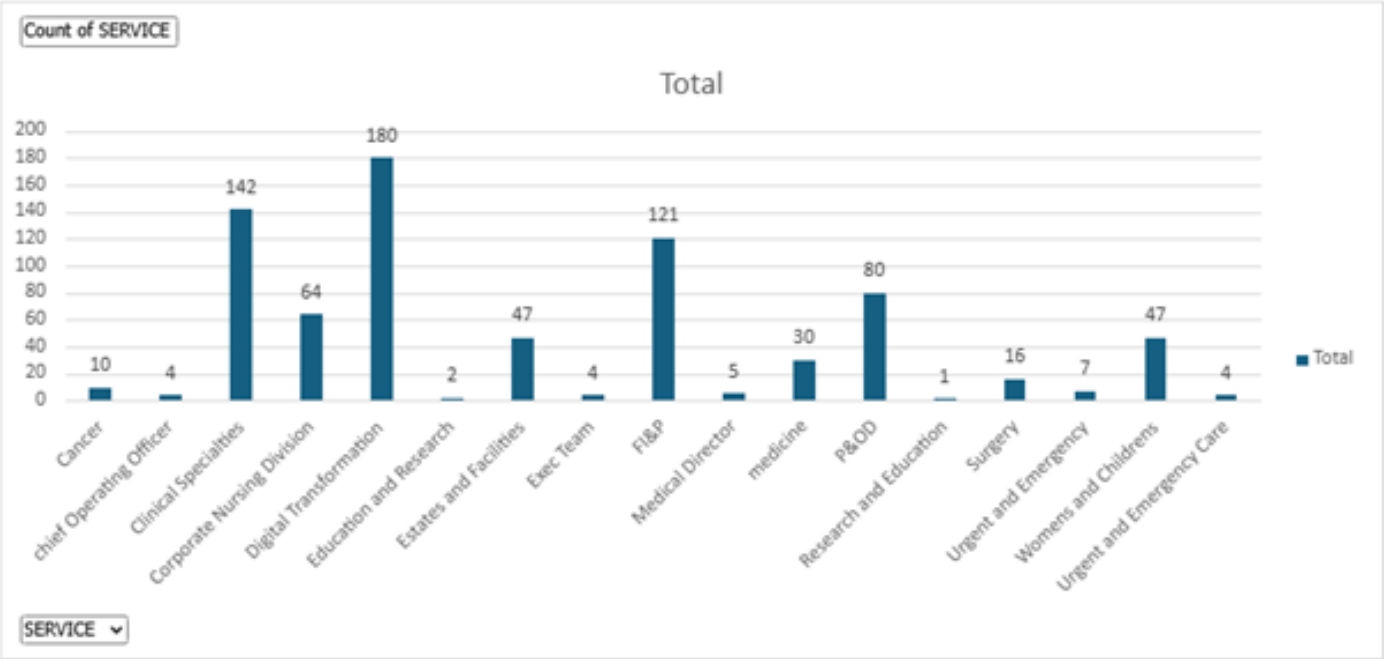
During the year ended 31 March 2026, a total of 5 breaches in relation to information governance were reported in line with the Trust's incident reporting policy. These were reviewed in line with the automated Data Security Protection Incident Tool and none required reporting to the Information Commissioners Office (ICO).

The Trust complies with NHS Digital guidance for reporting, managing and investigating information governance serious incidents, and alerts the Department of Health and the Information Commissioner's Office (ICO) of information governance serious incidents requiring investigation. For 2025-26, the Trust did not report any serious incidents that required further action.

The Information Governance Group has oversight of the processing freedom of information (FOI) requests on behalf of the Trust. In 2025-26, the Trust recorded 770 FOI requests compared to last year which received 731 requests.

The requests have ranged from workforce and staffing data, waiting times and service performance, clinical activity and patient outcomes, finance and procurement (including agency, insourcing and outsourcing spend), policies and governance procedures, and patient experience such as complaints and incidents. Requests have also included more specialised topics, such as digital systems, research activity, and specific clinical pathways.

The requesters have been individuals from the public, pressure groups, marketing companies and journalists. Areas of focus for Freedom of Information requests:



The ICO expects public authorities to respond to more than 90% of requests within 20 working days as statutory requirement. The Trust maintained a good response rate throughout the year, recording 93% compliance in 2025/26.

Internal reviews

The Trust received eight internal review requests during the reporting year. These requests primarily related to workforce information, procurement and contract data, financial spend, digital budgets, and incident reporting, seeking further disclosure where information had been withheld or partially disclosed.

Following review, the Trust upheld the original responses in all cases. Information was withheld where appropriate under relevant exemptions, including:

- Section 40(2) (personal data), in relation to very senior manager (VSM) information
- Section 43(2) (commercial interests), in relation to procurement, supplier, and contract spend data
- Section 21 (information reasonably accessible), where information was already publicly available
- Section 12 (cost of compliance), where data was not held in a reportable format and would require disproportionate effort to extract

The internal reviews concluded that the Trust had appropriately applied exemptions in line with the Freedom of Information Act 2000, and that the balance of the public interest favoured maintaining those exemptions in each case.

Data quality and governance

Data Quality is monitored by the Digital Data Technology Group, which reports to the lead executive for Digital, the Chief Finance Officer. The Finance and Performance Committee hold assurance oversight, with any data integrity risks that may impact on patient safety, escalated to the Quality Committee.

Internal Audit reviewed the data quality of the Cancer Faster Diagnosis Standard and provided a limited opinion with one high risk finding and two remedial actions which were agreed and implemented by their due date of 31 March 2026.

The Trust has been using artificial intelligence to support improvements in the accuracy of its data validation in respect to referral to treatment time for patient lists. This has further strengthened the data quality of information flows. Data validation is underpinned by the patient access policy and by RTT rules, whereby the patients who have been waiting the longest, are reviewed and tracked at a patient level.

The Trust continues to review its current information relating to constitutional standards, so as to be able to provide an aggregated view at Trust level. Dashboards at speciality level are available on the Trusts data hub to support operational delivery and board and committee reporting.

Recognising the importance of the integrity of the data we hold and process, the Board also monitors our position on Data Quality through the BAF Risk 7. There is a DQ improvement plan that sets out our actions for oversight, process, people, system and monitoring alongside the wider Digital Delivery Plan.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. This includes consideration of the regulatory feedback and actions arising after the financial year end and up to the approval of the annual report and accounts. This includes the final CQC report of the Emergency Department at DRI and the section 29A warning notice issued 28 January 2026, and initial feedback from the unannounced CQC inspection of the Children and Young Peoples Service. I have drawn on performance information available to me and comments made by external auditors in their management letters and the information provided by the external well-led and cultural reviews. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control includes:

- The structure, nature and content of Board meetings during the year ended 31 March 2026, which enabled the Board to provide adequate challenge on and gain suitable assurance in relation to issues relating to performance, quality, and safety within the Trust;
- The Board and its committees have been actively involved in reviewing the Board Assurance Framework and Trust Risk Register. These documents provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
- The Board has monitored progress against the top risks facing the organisation and throughout the year has assured itself that the actions to address risks against the strategic objectives are proportionate and effective across the range of its business.
- The Audit and Risk Committee has provided assurance on the system of internal control, especially in regard to corporate risk and counter fraud;
- Internal Audit has reviewed the Trust's internal controls based on the approved audit plan. Where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management for delivery within the agreed timeframes.

- The Head of Internal Audit provided a moderate opinion based on consideration of the external well-led and cultural reviews and the Section 29a CQC warning notice.
- Assurances from Board committees and risk managers on issues relating to clinical governance, information governance, risk management, and clinical leadership;
- Assurances throughout the year through regulatory reviews, and internal effectiveness reviews.
- In relation to the financial statements in 2025-26, external auditors have identified a significant weakness in VFM arrangements regarding how the body monitors and ensures appropriate standards, such as meeting legislative requirements
- Actions resulting from recommendations made within the external well-led review that took place within the 2025-26 financial year which are progressing and the delivery plan will continue to be reported through the public board arena.
- External regulatory feedback and actions from the CQC.

A system of continuous improvement and development work in the control environment is undertaken to strengthen internal controls and mitigate gaps on an ongoing basis and is informed and supported by regulatory and audit feedback.

Conclusion

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have improved their system of governance that supports the achievement of its strategic objectives. Control issues identified throughout the year have been or are being addressed, these are based on the assessment above and information available during the period 1 April 2025 to 31 March 2026 and up to the time of signing the accounts.

The CQC section 29A warning notice issued after the year end and up to the approval of the annual report and accounts have been assessed and are being addressed through a formal CQC improvement plan, overseen by the executive team, the Board of Directors and its committees.

Zara Jones
Acting Chief Executive
16 July 2026

Independent auditor's report to the Council of Governors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Opinion

We have audited the financial statements of Doncaster and Bassetlaw Teaching Hospital NHS Foundation for the year ended 31 March 2026 which comprise Foundation Trust and Group Statement of Comprehensive Income, the Foundation Trust and Group Statement of Financial Position, the Foundation Trust and Group Statement of Changes in Equity, the Foundation Trust and Group Statement of Cash Flows, and the related notes 1 to 46, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2025-26 as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- Give a true and fair view of the financial position of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and of the Group as at 31 March 2026 and of Foundation Trust's and Group's income and expenditure for the year then ended;
- Have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025 to 2026; and
- Have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust and the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group or Foundation Trust's ability to continue as a going concern for a period to 31 July 2027.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's and the Group's ability to continue as a going concern.

In evaluating the Accounting Officer's conclusions, we have considered the requirement of the DHSC Group Accounting Manual for entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services they provide will continue into the future, and had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) regarding the application of ISA (UK) 570 Going Concern to public sector entities.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- Other information published together with the audited financial statements is consistent with the financial statements; and
- The parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

In respect of the following, we have matters to report by exception:

Report on the Foundation Trust proper arrangements to secure economy, efficiency and effectiveness in its use of resources

In relation to Governance – how the body how the body monitors and ensures appropriate standards, such as meeting legislative requirements

Our judgement on the nature of the significant weakness identified:

In 2023, the Trust was inspected by the Care Quality Commission (CQC), following which its overall rating was reduced from Good to Requires Improvement in the Safe, Effective, Responsive, and Well-led domains. In response, the Trust commissioned external well-led and cultural reviews.

The reports, received in November 2025, identified a number of concerns. These include the Board's reliance on reassurance rather than assurance; limited evidence to support assurance ratings; gaps in the Integrated Quality and Performance Report; insufficient prominence given to patient experience; overstated assurances in relation to estates; a lack of clarity over the role of Trust Leadership Team in operational governance; and the need to embed the Trust's values in day-to-day operations. There has been several changes at Board level in the period since the report was published, including the Chair, Chief Executive Officer and Chief Medical Officer.

Concerns have been raised by NHS England and the CQC in relation to the Trust's leadership. Following an unannounced inspection in December 2025 and a follow-up inspection in January 2026, the Trust received an improvement notice in respect of its Urgent and Emergency Care Department. The notice identified the need for improvement to ensure that risks to service users are appropriately and safely assessed and managed, including the safe and effective management and prevention of infection risk.

The evidence on which our view is based:

We have obtained and reviewed:

- CQC inspection report of 8 – 9 December 2025 and 6 January 2026.
- CQC letter on the s29A outcome following the submission of DBTH's written representations.
- Representations from the Trust to the CQC following the warning notice.

- Correspondence between the Trust and NHS England.
- Correspondence between the Trust and the CQC.
- Externally commissioned Culture Review.
- Externally commissioned Well-led Review.
- The Trust's subsequent action plans in response to the externally commissioned review

Impact on the local body:

Failure to respond adequately and in a timely manner to CQC findings increases the risk that weaknesses in governance arrangements persist, particularly in relation to the monitoring of regulatory compliance and patient safety standards. This could lead to deterioration in service quality and further regulatory intervention by CQC and/or NHS England.

Action the body should take to address the weakness:

The Trust should approve a single Board-owned improvement plan covering all actions arising from CQC, NHS England and external governance and culture reviews. The plan should include named executive owners, measurable deliverables, target dates and evidence requirements, with progress monitored by the Board and supported by internal and external assurance until actions are complete and embedded.

This issue is evidence of significant weaknesses in proper arrangements for governance, including how the Trust monitors and ensures appropriate standards, such as meeting legislative requirements, are met.

Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of the Accounting Officer's responsibilities on pages 70 and 71 the chief executive is the accounting officer of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group and the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the group or the Foundation Trust, or have no realistic alternative but to do so.

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the group and Foundation Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered

material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

- We understood how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance through improper recognition of revenue and improper recognition of expenditure, and management override of controls to be our fraud risks.

To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we have reviewed the Foundation Trust's manual year end income accruals and contract income, challenged assumptions and corroborated the income to appropriate evidence. We also performed risk-based journal testing and tested variances in the agreement of balances exercise above an assigned testing threshold.

- To address our fraud risk around the manipulation of reported financial performance through improper recognition of expenditure, we reviewed the Trust's year-end expenditure

accruals, challenging assumptions and agreeing balances to supporting evidence, performed risk-based journal testing focused on year-end adjustments, tested variances in the intra-NHS agreement of balances exercise above an assigned threshold and corroborated differences with counterparties, and performed completeness testing, including cut-off procedures, to ensure expenditure was recorded in the correct financial year.

- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately. We also tested and challenged the assumptions used in calculating accounting estimates and considered any significant and unusual transactions outside the normal course of business.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in March 2026, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

Use of our report

This report is made solely to the Council of Governors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. Our audit work has been undertaken so that we might state to the Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Claire Mellons (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Newcastle upon Tyne

Date **16/07/2026**

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Date **16/07/2026**

Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	597,801	571,728	597,801	571,728
Other operating income	4	56,847	60,398	65,242	69,581
Operating expenses	7	(661,904)	(658,809)	(670,196)	(667,892)
Operating deficit from continuing operations		**(7,256)**	**(26,683)**	**(7,153)**	**(26,583)**
Finance income	12	1,942	2,116	1,709	2,044
Finance expenses	13	(358)	(304)	(358)	(304)
PDC dividends payable		(8,451)	(7,591)	(8,451)	(7,591)
Net finance costs		**(6,867)**	**(5,779)**	**(7,100)**	**(5,851)**
Other gains / (losses)	14	428	(34)	-	(2)
Corporation tax expense		(67)	(73)	-	-
Deficit for the year		**(13,762)**	**(32,569)**	**(14,253)**	**(32,436)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Revaluations	8	27	1,234	27	1,234
Total comprehensive expense for the period		**(13,735)**	**(31,335)**	**(14,226)**	**(31,202)**
Deficit for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(13,762)	(32,569)	(14,253)	(32,436)
TOTAL		**(13,762)**	**(32,569)**	**(14,253)**	**(32,436)**
Total comprehensive expense for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(13,735)	(31,335)	(14,226)	(31,202)
TOTAL		**(13,735)**	**(31,335)**	**(14,226)**	**(31,202)**

For information with reference to the Adjusted Financial Performance, used for system reporting to NHS England, see Note 46.

Statement of Financial Position

	Note	Group 31 March 2026 £000	Group 31 March 2025 £000	Trust 31 March 2026 £000	Trust 31 March 2025 £000
Non-current assets					
Intangible assets	16	13,437	9,236	13,437	9,236
Property, plant and equipment	17	306,173	277,301	306,173	277,301
Right of use assets	18	4,052	4,537	4,052	4,537
Other investments / financial assets	22	3,677	8,095	550	550
Receivables	25	2,231	2,738	2,231	2,738
Total non-current assets		**329,570**	**301,907**	**326,443**	**294,362**
Current assets					
Inventories	24	9,855	9,398	9,082	8,787
Receivables	25	24,940	27,986	26,906	33,953
Cash and cash equivalents	28	54,411	42,248	53,438	40,851
Total current assets		**89,206**	**79,632**	**89,426**	**83,591**
Current liabilities					
Trade and other payables	29	(98,915)	(90,743)	(99,901)	(90,559)
Borrowings	31	(1,492)	(1,467)	(1,492)	(1,467)
Provisions	34	(567)	(596)	(567)	(596)
Other liabilities	30	(2,454)	(5,020)	(2,454)	(5,020)
Total current liabilities		**(103,428)**	**(97,826)**	**(104,414)**	**(97,642)**
Total assets less current liabilities		**315,348**	**283,713**	**311,455**	**280,311**
Non-Current liabilities					
Borrowings	31	(9,660)	(10,620)	(9,660)	(10,620)
Provisions	34	(2,213)	(2,388)	(2,213)	(2,388)
Total non-current liabilities		**(11,873)**	**(13,008)**	**(11,873)**	**(13,008)**
Total assets employed		**303,475**	**270,705**	**299,582**	**267,303**
Financed by					
Public dividend capital		435,027	388,522	435,027	388,522
Revaluation reserve		61,180	61,153	61,180	61,153
Income and expenditure reserve		(196,625)	(182,372)	(196,625)	(182,372)
Charitable fund reserves	44	3,295	2,987	-	-
Doncaster & Bassetlaw Healthcare Services Ltd	45	598	415	-	-
Total taxpayers' equity		**303,475**	**270,705**	**299,582**	**267,303**

The notes on pages 7 to 50 form part of these accounts.

Signed 

Date **16/07/2026**

Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	DBHS Limited	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025	**388,522**	**61,153**	**(182,372)**	**2,987**	**415**	**270,705**
(Deficit) / surplus for the year	-	-	(14,253)	308	183	**(13,762)**
Net Impairments	-	27	-	-	-	**27**
Public dividend capital received	46,505	-	-	-	-	**46,505**
Taxpayers' and others' equity at 31 March 2026	**435,027**	**61,180**	**(196,625)**	**3,295**	**598**	**303,475**

Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	DBHS Limited	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024	347,258	59,919	(149,936)	3,335	200	**260,776**
(Deficit) / surplus for the year	-	-	(32,436)	(348)	215	**(32,569)**
Net Impairments	-	1,234	-	-	-	**1,234**
Public dividend capital received	41,264	-	-	-	-	**41,264**
Taxpayers' and others' equity at 31 March 2025	**388,522**	**61,153**	**(182,372)**	**2,987**	**415**	**270,705**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025	**388,522**	**61,153**	**(182,372)**	**267,303**
(Deficit) for the year	-	-	(14,253)	**(14,253)**
Net Impairments	-	27	-	**27**
Public dividend capital received	46,505	-	-	**46,505**
Taxpayers' and others' equity at 31 March 2026	**435,027**	**61,180**	**(196,625)**	**299,582**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024	**347,258**	**59,919**	**(149,936)**	**257,241**
(Deficit) for the year	-	-	(32,436)	**(32,436)**
Net Impairments	-	1,234	-	**1,234**
Public dividend capital received	41,264	-	-	**41,264**
Taxpayers' and others' equity at 31 March 2025	**388,522**	**61,153**	**(182,372)**	**267,303**

Information on reserves

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential. If this is the case, a charge is made to the Statement of Comprehensive Income.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted.

DBHS Ltd reserve
This reserve comprises the ring-fenced funds held by Doncaster & Bassetlaw Healthcare Services Limited ("DBHS Ltd") which is a wholly owned subsidiary.

Statement of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(7,256)	(26,683)	(7,153)	(26,583)
Non-cash income and expense:					
Depreciation and amortisation	7.1	19,605	19,786	19,605	19,786
Net impairments	8	13,495	32,042	13,495	32,042
Income recognised in respect of capital donations	4	(270)	(3,042)	(270)	(3,042)
(Increase)/Decrease in receivables and other assets		1,644	(907)	5,645	(4,944)
(Increase)/Decrease in inventories		(457)	369	(295)	440
Increase/(Decrease) in payables and other liabilities		(7,860)	(3,308)	(6,993)	(3,153)
(Decrease) in provisions		(244)	(42)	(244)	(42)
Movements in charitable fund working capital		4,776	(2,808)	-	-
Corporation tax paid		(73)	(52)	-	-
Other movements in operating cash flows		(40)	(23)	(46)	198
Net cash flows from / (used in) operating activities		**23,320**	**15,332**	**23,744**	**14,702**
Cash flows from investing activities					
Interest and dividends received		1,709	1,844	1,709	2,044
Purchase of intangible assets		(6,109)	(2,216)	(6,109)	(2,216)
Purchase of non-current assets and investment property		(45,587)	(43,193)	(45,587)	(43,193)
Receipt of cash donations to purchase capital assets		270	3,042	270	3,042
Net cash flows (used in) investing activities		**(49,717)**	**(40,523)**	**(49,717)**	**(40,323)**
Cash flows from financing activities					
Public dividend capital received		46,505	41,264	46,505	41,264
Movement on loans from DHSC		(543)	(543)	(543)	(543)
Capital element of lease liability repayments		(1,244)	(1,723)	(1,244)	(1,723)
Interest on loans		(194)	(209)	(194)	(209)
Interest element of lease liability repayments		(79)	(47)	(79)	(47)
PDC dividend paid		(5,885)	(8,581)	(5,885)	(8,581)
Net cash flows from financing activities		**38,560**	**30,161**	**38,560**	**30,161**
Increase in cash and cash equivalents		**12,163**	**4,970**	**12,587**	**4,540**
Cash and cash equivalents at 1 April		**42,248**	**37,278**	**40,851**	**36,311**
Cash and cash equivalents at 31 March	28	**54,411**	**42,248**	**53,438**	**40,851**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2025/26, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the Group accounting manual 2025/26 accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

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

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the South Yorkshire Integrated Care System (ICS). The ICS has stated its immediate strategic plans, focusing on delivering the objectives set out in NHS England's 2026/27 priorities and operational planning guidance, and its response to the NHS long-term plan. The ICS plans assume the continued provision of services by the Trust. No circumstances were identified causing the Directors to doubt the continued provision of NHS services. The ICS plans align activity, workforce, mental health and capital submissions and fully account contracting arrangements.

In 2026/27 the Trust delivered its committed financial plan. This included delivery of £31.4m of cost savings in-year, the recurrent element of which will yield ongoing savings of £22.3m every year going forward.

The Group reported a cash position at 31 March 2026 of £54.4m, which includes a capital creditors balance of £40.8m and has not needed to seek additional cash support 2025/26 although there are mechanism for doing so. Cash levels are expected to remain constrained throughout 2026/27 and for the remainder of the going concern period to 31 July 2027

For 2026/27, the Trust submitted a breakeven plan to NHS England supported by a lower level of deficit support funding than in 2025/26. Delivery of the plan is dependent on a significant level of expected financial efficiencies.

If the financial efficiencies are not delivered and/or are not cash releasing, the Trust is likely to need cash support to maintain a continuity of service throughout 2026/27 and into 2027/28. Funding sources are available from within the NHS system, although are often provided with a number of conditions.

Key assumptions underlying the Trusts medium term plan and cash projections include:
- a continuation of income and expenditure flows and performance in line with 2026/27 plans
- a continued need to deliver financial efficiencies

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

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the Corporate Trustee to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Trust's accounting policies and

• eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

The Trust has an investment of £550k of share capital in a wholly owned subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd currently provides out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen in Note 45. Its year end is the same as the Trust and Group.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In both 2024/25 and 2025/26, API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation.

Note 1.4.1 Revenue from contracts with customers (cont.)

Revenue from NHS contracts (cont)

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under these schemes is part of how care is provided to patients. As such, BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants. This is explained further in Note 1.4.2.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised when all conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1.5 Expenditure on employee benefits (cont.)

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Note 1.7.3 Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.7.4 De-recognition
Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.5 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Land	Not depreciated	
Buildings, excluding dwellings	14	59
Dwellings	21	36
Plant & machinery	4	31
Transport equipment	9	9
Information technology	3	10
Furniture & fittings	8	10

Right of use assets are depreciated over the shorter of the useful life or the lease term.

Assets in the course of construction are not depreciated.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
All intangible assets	3	12

Note 1.9 Inventories

The Trust has some inventories which are valued at the lower of cost and net realisable value, using the first-in first-out cost formula, with the rest being valued at weighted average cost.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost. Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets / liabilities measured at amortised cost are those held within a business model whose objective is to hold financial assets / liabilities in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Note 1.11.3 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12 month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.4 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11.5 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.12.1 The Trust as lessee
Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.12.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 35.2 but it is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable. There are no such contingent assets.

Contingent liabilities are not recognised, but are disclosed in note 36, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital (PDC) and PDC Dividend
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Foreign exchange
The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction.

At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise. The Trust performs all its transactions in Sterling.

Note 1.18 Corporation tax

As the Trust operates a wholly owned subsidiary, this entity is liable to corporation tax regulations. At present, the subsidiary does not have significant assets, and as such, deferred tax is not applicable. The subsidiary is liable to corporation tax in line with existing rates.

Note 1.19 Third party assets
The Trust does not hold any third party cash or cash equivalents.

Note 1.20 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks. The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. Details can be found in Note 41.

Note 1.22 Critical judgements in applying accounting policies and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by the Trust's senior management. Areas of estimation uncertainty or significant judgement made by management in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements are:

Income estimates
In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals
In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted. This is done utilising data extracted from the Trust's accounts payable system, allied with professional judgement of the Trust's expenditure profile and information from the Trust's departmental budget managers. The Trust is also required to account for the cost of annual leave carried forward, which is based on a data collection exercise.

Valuation of property, plant and equipment
For Trust assets which are held for their service potential and are in use, they are valued at their current value in existing use.

For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV).

For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book. This establishes the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusts this value to take account of age and obsolescence. This obsolescence includes physical obsolescence (the wearing out of the asset over time) and functional obsolescence (the design and layout make it less fit for purpose than a more modern asset).

When revaluing an asset adopting the DRC approach, all of the construction and building materials cost of providing a modern equivalent asset have to be assessed using the prices at the date of valuation (ie 31 March 2026), before allowing for the depreciation of the asset.

The Trust has an ageing property portfolio, in a poor state of repair due to ongoing capital spending restrictions, which therefore impacts on the assumptions made in the valuation.

For land, this valuation methodology is performed on an alternative site basis, whereby the value is determined based on the cost of purchasing notional replacement sites in the same locality as the existing sites, taking into account the Trust's requirements to serve the local population. The application of valuation methodologies are covered in the accounting policies at Note 1.7.

In order to significantly reduce the risk of material misstatement for the land and buildings portfolio, the Trust commissions annual valuations from a RICS registered valuer. Generally, the Trust has a desktop valuation each year, and a full valuation every five years. The Trust commissioned a desktop property revaluation exercise as at 31 March 2026, with the last full revaluation exercise taking place at 31 March 2024.

The Trust estimates the useful lives of property, plant and equipment based on the period over which the assets are expected to be available for use. The estimated useful lives of property, plant and equipment per Note 1.7.6 are reviewed periodically and are updated if expectations differ from previous extimates due to physical wear and tear, technical, legal or other limits on the use of the relevant assets.

Asset lives applied to the land and property portfolio are provided by the Trust's externally appointed and professionally qualified valuers.

Note 1.22 Critical judgements in applying accounting policies and key sources of estimation uncertainty contd

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated in the case of provisions for injury benefit claims and early retirements. The level of this provision is also based on information provided by the Government Actuaries Department. Other provisions that may arise are employee related claims and legal claims, which are based on information received from the Trust's insurers and internally generated information.

Impairment of trade receivables
In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables based on professional judgement and the type of debts typically held by the Trust.

Other areas
There are no other critical judgements, key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 14 Regulatory Deferral Accounts - Not UK endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted

Note 1.25 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 2 Operating Segments

The Trust Board, as the chief operating decision maker as defined by IFRS 8, consider that all of the Trust's activities fall under the single segment of 'Provision of Healthcare'.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature) - Trust and Group

	2025/26 £000	2024/25 £000
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	143,325	133,601
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	394,136	384,434
High cost drugs income from commissioners	31,519	26,633
Community services		
Income from other sources (e.g. local authorities)	273	678
All services		
Private patient income	2,729	3,016
Consultants / Agenda for Change pay offer central funding	-	1,483
Additional pension contribution central funding	23,384	21,883
Other Clinical income	2,435	-
Total income from activities	**597,801**	**571,728**

In 2024/25, £2,069k was reported within "Aligned payment & incentive (API) income - Fixed (not variable based on activity)", in 2025/26 this has been reclassified and presented within "Other clinical income".

Note 3.2 Income from patient care activities (by source) - Trust and Group

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	41,568	53,994
Integrated care boards	550,796	511,954
NHS Foundation Trusts	-	17
Local authorities	273	678
Non-NHS: private patients	2,729	3,016
Non-NHS: overseas patients (chargeable to patient)	986	701
Injury cost recovery scheme	1,421	1,338
Non NHS: other	28	30
Total income from activities	**597,801**	**571,728**
Of which:		
Related to continuing operations	597,801	571,728

Note 3.3 Overseas visitors (relating to patients charged directly by the provider) - Trust and Group

	2025/26	2024/25
	£000	£000
Income recognised this year	986	701
Cash payments received in-year	177	87
Amounts added to provision for impairment of receivables	855	290
Amounts written off in-year	425	468

Note 4 Other operating income

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Research and development (contract)	853	851	853	851
Education and training (excluding notional apprenticeship levy income)	24,917	24,777	24,917	24,777
Non-patient care services to other bodies	25,888	27,812	35,469	37,415
Other contract income	2,051	1,547	2,051	1,547
Education and training - notional income from apprenticeship fund	1,109	1,382	1,109	1,382
Rental revenue from operating leases	573	567	573	567
Donations/grants of physical assets (non-cash) - received from other bodies	270	3,042	270	3,042
Charitable fund incoming resources	1,186	420	-	-
Total other operating income	**56,847**	**60,398**	**65,242**	**69,581**
Of which:				
Related to continuing operations	56,847	60,398	65,242	69,581

Note 5.1 Income from activities arising from commissioner requested services - Trust

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	597,801	571,728
Income from services not designated as commissioner requested services	65,242	69,581
Total	**663,043**	**641,309**

For the Trust, commissioner requested services are all patient care activities.

Note 5.2 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings relating to services designated as commissioner requested services. Equipment that has been disposed, has been disposed of during the normal course of business.

Note 6 Fees and charges (Group)

The Group does not have any material fees or charges.

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	15,488	15,182
Purchase of healthcare from non-NHS and non-DHSC bodies	10,165	12,227
Staff and executive directors costs	442,040	415,571
Remuneration of non-executive directors	176	170
Supplies and services - clinical (excluding drugs costs)	40,653	41,451
Supplies and services - general	7,950	8,076
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	53,435	53,906
Consultancy costs	455	174
Establishment	3,673	3,365
Premises	21,131	24,346
Transport (including patient travel)	2,156	2,118
Depreciation on property, plant and equipment	17,697	17,805
Amortisation on intangible assets	1,908	1,981
Net impairments	13,495	32,042
Movement in credit loss allowance: contract receivables / contract assets	1,056	(302)
Increase in other provisions	371	454
Change in provisions discount rate(s)	(95)	(58)
Audit fees payable to the external auditors *		
audit services - statutory audit	249	294
audit services - audits of subsidiaries	70	90
Internal audit costs	76	70
Clinical negligence	17,956	17,794
Legal fees	706	1,038
Insurance	853	928
Research and development	868	880
Education and training	6,676	6,891
Car parking and security	1,186	1,373
Other	6	1
Other NHS charitable fund resources expended	1,504	942
Total	**661,904**	**658,809**
Of which:		
Related to continuing operations	661,904	658,809

* - Statutory audit fees recognised in 2025/26 includes £30k of cost overruns relating to 2024/25. Also, the audit of subsidiaries is performed by a different audit firm than the Group audit.

Note 7.2 Other auditor remuneration (Group)

	2025/26	2024/25
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any subsidiary of the Trust	70	90
Total	**70**	**90**

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work for the Trust is £2,000k.

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	13,495	32,042
Total net impairments charged to operating surplus / deficit	**13,495**	**32,042**
Revaluation / impairments (and reversals) of property, plant and equipment (credited) / charged to the revaluation reserve	(27)	(1,234)
Total net impairments	**13,468**	**30,808**

The impairments arose due to a revaluation exercise on all land and buildings under the modern equivalent asset basis, as a result of changes in market value.

Note 9 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	317,790	301,980
Social security costs	40,740	31,428
Apprenticeship levy	1,542	1,499
Employer's contributions to NHS pensions	35,769	33,532
Pension cost - employer contributions paid by NHSE on provider's behalf	23,384	21,883
Pension cost - other	40	138
Temporary staff (including agency and external bank)	29,040	31,118
Total gross staff costs	**448,305**	**421,578**
Total staff costs	**448,305**	**421,578**
Of which		
Costs capitalised as part of assets	1,358	1,128
Disclosed within:		
Staff and executive directors costs	442,040	415,571
Research and development	819	878
Education and training	4,088	4,001
	446,947	**420,450**

Note 9.1 Retirements due to ill-health (Group)

During 2025/26, there were 6 early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £394k (£314k in 2024/25). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

There are no Director long term incentive schemes, other pension benefits, guarantees or advances.

Note 9.2 Exit Packages

In 2025/26, there was one exit package for contractual payment in lieu of notice, totalling £119k. (2024/25: nil)

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.
An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 10 Pension costs (cont)

c) Alternative pension schemes

As a result of "automatic enrolment", the Trust has taken steps to ensure those members of staff who are not eligible for the NHS Pension Scheme, are enrolled into a pension scheme. The Trust treats such pension arrangements as a defined contribution pension and as such, no actuarial assumptions are required to measure the obligation or the expense and there is not possibility of any actuarial gain or loss.

Note 11 Operating leases (Group)

Note 11.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is the lessor.

The Trust has a number of leasing arrangements for the use of land and buildings, mainly with other NHS organisations. The only significant leasing arrangement not with another NHS organisation is with Parkhill Hospital at Doncaster Royal Infirmary.

	2025/26	2024/25
	£000	£000
Operating lease revenue		
Minimum lease receipts	573	567
Total	**573**	**567**

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	573	571
Total	**573**	**571**

Note 12 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,709	1,844
NHS charitable fund investment income	233	272
Total finance income	**1,942**	**2,116**

Note 13.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2025/26	2024/25
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	193	206
Interest on lease obligations	79	50
Total interest expense	**272**	**256**
Unwinding of discount on provisions	86	48
Total finance costs	**358**	**304**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

In 2025/26, the Trust and Group incurred costs totalling £8k in relation to this legislation. (2024/25: £nil)

Note 14 Other gains (Group)

	2025/26	2024/25
	£000	£000
(Losses) on disposal of property, plant and equipment	-	(2)
Gains / (losses) on charitable fund investment revaluations	428	(32)
Total gains on disposal of assets	**428**	**(34)**
Total other gains	**428**	**(34)**

Note 15 Trust income statement and statement of comprehensive income

The Trust's deficit for the period was £14,253k (2024/25: £32,436k). The Trust's total comprehensive expense for the period was £14,226k (2024/25: £31,202k).

Note 16.1 Intangible assets - 2025/26

Group and Trust	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Gross cost at 1 April 2025	**28,292**	**-**	**27**	**28,319**
Additions	689	5,420	-	**6,109**
Gross cost at 31 March 2026	**28,981**	**5,420**	**27**	**34,428**
Amortisation at 1 April 2025	**19,083**	**-**	**-**	**19,083**
Provided during the year	1,908	-	-	**1,908**
Amortisation at 31 March 2026	**20,991**	**-**	**-**	**20,991**
Net book value at 31 March 2026	**7,990**	**5,420**	**27**	**13,437**
Net book value at 1 April 2025	**9,209**	**-**	**27**	**9,236**

There are items with a nil Net Book Value for which the Trust is working through to ensure that they are in operational use. The gross cost and accumulated depreciation value of these items are:

	13,788	**-**	**-**	**13,788**

The balance of Intangible assets under construction relates to the intangible assets for the Trust's new Electronic Patient Record (EPR) system that is not yet completed. In Note 18.1, there is a balance of £6,866k within Information Technology additions which relate to tangible assets under the same EPR capital scheme.

Note 16.2 Intangible assets - 2024/25

Group and Trust	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**26,029**	**-**	**27**	**26,056**
Additions	2,216	-	-	**2,216**
Reclassifications	47	-	-	**47**
Valuation / gross cost at 31 March 2025	**28,292**	**-**	**27**	**28,319**
Amortisation at 1 April 2024	**17,102**	**-**	**-**	**17,102**
Provided during the year	1,981	-	-	**1,981**
Amortisation at 31 March 2025	**19,083**	**-**	**-**	**19,083**
Net book value at 31 March 2025	**9,209**	**-**	**27**	**9,236**
Net book value at 1 April 2024	**8,927**	**-**	**27**	**8,954**

Note 17.1 Property, plant and equipment - 2025/26

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025	**8,299**	**207,056**	**2,947**	**12,844**	**77,366**	**250**	**27,329**	**6,047**	**342,138**
Additions	-	14,912	-	19,517	12,641	-	10,982	377	**58,429**
Additions - donated	-	-	-	-	270	-	-	-	**270**
Impairments charges to operating expenses	-	(21,877)	-	-	-	-	-	-	**(21,877)**
Impairments charged to the revaluation reserve	-	(4,555)	(7)	-	-	-	-	-	**(4,562)**
Revaluations / reversal of impairments credited to the revaluation reserve	-	4,507	82	-	-	-	-	-	**4,589**
Reclassifications	-	12,337	-	(12,325)	(12)	-	-	-	**-**
Disposals	-	-	-	-	(1,824)	-	-	(93)	**(1,917)**
Valuation/gross cost at 31 March 2026	**8,299**	**212,380**	**3,022**	**20,036**	**88,441**	**250**	**38,311**	**6,331**	**377,070**
Accumulated depreciation at 1 April 2025	**-**	**-**	**-**	**-**	**44,776**	**242**	**14,686**	**5,133**	**64,837**
Provided during the year	-	8,226	156	-	5,955	3	1,842	177	**16,359**
Impairments charges to operating expenses	-	(8,226)	(156)	-	-	-	-	-	**(8,382)**
Disposals	-	-	-	-	(1,824)	-	-	(93)	**(1,917)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**48,907**	**245**	**16,528**	**5,217**	**70,897**
Net book value at 31 March 2026	**8,299**	**212,380**	**3,022**	**20,036**	**39,534**	**5**	**21,783**	**1,114**	**306,173**
Net book value at 1 April 2025	**8,299**	**207,056**	**2,947**	**12,844**	**32,590**	**8**	**12,643**	**914**	**277,301**

There are items with a nil Net Book Value for which the Trust is working through to ensure that they are in operational use. The gross cost and accumulated depreciation value of these items are:

	-	**-**	**-**	**-**	**29,867**	**225**	**13,232**	**5,131**	**48,455**

There is a balance of £6,866k within Information Technology additions which relate to tangible assets under the same EPR capital scheme, which are not yet available for use.

Note 17.2 Property, plant and equipment - 2024/25

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**8,299**	**201,693**	**3,000**	**29,376**	**68,841**	**250**	**17,801**	**5,654**	**334,914**
Additions	-	18,804	-	8,962	6,086	-	9,575	405	**43,832**
Additions - donations of physical assets (non-cash)	-	-	-	-	3,042	-	-	-	**3,042**
Impairments charges to operating expenses	-	(40,222)	-	-	-	-	-	-	**(40,222)**
Impairments charged to the revaluation reserve	-	(2,982)	(97)	-	-	-	-	-	**(3,079)**
Revaluations / reversal of impairments credited to the revaluation reserve	-	4,269	44	-	-	-	-	-	**4,313**
Reclassifications	-	25,494	-	(25,494)	(10)	-	(47)	10	**(47)**
Disposals	-	-	-	-	(593)	-	-	(22)	**(615)**
Valuation/gross cost at 31 March 2025	**8,299**	**207,056**	**2,947**	**12,844**	**77,366**	**250**	**27,329**	**6,047**	**342,138**
Accumulated depreciation at 1 April 2024	**-**	**-**	**-**	**-**	**40,370**	**239**	**11,496**	**5,001**	**57,106**
Provided during the year	-	8,051	129	-	4,999	3	3,190	154	**16,526**
Impairments charges to operating expenses	-	(8,051)	(129)	-	-	-	-	-	**(8,180)**
Disposals	-	-	-	-	(593)	-	-	(22)	**(615)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**44,776**	**242**	**14,686**	**5,133**	**64,837**
Net book value at 31 March 2025	**8,299**	**207,056**	**2,947**	**12,844**	**32,590**	**8**	**12,643**	**914**	**277,301**
Net book value at 1 April 2024	**8,299**	**201,693**	**3,000**	**29,376**	**28,471**	**11**	**6,305**	**653**	**277,808**

Note 17.3 Property, plant and equipment financing - 2025/26

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2026									
Owned - purchased	8,299	211,957	3,022	20,036	35,232	5	21,763	1,050	**301,364**
Owned - donated/granted	-	423	-	-	4,302	-	20	64	**4,809**
NBV total at 31 March 2026	**8,299**	**212,380**	**3,022**	**20,036**	**39,534**	**5**	**21,783**	**1,114**	**306,173**

Note 17.4 Property, plant and equipment financing - 2024/25

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2025									
Owned - purchased	8,299	206,617	2,947	12,844	27,744	8	12,620	861	**271,940**
Owned - donated/granted	-	439	-	-	4,846	-	23	53	**5,361**
NBV total at 31 March 2025	**8,299**	**207,056**	**2,947**	**12,844**	**32,590**	**8**	**12,643**	**914**	**277,301**

Note 18.1 Right of Use Assets - 2025/26

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2025	**5,580**	**934**	**641**	**1,240**	**8,395**
Lease additions and restatements	280	573	-	-	**853**
Valuation/gross cost at 31 March 2026	**5,860**	**1,507**	**641**	**1,240**	**9,248**
Accumulated depreciation at 1 April 2025	**1,983**	**675**	**477**	**723**	**3,858**
Provided during the year - right of use asset	609	395	86	248	**1,338**
Accumulated depreciation at 31 March 2026	**2,592**	**1,070**	**563**	**971**	**5,196**
Net book value at 31 March 2026	**3,268**	**437**	**78**	**269**	**4,052**
Net book value at 1 April 2025	**3,597**	**259**	**164**	**517**	**4,537**

Note 18.2 Right of Use Assets - 2024/25

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2024	**5,134**	**799**	**523**	**1,240**	**7,696**
Lease restatements	446	135	118	-	**699**
Valuation/gross cost at 31 March 2025	**5,580**	**934**	**641**	**1,240**	**8,395**
Accumulated depreciation at 1 April 2024	**1,346**	**458**	**300**	**475**	**2,579**
Provided during the year - right of use asset	637	217	177	248	**1,279**
Accumulated depreciation at 31 March 2025	**1,983**	**675**	**477**	**723**	**3,858**
Net book value at 31 March 2025	**3,597**	**259**	**164**	**517**	**4,537**
Net book value at 1 April 2024	**3,788**	**341**	**223**	**765**	**5,117**

Note 18.3 Right of Use Assets - Summary Information - 2025/26

The financial impact of the Right of Use Assets can be summarised by the following table, in line with paragraph 53 and 54 of IFRS 16:

	Note	2025/26	2024/25
Depreciation charge for RoU assets by class of underlying asset			
- Property (land and buildings)		609	637
- Plant & machinery		395	217
- Transport equipment		86	177
- Information technology		248	248
Total	18	**1,338**	**1,279**
Interest expense on lease liabilities	31	(79)	(47)
Total cash outflow for leases	31	(1,244)	(1,723)
Additions / Adjustments to right of use assets	18	853	699
Net Book Value of Right of Use assets by the following asset classification;			
- Property (land and buildings)		3,268	3,597
- Plant & machinery		437	259
- Transport equipment		78	164
- Information technology		269	517
Total	18	**4,052**	**4,537**

Note 19 Donations of property, plant and equipment

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust has received donated assets totalling £270k in 2025/26. In 2024/25, donated assets totalling £3,042k were received.

Note 20 Revaluations of property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 to ensure that property is stated at fair value. The default frequency of these valuations is currently every five years, in accordance with the FT ARM. However, interim valuations are also carried out as deemed appropriate by the Trust. Valuations are performed by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual. The Trust commissioned an desktop valuation of its land and buildings as at 31st March 2026, which was undertaken by Cushman & Wakefield.

Note 21 Investment Property

The Trust does not hold any Land, Buildings or Dwellings on an Investment only basis.

Note 22 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**8,095**	**8,218**	**550**	**550**
Acquisitions in year	4,177	3,275	-	-
Movement in fair value through income and expenditure	428	(32)	-	-
Disposals	(9,023)	(3,366)	-	-
Carrying value at 31 March	**3,677**	**8,095**	**550**	**550**

The Group investments relate to investments made by Doncaster & Bassetlaw Teaching Hospitals Charitable Funds as part of a diverse investment portfolio.

Note 22.1 Other investments / financial assets (current)

The Trust does not hold either other investments or financial assets (current).

Note 23 Disclosure of interests in other entities

The Trust does not hold any interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 24 Inventories

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Drugs	2,817	2,908	2,044	2,297
Consumables	7,038	6,490	7,038	6,490
Total inventories	**9,855**	**9,398**	**9,082**	**8,787**

Inventories recognised in expenses for the year were £76,528k (2024/25: £75,556k). Write-down of inventories recognised as expenses for the year were £76k (2024/25: £17k).

Note 25.1 Receivables

	Group		Trust	
	2026 £000	2025 £000	2026 £000	2025 £000
Current				
Contract receivables	18,706	16,050	19,734	17,495
Allowance for impaired contract receivables / assets	(2,102)	(1,781)	(2,102)	(1,781)
Prepayments (non-PFI)	3,698	3,348	4,588	2,457
PDC dividend receivable	-	1,909	-	1,909
VAT receivable	-	5,827	-	5,276
Clinician pension tax provision reimbursement funding from NHSE	44	37	44	37
Other receivables	4,594	2,596	4,642	8,560
Total current receivables	**24,940**	**27,986**	**26,906**	**33,953**
Non-current				
Contract receivables	2,225	2,734	2,225	2,734
Clinician pension tax provision reimbursement funding from NHSE	679	725	679	725
Allowance for impaired contract receivables / assets	(673)	(721)	(673)	(721)
Total non-current receivables	**2,231**	**2,738**	**2,231**	**2,738**
Of which receivable from NHS and DHSC group bodies:				
Current	12,613	12,431	12,613	12,431
Non-current	679	725	679	725

Note 25.2 Allowances for credit losses

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**2,502**	**-**	**2,502**	**-**
New allowances arising	1,117	-	1,117	-
Changes in the calculation of existing allowances	-	-	-	
Reversals of allowances (where receivable is collected in-year)	(61)	-	(61)	-
Utilisation of allowances (write offs)	(783)	-	(783)	-
Allowances as at 31 Mar 2026	**2,775**	**-**	**2,775**	**-**

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**3,543**	**-**	**3,543**	**-**
New allowances arising	720	-	720	-
Reversals of allowances (where receivable is collected in-year)	178	-	178	-
Reversals of allowances (where receivable is collected in-year)	(1,200)	-	(1,200)	-
Utilisation of allowances (write offs)	(739)	-	(739)	-
Allowances as at 31 Mar 2025	**2,502**	**-**	**2,502**	**-**

Note 26 Other assets

The Trust does not have any receivables classified as other assets.

Note 27 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 28 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**42,248**	**37,278**	**40,851**	**36,311**
Net change in year	12,163	4,970	12,587	4,540
At 31 March	**54,411**	**42,248**	**53,438**	**40,851**
Broken down into:				
Cash at commercial banks and in hand	433	1,142	-	-
Cash with the Government Banking Service	53,978	41,106	53,438	40,851
Total cash and cash equivalents as in SoFP and SOCF	**54,411**	**42,248**	**53,438**	**40,851**

Note 29 Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Trade payables	15,403	17,600	16,432	18,946
Capital payables	40,808	27,696	40,808	27,696
Accruals	27,533	31,582	27,473	30,862
Social security costs	8,716	8,138	8,712	8,138
VAT payable	218	-	742	-
Other taxes payable	68	72	-	-
PDC Dividend payable	657	-	657	-
Pension contributions payable	4,804	4,620	4,804	4,620
Other payables	273	297	273	297
NHS charitable funds: trade and other payables	435	738	-	-
Total current trade and other payables	**98,915**	**90,743**	**99,901**	**90,559**
Of which payables from NHS and DHSC group bodies:				
Current	10,188	10,726	10,188	10,726

Note 30 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	2,454	5,020	2,454	5,020
Total other current liabilities	**2,454**	**5,020**	**2,454**	**5,020**

Note 31 Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Loans from DHSC	564	565	564	565
Lease liabilities	928	902	928	902
Total current borrowings	**1,492**	**1,467**	**1,492**	**1,467**
Non-current				
Loans from DHSC	7,331	7,874	7,331	7,874
Lease liabilities	2,329	2,746	2,329	2,746
Total non-current borrowings	**9,660**	**10,620**	**9,660**	**10,620**

Note 31.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**8,439**	**3,648**	**12,087**
Cash movements:			
Financing cash flows - payments and receipts of principal	(543)	(1,244)	**(1,787)**
Financing cash flows - payments of interest	(194)	(79)	**(273)**
Non-cash movements:			
Additions	-	853	**853**
Application of effective interest rate	193	79	**272**
Carrying value at 31 March 2026	**7,895**	**3,257**	**11,152**

Note 31.2 Lease liabilities - maturity analysis

	31 March 2026
	£000
Undiscounted future lease payments payable in:	
- not later than one year;	928
- later than one year and not later than five years;	1,977
- later than five years	477
Total gross future lease payments	3,382
Finance charges allocated to future periods	(125)
Total net lease liabilities	**3,257**
Of which:	
Current - due in not later than one year	928
Non current - due in over one year	2,329
	3,257

Note 32 Other financial liabilities

Neither the Group or Trust has any other financial liabilities.

Note 33 Finance leases

Note 33.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor

The Trust/Group does not have any finance lease receivables as a lessor.

Note 34.1 Provisions for liabilities and charges analysis - Group and Trust

Group and Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Clinicians' pension reimbursement	Lease Dilapidations (previously charged to revenue)	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**888**	**834**	**262**	**762**	**238**	**2,984**
Change in the discount rate	(69)	(26)	-	(55)	-	**(150)**
Arising during the year	74	95	134	14	-	**317**
Utilised during the year	(63)	(125)	(30)	(44)	-	**(262)**
Reversed unused	-	(79)	(116)	-	-	**(195)**
Unwinding of discount	21	19	-	46	-	**86**
At 31 March 2026	**851**	**718**	**250**	**723**	**238**	**2,780**
Expected timing of cash flows:						
- not later than one year;	113	160	250	44	-	**567**
- later than one year and not later than five years;	314	406	-	111	238	**1,069**
- later than five years.	424	152	-	568	-	**1,144**
Total	**851**	**718**	**250**	**723**	**238**	**2,780**

The provision for legal claims is in respect of employer's liability and public liability cases made against the Trust. This figure is based on information provided by NHS Resolution which at present represents the Trust's best assessment of the likely future costs associated with processing the claims. The eventual settlement costs and legal expenses may be higher or lower than that provided.

Pensions: Early departure costs and Pensions: injury benefits are calculated based on information provided by the NHS Business Services Authority - Pensions Division. There are uncertainties surrounding these provisions as the amounts incorporate assumptions made concerning the life expectancy of the individuals.

Clinicians' pension reimbursement relates to where the Trust makes good any tax incurred relating to clinicians' pensions through their work in the NHS. This is funded via NHS England, which can be seen by an equal and opposite entry within Receivables.

Note 34.2 Clinical negligence liabilities

At 31 March 2026, £234,757k (31 March 2025: £204,105k) was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	86	55	86	55
Gross value of contingent liabilities	**86**	**55**	**86**	**55**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**86**	**55**	**86**	**55**

The contingent liabilities relate to personal litigation claims above the amount included in provisions up to the maximum excess amount for which the Trust is liable.

Note 36 Contractual capital commitments

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	999	-	999	-
Intangible assets	10,080	-	10,080	-
Total	**11,079**	**-**	**11,079**	**-**

Note 37 Other financial commitments

The Trust/Group does not have any commitments to make payments under non-cancellable contracts.

Note 38 Defined benefit pension schemes

The Trust does not operate any material defined pension schemes other than the statutory NHS Pension Scheme.

Note 39 Financial instruments

Note 39.1 Financial risk management

International Financial Reporting Standard 7 ("IFRS 7") requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICBs) and the way those ICBs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating and changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit risk

Credit risk is the risk of financial loss to the Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Trust's trade receivables. As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

The carrying amount of financial assets represents the maximum credit exposure. Therefore the maximum exposure to credit risk at the reporting date for the Group was £80,519k (2024/25: £69,983k), being the total of the carrying amount of financial assets.

With regard to the credit quality of financial assets and impairment losses, the movement in the allowance for impairment in respect of trade receivables during the year is disclosed in note 40.2.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's financial assets that is currently subject to a variable rate is cash held in the Foundation Trust's main bank accounts and in a short term deposit account. The Trust is therefore not exposed to significant risk of fluctuations in interest rates.

The Trust's operating costs are incurred under contracts with Integrated Care Boards and other NHS or Government bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from cash reserves, loans or through the issue of PDC. All major capital expenditure is supported by detailed financial assessment including the assessment of cash flow requirements and impact on liquidity and any funding is within the Trust's prudential borrowing limit, as set by NHS England. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2026 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	23,473	-	-	**23,473**
Cash and cash equivalents	53,978	-	-	**53,978**
Consolidated NHS Charitable fund financial assets	433	3,677	-	**4,110**
Total at 31 March 2026	**77,884**	**3,677**	**-**	**81,561**

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2025 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	19,640	-	-	**19,640**
Cash and cash equivalents	41,106	-	-	**41,106**
Consolidated NHS Charitable fund financial assets	1,142	8,095	-	**9,237**
Total at 31 March 2025	**61,888**	**8,095**	**-**	**69,983**

The only Group financial assets held at fair value through the I&E are the Investments held within the NHS Charitable Fund. These have been valued in a consistent manner throughout.

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2026 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	24,549	-	-	**24,549**
Cash and cash equivalents	53,438	-	-	**53,438**
Total at 31 March 2026	**77,987**	**-**	**-**	**77,987**

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2025 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	27,049	-	-	**27,049**
Cash and cash equivalents	40,851	-	-	**40,851**
Total at 31 March 2025	**67,900**	**-**	**-**	**67,900**

Note 39.2 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026 under IFRS 9			
Loans from the Department of Health and Social Care	7,895	-	**7,895**
Obligations under leases	3,257	-	**3,257**
Trade and other payables excluding non financial liabilities	83,355	-	**83,355**
IAS 37 provisions which are financial liabilities	2,780	-	**2,780**
Consolidated NHS charitable fund financial liabilities	435	-	**435**
Total at 31 March 2026	**97,722**	**-**	**97,722**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025 under IFRS 9			
Loans from the Department of Health and Social Care	8,439	-	**8,439**
Obligations under leases	3,648	-	**3,648**
Trade and other payables excluding non financial liabilities	76,442	-	**76,442**
IAS 37 provisions which are financial liabilities	2,984	-	**2,984**
Consolidated NHS charitable fund financial liabilities	738	-	**738**
Total at 31 March 2025	**92,251**	**-**	**92,251**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026 under IFRS 9			
Loans from the Department of Health and Social Care	7,895	-	**7,895**
Obligations under leases	3,257	-	**3,257**
Trade and other payables excluding non financial liabilities	84,324	-	**84,324**
IAS 37 provisions which are financial liabilities	2,780	-	**2,780**
Total at 31 March 2026	**98,256**	**-**	**98,256**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025 under IFRS 9			
Loans from the Department of Health and Social Care	8,439	-	**8,439**
Obligations under leases	3,648	-	**3,648**
Trade and other payables excluding non financial liabilities	77,068	-	**77,068**
IAS 37 provisions which are financial liabilities	2,984	-	**2,984**
Total at 31 March 2025	**92,139**	**-**	**92,139**

Note 39.3 Fair values of financial assets and liabilities

The book value (carrying value) of receivables is a reasonable approximation of the fair value of the asset.

The book value (carrying value) of payables is a reasonable approximation of the fair value of the asset.

Note 39.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
In one year or less	85,850	79,243	86,384	80,586
In more than one year but not more than five years	5,360	5,391	5,360	5,391
In more than five years	6,851	7,766	6,851	7,766
Total	**98,061**	**92,400**	**98,595**	**93,743**

Note 40 Losses and special payments

	2025/26		2024/25	
Group and Trust	number of cases Number	value of cases £000	number of cases Number	value of cases £000
Bad debts	198	607	230	478
Total losses - bad debts	**198**	**607**	**230**	**478**
Compensation under court order or legally binding arbitration award	11	72	21	60
Ex-gratia payments	15	8	11	5
Total special payments	**26**	**80**	**32**	**65**
Total losses and special payments	**224**	**687**	**262**	**543**

Note 41 Gifts

In 2024/25 and 2025/26, the Trust did not make any gifts.

Note 42 Related parties

The total value of receivables and payables balances held with related parties as at 31 March, together with the associated income and expenditure transactions during 2025/26 and 2024/25, is:

Group and Trust 2025/26	Receivables 31 March 2026 £000	Payables 31 March 2026 £000	Income 2025/26 £000	Expenditure 2025/26 £000
Other NHS bodies	12,613	12,062	615,954	51,872
Other bodies (including WGA bodies)	9	13,899	556	101,542
	12,622	**25,961**	**616,510**	**153,414**

Group and Trust 2024/25	Receivables 31 March 2025 £000	Payables 31 March 2025 £000	Income 2024/25 £000	Expenditure 2024/25 £000
Other NHS bodies	12,431	12,337	591,602	50,018
Other bodies (including WGA bodies)	5,827	12,970	708	88,974
	18,258	**25,307**	**592,310**	**138,992**

The Department of Health and Social Care ("the Department") is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities include NHS England, Integrated Care Boards, NHS Foundation Trusts, NHS Trusts, NHS Resolution, the NHS Business Services Authority and the NHS Purchasing and Supply Agency.

"Other bodies (including WGA bodies)" includes local authories, HM Revenue & Customs and NHS Pension Scheme.

The Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs (including National Insurance Fund), NHS Pension Scheme and Doncaster Metropolitan Borough Council.

The Government Accounting Manual identifies the Department's Ministers, senior officials and entities controlled or influenced by them as being related parties. Income from such bodies was £104k in 2025/26, with no associated receivables at 31 March 2026. Expenditure to such bodies was £39k in 2025/26 with no associated payables at 31 March 2026. These figures are excluded from the table above. There were no such transactions or balances in 2024/25.

Note 43 Events after Balance Sheet Date

There are no such events to report

Note 44 NHS Charitable Fund

The Trust is the Corporate Trustee of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Charitable Fund (registered charity number 1057917). The object is for funds to be used “for any purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Doncaster and Bassetlaw Hospitals NHS Foundation Trust”.

Summary statement of financial activities

	Total Funds	
	2025/26	**2024/25**
	£000	**£000**
Incoming resources	1,186	420
Resources expended	(1,539)	(1,008)
Net outgoing resources	**(353)**	**(588)**
Investment Income	233	272
Gains/(losses) on revaluation and disposal of investment	428	(32)
Net movement in funds	**308**	**(348)**
Fund balances at 1 April	2,987	3,335
Fund balances at 31 March	**3,295**	**2,987**

	Total Funds	
	2025/26	**2024/25**
Investment assets	3,677	8,095
Cash and receivables	433	1,142
Current liabilities	(815)	(6,250)
Total net assets	**3,295**	**2,987**

	2026	**2025**
	£000	**£000**
Unrestricted income funds	2,005	1,100
Other restricted income funds	1,290	1,887
	3,295	**2,987**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 45 Doncaster & Bassetlaw Healthcare Services Ltd

The Trust has a wholly owned subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd currently provides Out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen below:

Summary statement of financial activities

	2025/26 £000	2024/25 £000
Incoming resources	11,867	11,732
Resources expended	(11,684)	(11,317)
Net incoming resources	**183**	**415**
Dividends paid	-	(200)
Net movement in assets	**183**	**215**

	2025/26 £000	2024/25 £000
Current assets	2,816	2,757
Cash	540	255
Current liabilities	(2,208)	(2,047)
Total net assets	**1,148**	**965**
Share Capital	550	550
Income & Expenditure reserve	598	415
Total net assets	**1,148**	**965**

Note 46 Adjusted Financial Performance

	2025/26 £000	2024/25 £000
(Deficit) for the period for Trust	(14,253)	(32,436)
Surplus / (deficit) for the period for wholly owned subsidiary	183	215
(Deficit) for the period for non-charity aspects of the Group	(14,070)	(32,221)
Add back all I&E impairments	13,495	32,042
Remove capital donations/grants I&E impact	592	(2,244)
Adjusted financial performance surplus/(deficit)	**17**	**(2,423)**
Planned adjusted financial performance surplus/(deficit)	**-**	**(2,428)**

"Adjusted financial performance" is used for system reporting to NHS England.
It excludes technical non-recurrent adjustments to enable NHS England to monitor the underlying performance of the Trust.

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust