Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

3 November 2026

09:30 GMT Europe/London

Boardroom, Montagu Hospital, Adwick Rd, Mexborough S64 0AZ

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2611 - A OPENING ITEMS

09:30

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 3 November v1.6.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
Tuesday 3 November 2026 at 9:30am
Boardroom, Montagu Hospital

Time	Item		Purpose
09:30	**A**	**OPENING ITEMS**	
10 mins	**A1**	Welcome, apologies for absence and declarations of interest *Mark Bailey, Interim Chair*	*Note and review*
	A2	Minutes of the previous meeting held on 1 September 2026 *Mark Bailey, Interim Chair*	*Approve*
	A3	Matters Arising and Actions from Previous Meeting *Mark Bailey, Interim Chair*	*Review*
09:40	**B**	**BOARD REFLECTION AND LEARNING**	
10 mins	**B1**	Chair's Report including Partnership Update *Mark Bailey, Interim Chair*	*Note*
10 mins	**B2**	Chief Executive's Report including Partnership Update *Richard Jenkins, Interim Chief Executive*	*Note*
10 mins	**B3**	Shirley's Story *Karen Jessop, Chief Nurse*	*Note*
10:10	**C**	**ASSURANCE – Patients, People, Partnership & Pounds**	
15 mins	**C1**	Imperatives Report – Month 6 *Michael Wright, Interim Deputy Chief Executive* *Executive Directors*	*Note*
5 mins	**C2**	Finance & Performance Committee Chair's Assurance Log *Non-executive Director*	*Assurance*
5 mins	**C3**	Quality Committee Chair's Assurance Log *Helen Best, Non-executive Director*	*Assurance*
5 mins	**C4**	People Committee Chair's Assurance Log *Lucy Nickson, Non-executive Director*	*Assurance*
5 mins	**C5**	Audit & Risk Committee Chair's Assurance Log *Kath Smart, Non-executive Director*	*Assurance*
10 mins	**C6**	Board Assurance Framework Compliance & Risk Register *Brenda Thomas, Interim Company Secretary* *Executive Directors*	*Approve*
BREAK 10:55 – 11:10			

11:10	**D**	**PERFORMANCE**	
15 mins	**D1**	Integrated Performance Report *(including finance report)* *Michael Wright, Interim Deputy Chief Executive* *Executive Directors*	*Assurance*
11:25	**E**	**PATIENTS**	
10 mins	**E1**	Perinatal Safety and Quality Interim Report *Karen Jessop, Chief Nurse & Nick Mallaband, Chief Medical Officer* *Lois Mellor, Director of Midwifery & Tomas Barani, Clinical Director Obstetrics & Gynaecology*	*Assurance*
10 mins	**E2**	Maternity and Neonatal 10 Point Plan and Triage Specification Progress Update *Karen Jessop, Chief Nurse & Nick Mallaband, Chief Medical Officer* *Lois Mellor, Director of Midwifery & Tomas Barani, Clinical Director Obstetrics & Gynaecology*	*Assurance / Decision*
20 mins	**E3**	Thirlwall Inquiry Report Immediate Actions *Karen Jessop, Chief Nurse* *Laura Churm, Divisional Lead Nurse for Paediatrics* *Syam Pramod, Clinical Director Acute Paediatrics*	*Discuss*
10 mins	**E4**	Tackling Health Inequalities Update *Michael Wright Interim Deputy Chief Executive* *Kelly Mackenzie, Consultant in Public Health*	*Note*
12:15	**F**	**PEOPLE**	
10 mins	**F1**	Guardian of Safe Working Hours Quarterly Report *Zoe Lintin, Chief People Officer* *Dr Mohammad Khan, Guardian of Safe Working Hours*	*Assurance*
12:25	**G**	**GOVERNANCE**	
5 mins	**G1**	Constitution, Scheme of Reservation & Delegation & Standing Financial Instructions *Sam Wilde, Chief Finance Officer* *Brenda Thomas, Interim Company Secretary*	*Approve*
5 mins	**G2**	Emergency Planning, Resilience & Response Compliance against Core Standards *Denise Smith, Chief Operating Officer*	*Assurance*
5 mins	**G3**	Use of Trust Seal Annual Report *Michael Wright, Interim Deputy Chief Executive* *Brenda Thomas, Interim Company Secretary*	*Note*
12:40	**H**	**INFORMATION**	
-	**H1**	Provider Capability Self-Assessment *Michael Wright, Interim Deputy Chief Executive*	*Information*
-	**H2**	Board of Directors Work Plan *Brenda Thomas, Interim Company Secretary*	*Information*
12:40	**I**	**INTEGRATED ASSURANCE**	
5 mins	**I1**	Triangulation of information to identify agenda item themes *Mark Bailey, Interim Chair*	*Discussion*

5 mins	**I2**	Board Effectiveness and Demonstrating the DBTH Way - Was sufficient time allocated to enable focused discussion for items? - Did papers contain the appropriate level of detail? - Was open and productive debate achieved? - What could we do less of or more of going forward? - Were discussions courteous and in line with the DBTH Way? *Mark Bailey, Interim Chair*	*Discussion*
12:50	**J**	**CLOSING ITEMS**	
10 mins	**J1**	Pre-submitted Questions from members of the Public and Governors *Mark Bailey, Interim Chair*	*Discussion*
10 mins	**J2**	Any other business (to be agreed with the Chair prior to the meeting) *Mark Bailey, Interim Chair*	*Discussion*

Date and time of next meeting:
Date: Tuesday 5 January 2027
Time: 9:30am
Venue: Boardroom, Doncaster Royal Infirmary

K	**MEETING CLOSE**	**13:10**

Withdrawal of Press and Public

Board to resolve: *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

2611- A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

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

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

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

REFERENCES

Only PDFs are attached

A1 - DBTH Register of Interests and FPPT Declarations.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	03 November 2026
Report Title/ Ref:	**Register of Directors' Interests and Fit and Proper Person Declarations**			
Executive Sponsor:	Mark Bailey, Interim Chair			
Author:	Brenda Thomas, Interim Company Secretary			
Appendices:	None			
Purpose of the report	**Assurance**	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	No direct impact on BAF risks 1-7. The register and fit and proper person declarations underpin the well-led governance arrangements through which the Board oversees all strategic risks.			

Executive Summary - Key messages and Issues

Purpose of the report

The Trust is required to maintain and publish a register of the interests of its directors, and to be satisfied that every director meets the fit and proper person requirements. This report presents both to the Board.

Register of interests

The register is shown as at 12 October 2026 and includes all voting and non-voting directors, including those in interim and acting roles and corporate directors. The Chair plus six non-executive directors (NEDs) have declared interests, with two NEDs declaring none. All the executive and corporate directors have declared interests.

Fit and proper persons

Every director currently in post has signed the annual fit and proper person self-attestation. Section 2 summarises the declarations and sets out the status of the checks required under the NHS England Fit and Proper Person Test (FPPT) Framework, which supports the Chair's annual submission to the NHS England North East and Yorkshire Regional Director.

Recommendations

The Board is asked to:

- note the Register of Directors' Interests as at 12 October 2026;
- take assurance that all directors in post have made a fit and proper person declaration; and
- note that directors must notify the Company Secretary promptly of any change to their interests or fit and proper person status.

Healthier together - delivering exceptional care for all

Patients	Supports public and patient confidence that the Board is led by fit and proper directors and that decisions about care are made openly and free from undue influence.
People	Demonstrates that Board members meet the standards of probity, conduct and competence expected of NHS leaders, in line with the NHS Leadership Competency Framework and Trust values.
Partnerships	Several directors hold roles with partner organisations. Declaring these interests supports transparent joint working and the management of any conflicts as collaboration develops.
Pounds	No direct financial implications. Identifying interests helps protect the integrity of procurement, contracting and investment decisions.
Health Inequalities	No direct impact identified.

<table>
<tr><td>Legal/ Regulation:</td><td>Regulation 5 (Fit and proper persons: directors), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; NHS England Fit and Proper Person Test Framework for board members (2023); Code of Governance for NHS Provider Trusts; Managing Conflicts of Interest in the NHS; Trust Constitution and Standards of Business Conduct policy; CQC Well-led framework.</td></tr>
<tr><td>Partner ICB strategies</td><td>No direct impact. Supports the openness and accountability expected of providers by partner ICBs.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Not applicable</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Not applicable</td></tr>
<tr><td>Is this in line with Current risk appetite

N/A</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
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Register of Directors' Interests and Fit and Proper Person Declarations

1. Register of Directors' Interests

Directors are required to declare any interests that are relevant and material to the business of the Trust, on appointment and whenever they change. Interests are also declared at the start of each Board and committee meeting.

Register as at 12 October 2026

Chair and Non-Executive Directors	
Director	**Declared interests**
Mark Bailey Interim Chair	Non-Executive Chair, Doncaster and Bassetlaw Healthcare Services Ltd; Non-Executive Director, Derbyshire Community Health Services NHS FT; Executive Coach, NHS Leadership Academy (voluntary); Visiting Fellow, Cranfield University.
Kath Smart Non-Executive Director	Non-Executive Director and Audit Chair, Humber Teaching NHS FT; Non-Executive Director, InCommunities Limited (housing provider); Independent Non-Executive Director, St Leger Homes; Court Secretary, Foresters Friendly Society, Sheffield (Mutual Society); Senior Trust Associate Manager (TAM or 'Hospital Manager' under the Mental Health Act), Rotherham Doncaster and South Humber NHS FT.
Jo Gander Non-Executive Director	Member, Advisory Committee on Clinical Impact Awards (ACCIA) Yorkshire and Humber Sub-Committee; Non-executive Director, NHS Humber Health Partnership.
Stephen Radford Non-Executive Director	Non-Executive Director, Barnsley Hospital NHS FT; Associate, Proservartner; Resident Director, Hartcliffe Meadows (Penistone) Management Company Limited.
Lucy Nickson Non-Executive Director	Chief Executive, Day One Trauma Support (national charity).
Helen Best Non-Executive Director	*No relevant interests to declare*
Nadeem Murtaza Non-Executive Director	*No relevant interests to declare*

Executive and Corporate Directors	
Director	**Declared interests**
Richard Jenkins Interim Chief Executive	Joint Chief Executive, Barnsley Hospital NHS FT and The Rotherham NHS FT; Well-led Advisor, Care Quality Commission; Wife is a Community Nurse at York and Scarborough Teaching Hospitals NHS FT; Member of the Labour Party.
Michael Wright Interim Deputy Chief Executive	Managing Director, Barnsley Hospital NHS FT; Non-Executive Director, Yorkshire Ambulance Service NHS Trust.
Sam Wilde Chief Financial Officer	Director, Doncaster and Bassetlaw Healthcare Services Ltd; Member of NHS Benchmarking Network and Chair of its Steering Group.
Zoe Lintin Chief People Officer	Trustee, Board of the Students' Union, University of Sheffield; Director at InConcert People Limited.
Denise Smith Chief Operating Officer	Various family members work in the NHS; none within the South Yorkshire and Bassetlaw network.

Karen Jessop Chief Nurse	Well-led Advisor Care Quality Commission; Husband is a Very Senior Manager (Chief Nurse Information Officer) at Hull University Teaching Hospitals NHS Trust.
Nick Mallaband Chief Medical Officer	Director, Doncaster and Bassetlaw Healthcare Services Ltd.
Brenda Thomas Interim Company Secretary	Director, BVOT Consulting Ltd; Chair, Activate Hope (charitable incorporated organisation).
Emma Shaheen Director of Communications and Engagement	Sister is Deputy Director of Involvement, South Yorkshire ICB.

2. Fit and Proper Person Declarations

Under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the NHS England Fit and Proper Person Test Framework for board members, the Trust must be satisfied that each director is fit and proper for their role. Each director completes an annual self-attestation, supported by checks undertaken by the Trust. The Chair reviews the outcome for each director and signs the annual FPPT submission to the NHS England North East and Yorkshire Regional Director, with the Council of Governors informed as part of the Foundation Trust governance process.

The Trust confirms that every director currently in post has declared that they meet the requirements below.

Requirement	Each director has confirmed that they are / have:
Financial standing	Not an undischarged bankrupt or subject to sequestration; not subject to a bankruptcy restrictions order (or equivalent in Scotland or Northern Ireland); not subject to a debt relief order moratorium (Insolvency Act 1986, Part VIIA); and no undischarged composition, arrangement or trust deed with creditors. (i)-(iv)
Convictions and disqualification	No conviction in the British Islands in the last five years resulting in imprisonment (suspended or not) of three months or more without the option of a fine; not subject to an unexpired disqualification order under the Company Directors' Disqualification Act 1986. (v)-(vi)
Competence	Has the qualifications, competence, skills and experience necessary for the role. (vii)
Health	Able, after reasonable adjustments, to properly perform the tasks intrinsic to the role. (viii)
Conduct	Has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (lawful or not) in carrying on a regulated activity or providing a service elsewhere. (ix)
Safeguarding barring	Not included in the children's or adults' barred lists under the Safeguarding Vulnerable Groups Act 2006 (or equivalent). (x)
Legal prohibition	Not prohibited by or under any enactment from holding the office or carrying on the regulated activity. (xi)

Keeping declarations up to date

Directors must notify the Company Secretary promptly of any change to their interests or to their fit and proper person status, so that the register and their declaration remain accurate.

2611 - A2 MINUTES OF THE PREVIOUS MEETING HELD ON 1 SEPTEMBER 2026

Decision Item | Mark Bailey, Interim Chair | 09:30

REFERENCES

Only PDFs are attached

A2 - Board of Directors Draft Minutes - 1 September 2026.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the Board of Directors held in public on
Tuesday 01 September 2026 at 9:30am
in the Boardroom at Doncaster Royal Infirmary

Present:
Mark Bailey - Interim Chair (Chair)
Helen Best - Non-executive Director
Jo Gander - Non-executive Director
Richard Jenkins - Interim Chief Executive Officer
Karen Jessop - Chief Nurse
Zara Jones - Deputy Chief Executive
Zoe Lintin - Chief People Officer
Nadeem Murtaza - Non-executive Director
Lucy Nickson - Non-executive Director
Stephen Radford - Non-executive Director
Denise Smith - Chief Operating Officer
Sam Wilde - Chief Finance Officer
Michael Wright - Assistant Chief Executive

In attendance:
Joseph John - Medical Director for Operational Stability and Optimisation
Lois Mellor - Director of Midwifery (agenda item F1)
Anneleisse Siddall - Corporate Governance Officer (minutes)
Emma Shaheen - Director of Communications & Engagement
Brenda Thomas - Interim Company Secretary

Public in attendance:
Hannah Beardmore - Staff Side
Fiona Martin - Member of the Public
Tracey Priestley - Member of the Public
Gail Killoran - Member of the Public
Yetunde Elebuibon – Public Governor

Apologies:
Dr Nick Mallaband – Chief Medical Officer
Kath Smart - Non-executive Director

ACTION

P26/09/A1 **Welcome, apologies for absence and declarations of interest**

The Chair welcomed Board members and observers, including the Interim Chief Executive Officer, Interim Assistant Chief Executive and newly appointed Non-executive Director, Nadeem Murtaza.

The above apologies for absence were noted and the Medical Director for Operational Stability and Optimisation would deputise on behalf of the Chief Medical Officer in his absence.

The Assistant Chief Executive declared his position as a Non-executive Director of Yorkshire Ambulance Service.

P26/09/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 3 – Non-executive Director Oversight of National Reports/ Guidance – Non-executive Directors had signed up to weekly message from NHS England. **Action Closed.**

P26/09/B1 **Chair's Report including Partnership Update (Enclosure B1)**

The Chair confirmed that the Reset Programme would be instrumental in setting the tone for quality, people and colleagues. He emphasised the need for the Trust to maintain a sustainable outlook, including financial sustainability within its strategic plans for outstanding care and learning, every day.

The Chair noted that the full agenda would require difficult conversations and guided Board members to support one another throughout the process.

In response, The Chief Nurse referenced a recent coroner's inquest outcome which resulted in a prevention of future deaths report with a neglect rider, the Chief Nurse acknowledged the failings identified and committed to the ongoing improvements identified.

The Board received and noted the Chair's report, which covered local and national areas of focus and activity since the previous meeting.

The Board:
- ***Noted the Chair's Report***

P26/09/B2 **Chief Executive's Report (Enclosure B2)**

The Interim Chief Executive reflected on his first few days in post, to which he had received a warm welcome and, during visits across the Trust, had observed colleagues' enthusiasm and pride. He formally thanked the Deputy Chief Executive for her leadership during the previous seven months, which the Board acknowledged.

The Interim Chief Executive described the Trust as a complex organisation and recognised the scale of work required to deliver the financial plan whilst supporting colleagues in a balanced and compassionate way. His initial priorities included reducing long waits, strengthening medical engagement and changing working patterns, which would remain areas of focus over the coming months.

The Interim Chief Executive advised that the Trust faced a multi-year challenge. Executive colleagues had reviewed grip and control arrangements, and an experienced Turnaround Director, had been appointed to provide additional support. The Reset Programme and turnaround work were complementary; however, progress was not yet sufficient to provide confidence in delivery of the financial plan. He emphasised that improvement related to operational efficiency as well as finance and that the Trust's financial commitments must be delivered compassionately.

The Interim Chief Executive reported that operational performance was not on track and would be subject to NHS England oversight. He considered that the Trust had strong foundations and committed colleagues but emphasised the need for clear focus and prioritisation.

Non-executive Director, Stephen Radford, asked about partnership working and enquired whether unresolved differences concerning service delivery and the Mexborough Elective Orthopaedic Centre of Excellence (MEOC) could be expedited. The Interim Chief Executive confirmed that agreement had not been reached and that the former MEOC Board had ceased approximately six months earlier. An effective arrangement was required for all three trusts. The Chief Finance Officers would initially seek to resolve the financial differences, with the Deputy Chief Executive becoming involved if required. Any agreement must be fair to all three trusts; if a collective resolution could not be achieved, an independent person might be required to determine an impartial outcome.

Non-executive Director, Lucy Nickson, enquired whether the Turnaround Directors appointment was limited. The Interim Chief Executive confirmed that the appointment would continue until the end of the financial year. Equivalent support had been introduced at Barnsley and Rotherham to provide consistency and additional senior expertise. The appointment did not alter existing accountabilities and was intended to support delivery of the Board's plan.

The Chair enquired whether the Turnaround Director would support the work arising from the regional office letter. The Interim Chief Executive confirmed that he would provide independent support for this work before progressing turnaround activity alongside the Chief Finance Officer. He recognised that the Board had set a challenging plan and that every effort was being made to deliver it, though early underperformance would be difficult to recover later in the year.

The Board:

- ***Noted The Interim Chief Executive's Report***

P26/09/B3 **Reset Programme Update (Enclosure B3)**

The Deputy Chief Executive presented the Reset Programme Update and emphasised the need for confidence in the plans agreed with NHS England. She reported that progress had fluctuated, but the Trust remained confident in the access and flow pillars and work developed through them. She highlighted challenges in translating workforce plans into savings and confirmed that the overall requirement remained unchanged.

She advised that the risk-adjusted position had reduced and the Trust was considering further measures to release cash. She noted that the detailed position had been discussed by the Finance and Performance Committee.

The Board:

- ***Noted the Reset Programme Update***

P26/09/C1 **Integrated Performance Report including Finance Report (Enclosure C1)**

The Integrated Performance Report (IPR) overall position remained at moderate risk. Cancer performance had improved, although delivery needed to remain in line with plan. Productivity had reached the top quartile; however, temporary staffing pressures continued. Sepsis performance remained below standard and venous thromboembolism (VTE) performance had deteriorated.

The Chief Operating Officer confirmed that 4-hour Urgent and Emergency Care performance remained below plan despite improvement, however an Extended Medicine Ambulatory Care (EMAC) had since been implemented to progress plans. Trauma and Orthopaedics (T&O) required 4 substantive consultants and additional beds to sustain Referral to Treatment (RTT) delivery. Progress was dependent on commissioner support and would be reviewed by the Finance & Performance (F&P) Committee. In response to the Chair, the Chief Finance Officer confirmed that the position regarding commissioner support remained unclear.

The Chief Operating Officer confirmed that work with East Midlands Ambulance Service would progress at pace. T&O and Ear, Nose and Throat (ENT) services remained key drivers of long waits, including 52-week waits. Cancer performance had exceeded plan across all three standards; however, the 62-day position remained unvalidated and below plan. MRI and audiology continued to affect diagnostic performance.

The Chief Nurse confirmed the introduction of a new metric for planned induction of labour and confirmed increased caesarean section capacity. Gram-negative infection performance had deteriorated, with patient safety learning processes in place. Maternity staffing had fallen below the trigger level; however, mitigation and escalation arrangements were active. Recruitment had concluded, although the appointed colleagues had not yet commenced in post.

The Medical Director for Operational Stability and Optimisation reported that the Summary Hospital-level Mortality Indicator (SHMI) remained elevated, particularly within medical specialties. Recruitment continued and the position was improving; however, further work was required to understand the underlying causes.

The Chief Finance Officer reported that financial risk had improved, although £21m of gross risk remained, principally related to the Reset Programme and South Yorkshire funding. The team aimed to reduce the underlying risk to £10m. Productivity had returned above pre-COVID levels but remained behind plan due to bank and agency usage. Cash support was expected by the autumn.

The Chief People Officer reported an increase in sickness absence during the summer holiday period. The flu vaccination programme was due to commence the following month, and the appraisal season had concluded, and the People Committee would receive the annual report in October 2026.

Non-executive Director, Jo Gander, requested an update on pathology against the Patient Safety Incident Response Framework (PSIRF) standards. The Chief Operating Officer confirmed that internal challenges remained in relation to breast services and the Faster Diagnosis Standard, and pathology issues had not been resolved.

Non-executive Director, Jo Gander, enquired how Deficit Support Funding affected delivery of the plan. The Chief Finance Officer confirmed that £12m remained at risk. Non-executive Director, Stephen Radford, added that Deficit Support Funding was dependent on full delivery of the plan and could not be assessed solely against Quarter 1 performance.

Non-executive Director, Stephen Radford, expressed concern that bank and temporary staffing had increased in month 4 whilst whole-time equivalent staffing had reduced and enquired how grip and control would be strengthened. The Chief Finance Officer shared the concern and confirmed that a second bank and agency deep dive would be presented in October, with recurring areas under review. The Chief People Officer confirmed that the Executive Team was systematically reviewing pace and overtime.

Non-executive Director, Stephen Radford, noted that additional sessions had increased month on month. The Interim Chief Executive confirmed that stronger grip and control presented a significant opportunity but required a longer-term plan and sustained focus. The Chair confirmed that the assurance work would return to the Finance and Performance Committee.

Non-executive Director, Stephen Radford, enquired why emergency department sepsis performance had deteriorated and what action was being taken. The Medical Director for Operational Stability and Optimisation confirmed that the cause remained unclear and was being investigated. Resident doctors were receiving education, consultants had been informed and a further update would be provided at the next Board meeting.

The Chief Nurse reported extensive work in relation to sepsis, including earlier collection of blood cultures, and proposed a Board deep dive. The Interim Chief Executive questioned whether patients with sepsis were consistently protected and suggested that a mortality review meeting examine unexpected deaths. He emphasised the need for strong and systematic processes. **NM**

Non-executive Director, Lucy Nickson, questioned why issues in delayed antibiotics persisted and also enquired how the readmission outlier had been identified and what this meant for the community. The Chief Operating Officer confirmed that a site-level deep dive had been commissioned to examine prevention. The Chief Nurse advised that work to link 30-day readmission and mortality data was in development.

Non-executive Director, Helen Best, requested clarification of the diagnostic plan due to the deterioration in MRI performance. The Chief Operating Officer confirmed that demand was being reviewed and approved capacity increases would maximise existing provision. Further consideration would be given to additional MRI machines and capacity.

The Interim Chief Executive emphasised the need for clarity regarding the areas requiring improvement and assurance that appropriate actions were in place. He cautioned that the new metric did not, in isolation, demonstrate high productivity. The Chief Finance Officer confirmed that overall productivity had returned to pre-COVID levels. The Interim Chief Executive requested greater focus on theatre productivity and its underlying drivers.

The Chair confirmed that the moderate assurance rating reflected a mixed position and requested that the trajectories for the principal areas of concern, including areas of the Reset Programme, be brought together for the Board. The summary should clearly identify which key performance targets and trajectories were on track, the actions taken to address concerns, where sufficient evidence supported Board assurance, and where performance remained off track, uncertain or unsupported by sufficient evidence, so that the limits of assurance were clear. **Execs**

The Board:

- ***Noted and took moderate assurance from the IPR***

P26/09/D1 **Q4 2025/26 Learning from Deaths Report**

The Chair confirmed that the Board had commissioned further work on Learning from Deaths (LFD) which was considered by the Quality Committee, reflecting a commitment to learning and transparency. The Chair acknowledged that internal and external questions remained and would be addressed including a formal response to questions raised outside the meeting.

The Medical Director for Operational Stability and Optimisation presented the Quarter 4 report and confirmed lower inpatient and total deaths than the previous year. 1 death had been incorrectly classified within LFD due to a documentation error. The Medical Examiner had scrutinised all deaths, and notifications and escalations had been received. 76 Structured Judgement Reviews had been requested, of which 14% had been completed, other delays had arisen from the use of multiple medical systems. Learning themes included delays in prescribing antibiotics, inconsistent blood sampling and antimicrobial testing. 5 reviews involving patients with a learning disability had been completed and concerns relating to microbiology had been identified. Although most patients had received good care, opportunities for improvement remained, particularly in documentation. The learning and good practice for future care would be shared with divisions and cascaded to frontline staff.

The Deputy Chief Executive Officer referred to the Summary Hospital-level Mortality Indicator (SHMI) and confirmed that substantial work remained. She questioned whether the report's language aligned with earlier discussions, particularly its description of an elevated but stabilised SHMI position, and asked what stability meant in practice. She also requested clarification on the action taken after issues were referred to divisions.

The Medical Director for Operational Stability and Optimisation confirmed that feedback had focused on the Medicine Division. It had been agreed that the team would return to individual departments to identify whether problems could be anticipated and to ensure that governance meetings had action plans addressing SHMI. This approach applied across all divisions, although the immediate focus remained on Medicine.

Non-executive Director, Lucy Nickson, said it was difficult to take assurance from the report as it contained little information about the impact of learning. Although the learning themes related to simple but essential care, the evidence did not demonstrate its effect.
Non-executive Director, Stephen Radford, asked whether the Structured Judgement Review (SJR) outcomes that was assessed as good were based solely on clinical review

or also included information from families. The Medical Director for Operational Stability and Optimisation confirmed that the conclusion generally arose from a systematic approach. The Chief Nurse added that the SJR considered different perspectives, including consultant, clinical and nursing input, and was based on the documentation available. Where there was no reference to family involvement, an assessment would be made in accordance with the national process.

The Medical Director for Operational Stability and Optimisation agreed that contact with carers should be made mandatory. Non-executive Director, Stephen Radford, maintained that, without speaking to families, the review remained incomplete and reflected only the medical perspective.

The Chief Finance Officer asked whether the planned Electronic Patient Record (EPR) would improve retrieving information from systems, and whether the main difficulty concerned the impact of reviews or the time required to complete them. The Medical Director for Operational Stability and Optimisation confirmed that he would expect the EPR system to assist once implemented. The Chief Nurse added that both access to records and the wider review process affected completion.

The Medical Director for Operational Stability and Optimisation acknowledged that the report described the process more clearly than its resulting learning and agreed further work was required, particularly due to reoccurring themes. The Chief Nurse confirmed that although the report had not drawn out the learning sufficiently, this did not mean that learning had not occurred.

Non-executive Director, Jo Gander, referred to the assurance level and confirmed that the Quality Committee had taken significant assurance based on the processes in place. Non-executive Director, Helen Best, said the report clearly stated what the Board was being asked to consider and demonstrated that a robust process existed, but the outcomes, learning and resulting changes needed to be included, however the Quality Committee assurance rating had been determined using additional supporting evidence rather than the paper alone.

Non-executive Director, Jo Gander, added that the same issue applied to sepsis, which had been subject to an in-depth and robust discussion about the processes in place.

The Interim Chief Executive confirmed that the outcomes were not at the required level and work needed to produce measurable improvement, and the area should be prioritised. He questioned why stronger outcomes were not evident if the processes were robust and confirmed that a discussion with The Chief Medical Officer was required.

The Chair understood from earlier reporting to the Board on the work of Quality Committee at that stage but the process, evidence and actions required further review.

The Board:

- ***Agreed that the Quality Committee would reconsider future Learning from Deaths assurance reviews in light of concerns raised on process improvement and confirmation of learning and impact outcomes.***

P26/09/D2 **Patient Engagement Event 2026**

The Chief Nurse presented the patient engagement event held in June 2026, and confirmed that of the 50 attendees, 97% of those wished to continue working alongside the Trust, demonstrating an opportunity to strengthen engagement with communities. Accessibility had been among the issues raised, and participants had placed high value on the involvement of staff. She recommended building on the event with wider Board support and proposed that the next event be held in Bassetlaw.

The Deputy Chief Executive Officer supported the approach and asked about the breadth of community representation. She emphasised that demonstrating how the Trust had responded to feedback was important for these sessions. The Chief Nurse confirmed the first event had focused on accessibility but cautioned against restricting future events to a single theme. She confirmed that the event formed one part of wider engagement activity and stressed the importance of engaging a broad range of people beyond hospital sites.

Non-executive Director, Lucy Nickson, asked how the Trust would demonstrate that it had listened to patients, how it would decide which matters to take to patients for further discussion and improvement, and who would lead the process. The Chief Nurse confirmed that responsibility would be shared between the Communications Team and the Chief Nurse Directorate.

The Chief People Officer welcomed the work and agreed that it aligned with the Trust's culture and leadership programme.

The Chair referred to engagement approaches used by other Trusts, to which the Chief Nurse confirmed that the Trust had undertook similar work through Doncaster Voices.

In response to the Chair, the Chief Nurse confirmed that feedback from events was shared with relevant wards and Departments. She added that Care Opinion was available and the Trust was meeting other Trusts to learn from its use of real-time patient feedback.

The Board:

- ***Supported Patient Engagement events.***

P26/09/D3 **2025/26 Patient Experience Annual Report**

The Chief Nurse presented the 2025/26 Patient Experience Annual Report and highlighted the breadth of activity used to understand patient experience. She confirmed that intelligence had been gathered through several routes, including digital patient stories, volunteers and seldom-heard community groups, which had provided greater insight into patients' experiences.

She reported that engagement with deaf and hearing-impaired people had led to tangible improvements, including the use of QR codes and wider changes to improve access to interpretation.

Changes to clinical practice had been made following complaints, improvements to training, and developments in maternity triage systems.

Colleagues had demonstrated the work more clearly and had explored opportunities to obtain real-time feedback so that the Trust could listen and respond quicker.

The Interim Chief Executive emphasised that patient experience remained central to the Trust but expressed concern about complaint response times, confirming that a six-month delay was unacceptable. He noted that response-time performance was absent from the report and requested that the target be reviewed. He also asked that future reports include response times, whether complaints were resolved promptly and whether appropriate feedback was provided.

The Chief Nurse confirmed that a post complaint experience survey was currently paused whilst a review was underway, this ensured that questions were reviewed to try and support increased responses due to a historically low response rate. She proposed adding a question to the survey to establish whether each complainant had been offered a meeting before making a complaint. She also confirmed that Friends and Family Test reporting included positive feedback and that reopening rates, together with 40-day and 6-day waits, were reported.

The Chief Nurse confirmed that complaints were triaged initially and prioritised according to need.

Non-executive Director, Nadeem Murtazam asked whether triangulation of intelligence was fed back to patients. The Chief Nurse confirmed that feedback was provided to patients but acknowledged that this had not been achieved consistently.

Non-executive Director Jo Gander acknowledged the substantial work undertaken by the Chief Nurse and expressed her appreciation.

The Board:

- ***Noted the 2025/26 Patient Experience Annual Report***

P26/09/D4 **<u>2026/27 Winter Plan</u>**

The Chief Operating Officer presented the winter plan that focused on increasing winter capacity through additional beds at Doncaster and Bassetlaw until April 2027. The bed would be opened only when required, alongside work to reduce length of stay. Nursing colleagues were reviewing staffing requirements to minimise reliance on bank and agency staff, and medical workforce requirements managed through locum arrangements.

The estimated cost was £2.5m, based on the previous year's expenditure, and had been set aside. Ward 22 had closed, creating an opportunity for it to reopen during winter, and building work was planned to increase bed capacity at Bassetlaw. Funding would be drawn down subject to the financial position. The Board Assurance Statement included a draft assessment and required further work. The Chief Operating Officer sought support for the plan to proceed to the Executive Team and Finance & Performance Committee under delegated authority ahead of submission to NHS England.

Non-executive Director, Stephen Radford, referred to an earlier discussion at the Finance & Performance Committee and enquired whether an alternative reserve

could be used. The Chief Finance Officer confirmed that other reserves were available but had been allocated to different areas.

In response to a question, the Chief Finance Officer advised that use of the proposed funding would adversely affect the Trust's outturn unless other reserves remained unused.

Non-executive Director, Stephen Radford, asked what lead time was required to secure additional staffing. The Chief Operating Officer confirmed that the estate was readily available, but staffing and bed openings were not arranged during holiday periods or out of hours. Emergency Department admissions were monitored, and plans were made approximately one week in advance, with site team discussions and executive oversight.

The Chief People Officer enquired whether any aspect of the self-assessments could prevent achievement of a green assessment. The Chief Operating Officer identified demand management schemes and cross-organisational working as areas of concern. Operational colleagues worked closely with the flu vaccination programme and the Chief Nurse's infection prevention and control teams, and daily operational arrangements were reported to be well planned and robust.

Non-executive Director, Helen Best, asked if there would be risk to the winter plan following the consultants' vote for industrial action. The Chief Operating Officer confirmed that this remained an overarching risk, although previous periods of industrial action had been managed effectively without additional delegations and informal discussions had taken place with senior leaders and well-rehearsed plans were in place.

The Deputy Chief Executive emphasised the need for consistent management of arrangements and processes and highlighted the financial implications, including an unfunded £1m. She questioned whether the Board had sufficient information on what would be deprioritised to fund the plan. Non-executive Director, Stephen Radford, confirmed that the Finance & Performance Committee had held a detailed discussion on improving the funding information and considered that use of reserves was a matter for the Executive Team. It was agreed that the prioritisation of reserves would be explored. **SW**

The Interim Chief Executive recognised the role of partner organisations and the need to identify areas of growth ensuring that ward capacity responded accordingly. He enquired whether the Board's earlier assumptions had underestimated winter requirements and what information was available that had not been known previously with associated costs. The Chief Finance Officer confirmed that the earlier plan had not specifically included the closure of Ward 22.

The Interim Chief Executive noted that this represented an unravelling of an efficiency assumption. The Chief Operating Officer advised that requirements would be reviewed daily. The Interim Chief Executive emphasised the need to mitigate the cumulative financial impact.

The Chair referred to the earlier extensive discussions regarding partner capacity and enquired whether submission of the plan should be deferred. The Interim Chief

Executive confirmed that the justification needed to be strengthened and the decision reconsidered, including an assessment of the best achievable outcome within the available budget. **SW/DS**

The Chair proposed that a subset of the Board consider the matter with conditional approval be given outside the Board meeting to align with the late September submission date.

The Board:

- ***Agreed the Winter Plan 2026/27 in principle but required further Executive review prior to final approval. Questions on impact of working within existing reserves and confirmation of joined up planning with local partners on discharge / referral for the 2026/27 Winter Plan must be considered.***

P26/09/D5 **Trauma & Orthopaedic Recovery Plan**

The Chief Operating Officer outlined the proposed 3-year recovery plan for T&O which were the largest specialties and most challenged areas. The approach was based on detailed demand, capacity work, and principal constraints identified within the admitted pathway. The plan comprised of 3 elements: addressing patients waiting over 62 weeks, improving use of existing theatre capacity and clearing the remaining backlog to support delivery of the referral to treatment trajectory. Three delivery options had been considered: wholly outsourcing activity, delivering an internally resourced solution, or using a combination of locums and substantive consultant appointments.

The Chief Operating Officer emphasised that the approach should not introduce further risk and noted that many consultants undertaking the work would be recruited from outside the local area.

Non-executive Director, Stephen Radford, identified that delivery of the plan was contingent on commissioner support and recruitment lead times presented a further risk. He enquired what contingency arrangements were in place. The Chief Operating Officer confirmed that another plan had not been developed but advised that commissioner discussions would continue.

The Interim Chief Executive suggested that halving clock starts would significantly improve performance and requested that productivity information, and the proposed use of funding should be included in the plan. He asked what contingency was available if no additional elective funding was received and whether unspent funding could be redistributed.

The Interim Chief Executive also acknowledged that the case was not yet sufficiently strong and emphasised the need for a clearly defined argument to regulators on the risks associated with 62-week waits and the priority required. He was supportive of the overall direction, subject to the plan also addressing demand, including musculoskeletal demand and Patient-Reported Outcome Measure scores. **DS**

The Chief Operating Officer confirmed that the Doncaster musculoskeletal pathway was not currently mandated, but conversations had taken place with Doncaster Place to progress this. She acknowledged that productivity alone would not deliver the

required recovery or long-term sustainability and that available system funding had already been allocated.

The Board:

- ***Agreed the T&O plan in principle but required further Executive review prior to final approval. Executive Directors to confirm position on mitigations in place or mitigations needed outside of investment in resourcing.***

P26/09/E1 **DBTH Way in Action and Well-led**

The Deputy Chief Executive confirmed that the Board was well sighted on the DBTH Way in Action and Well-led and its work undertaken. She confirmed that good progress had been made with appropriate actions in place. The report included detailed action plans with 17 well-led recommendations completed. The remaining partially completed actions were on track, with just 1 action off track due to the longer-term nature of the work. Examples of progress in leadership and governance were highlighted, reflecting the significant time invested in leadership approaches. The internal audit review was also linked to patient and lived experience.

The Chief People Officer confirmed that the DBTH Assembly had been launched to support colleague engagement, with a focus on behaviours and ongoing activity relating to Speaking Up for patient safety and leadership development. Culture change was recognised as a long-term process requiring sustained focus. The annual Staff Survey would provide a key measure, supported by pulse checks and ongoing departmental engagement. HR casework and Freedom to Speak Up concerns would be reviewed in September 2026.

The Deputy Chief Executive recommended that the Board take moderate assurance and proposed revised timescales to support governance. A formal review was planned for January 2027, with the work expected to transition into business as usual through the relevant committees. Culture work had been prioritised during recent months, and continued discussions would inform the required actions.

Non-executive Director, Lucy Nickson, welcomed the inclusion of patient lived experience alongside the broader culture work.

The Chief Operating Officer confirmed that the Board had received performance metrics and that further work was ongoing. External governance support was anticipated, and further iterations of the governance manual were expected.

The Interim Chief Executive enquired when the programme would conclude and transition into business as usual. The Deputy Chief Executive proposed that the timescale set out in the report should be used to embed the work alongside NHS England discussions before the programme transitioned into business as usual.

The Board:

- ***Noted and took Moderate assurance from the DBTH Way and Well-led report and supported the proposed revised timescales***

P26/09/F1 **Perinatal Safety and Quality (interim) report**

The Board received the Perinatal Safety and Quality (interim) Report which included perinatal metrics and confirmed that work on translation services continued with external partners. A response to the Ockenden review was expected in December 2026 and the Cultural Improvement Plan and Maternity Incentive Scheme requirements would also be considered.

The Chair confirmed that the Quality Committee held delegated authority. Non-executive Director, Jo Gander, noted that this was reflected in the Committee Chair's report and that the Board received only partial information on some areas, including matters relating to the British Association of Perinatal Medicine.

The Board:

- ***Received and took significant assurance from the Perinatal Safety & Quality (interim) Report.***
- ***Received and reviewed Q1 PMRT report, Trust Quality Metrics, data measures and the MOSS update.***
- ***Approved the Perinatal Culture Improvement Plan***

P26/09/F2 **Maternity and Neonatal 10 Point Plan & Triage Specification Baseline Assessment and NHSE Submission**

The Chief Nurse presented the baseline assessment for the Maternity and Neonatal 10 Point Plan and Triage Specification, which was due for submission to NHS England by 24 September 2026. The assessment identified areas of strong assurance, those requiring further improvement and the actions needed to meet the required timescales.

The Director of Midwifery confirmed that no significant concerns had been identified and that an improved position was expected. She outlined the findings from the maternity assessments completed for both sites and confirmed that issues had been identified at both Doncaster and Bassetlaw sites. Areas identified were insufficient sizing of the maternity triage area, data analysis capacity, strengthened patient feedback and the lack of recorded telephone calls.

The Director of Midwifery advised that 2 further requirements were specific to the new maternity specification, which included the expectation that maternity triage services should operate similarly to an Emergency Department. Doncaster had two appointment areas, whereas the smaller Bassetlaw area would require significant estates investment. It was not yet known whether additional funding would be available. The Chief Nurse confirmed that the assessment would be overseen by the Northeast and Yorkshire regional team following submission.

The Interim Chief Executive noted that the assessment reflected the current position and enquired what action would be taken before December 2026. The Chief Nurse confirmed that the Clinical Director would be required to attend the Board of Directors meeting, as the clinical representative.

The Chief Nurse noted that operating maternity services across two separate sites would present a challenge in meeting the requirements. The Medical Director for

Operational Stability and Optimisation confirmed that he had discussed the position with the Clinical Director, who was assured that the plans would progress as intended.

In response to a question from Non-executive Director, Lucy Nickson, the Chief Nurse advised that it was too early to assess impact, however, further updates would be reported to the Quality Committee and Board of Directors, as required.

The Chair acknowledged the limited time available to complete the submission, however, the Chief Nurse assured that this was just an initial baseline assessment and advised that a national taskforce may provide feedback through a wider national plan.

The Board:

- ***Noted and took moderate assurance from the Maternity and Neonatal 10 Point Plan & Triage Specification Baseline Assessment and approved the NHSE Submission.***

P26/09/F3 **Mortuary Oversight – Board Assurance Statement**

The Medical Director for Operational Stability and Optimisation outlined the Trust's approach to ensuring dignity in care after death. In June 2026, NHS England issued correspondence following concerns raised in Nottingham regarding the care of deceased patients. Trusts had been asked to review their arrangements to ensure deceased patients were treated with compassion, dignity and respect.

Non-executive Director, Lucy Nickson, enquired whether data and feedback were collected routinely. The Medical Director for Operational Stability and Optimisation confirmed that this was not undertaken formally, although medical examiners sought feedback from families regarding their experience of the process and mortuary arrangements. The Chief Nurse highlighted the role of the bereavement team and complaints received in relation to this theme.

The Deputy Chief Executive referred to previous discussions within committees and pathology meetings, she queried whether roles and responsibilities of each partner were clearly defined. She highlighted that the Health Building Note (HBN) mortuary checklist did not identify the governance arrangements and did not confirm who had completed the required checks. The Medical Director for Operational Stability and Optimisation acknowledged the need for coordination between the Trust and other services.

The Interim Chief Executive emphasised the need for clear and distinct responsibilities across the district general hospital arrangements.

In response to the Chair, the Medical Director for Operational Stability and Optimisation confirmed that the review had focused on five requirements set out by NHS England and the Chief Medical Officer was coordinating the overall response. The Interim Chief Executive requested that the response be coordinated to ensure all parties fulfilled their respective responsibilities. The Chief Nurse confirmed that mortuary arrangements had been included within the safeguarding policy and that unannounced visits were undertaken.

The Board:

- ***Noted the national requirements issued by NHS England and the Trusts Mortuary Oversight – Board Assurance Statement.***

P26/09/F4 **Fire Safety Policy**

The Chief Finance Officer confirmed that minor amendments had been made to the policy, including the addition of a memorandum.

The Board:

- ***Approved the Fire Safety Policy.***

P26/09/F5 **NHS Premises Assurance Model Assessment Report 2025/26**

The Chief Finance Officer presented the Premises Assurance Model, a compliance-based assessment, and recommended that the Board take moderate assurance across the four domains. Variation was reported across the categories, with facilities incorporated within the model and assessed as good.

Non-executive Director, Stephen Radford, confirmed that the Finance & Performance Committee had considered the assessment and taken moderate assurance.

The Chief Nurse referred to the infection prevention and control elements, and proposed that they be identified more clearly as estates policies, as the current wording made it difficult to determine specific requirements. Similar clarity was required in relation to completed risk assessments. She also noted that it would be helpful to include core members from the patient experience groups within the report.

The Interim Chief Executive enquired how compliance across the domains was being maintained. The Chief Finance Officer confirmed that the position remained broadly consistent.

The Chair enquired whether areas of non-compliance were being addressed through appropriate actions. The Chief Finance Officer confirmed that action plans were in place for all identified areas and were considered deliverable.

The Board:

- ***Approved and took moderate assurance from the NHS Premises Assurance Model Assessment Report 2025/26***

P26/09/G1 **2025-26 Annual Report & Accounts**

The Deputy Chief Executive Officer confirmed that the 2025-26 Annual Report & Accounts submission was made on 17 July 2026.

The Board:

- ***Noted the 2025-26 Annual Report & Accounts***

P26/09/H1 **Doncaster and Bassetlaw Healthcare Services Limited**

The Chief Finance Officer confirmed that the Wholly Owned Subsidiary reported strong financial performance year to date and that all required areas had been met.

The Board:

- ***Noted Doncaster and Bassetlaw Healthcare Services Limited report.***

P26/09/H2 **Constitution, Scheme of Reservation and Delegation & Standing Financial Instructions**

The Chief Finance Officer presented the Constitution, Scheme of Reservation and Delegation and Standing Financial Instructions, which had been considered by the Audit & Risk Committee. Amendments arising from the Committee's review had been incorporated, including clarification of high-value requisitions linked to approved contracts and the approval of contracts. The Finance & Performance Committee would have authority to approve items up to £500k, with matters above this threshold referred to the Board.

The Interim Chief Executive noted that the Executive Team's approval threshold was £250k, with matters between £250k and £500k requiring approval by the Finance & Performance Committee and items above £500k requiring Board approval. He considered that the £250k threshold was low and could present operational challenges.

Non-executive Director, Stephen Radford, enquired whether the revenue business case thresholds could be benchmarked against peer organisations. The Deputy Chief Executive highlighted the need to maintain an appropriate balance of external scrutiny.

The Interim Chief Executive confirmed that further review and clarification of the Standing Financial Instructions was required. **SW/BT**

The Board:

Agreed that the Constitution, Scheme of Reservation and Delegation and Standing Financial Instructions would be reviewed and returned to the Board in November 2026.

P26/03/H3 **Chair's Assurance Log – Finance & Performance Committee (Enclosure H1)**

The Board received the Finance & Performance Committee Chair's assurance log from July 2026's meetings, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

Moderate assurance had been taken in respect of the Green Delivery Plan, aligned to the Reset Programme. Significant assurance had been taken from the Digital Enablement Plan, with the Electronic Patient Record programme reported to be on track, and from the wider enablement projects.

The Board:

- ***Noted the Chair's Assurance Logs***

P26/09/H4 **Chair's Assurance Log – Quality Committee (Enclosure H2)**

The Board received the Quality Committee Chair's assurance log from August 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of

concern and decisions taken. The Committee Chair highlighted ongoing work in Sharps deep dive which received significant assurance and also highlighted the clinical care frameworks.

The Board:

- ***Noted the Chair's Assurance Log***

P26/09/H5 **Chair's Assurance Log – Audit & Risk Committee (Enclosure H4)**

The Board received the Audit & Risk Committee Chair's assurance log from July 2026's meeting, which summarised the assurance taken, areas of ongoing work, and matters of concern.

The Data Security and Protection Toolkit Annual Report received a low-risk opinion, equivalent to significant assurance. The Committee approved the Risk Management Policy and took significant assurance from the emergency preparedness, resilience and response arrangements.

The Board:

- ***Noted the Chair's Assurance Log***

P26/09/I1 **IPC annual Report**

The Board:

- ***Noted the IPC Annual Report***

P26/09/I2 **Safeguarding annual report**

The Board

- ***Noted the safeguarding annual report***

P26/09/J1 **Board Assurance Framework including Trust Risk Register**

The Board received the updated Board Assurance Framework and Trust Risk Register. Extreme risks had reduced by seven to 47. One risk had remained open for 96 months and was overdue for review. The digital risk had no active action, a potential assurance gap remained within Board Assurance Framework risk 7, and no risks had been escalated to the Hospital Leadership Team.

The Deputy Chief Executive confirmed that the Risk Management Group met monthly and reviewed risks unchanged for more than 12 months. Some estates risks could not reduce without wider improvements but remained visible. Risks would be recast where appropriate to ensure the principal strategic risks were recognised and discussed.

The Interim Chief Executive considered the financial risk assessment to be understated and asked whether sepsis was reflected in the Risk Register or Board Assurance Framework. The Deputy Chief Executive agreed that the Risk Management Group would review this, including whether all reasonable actions had been taken. **SW/ NM**

The Board

- ***Noted the report and current risk content.***

P26/09/J2 **Triangulation of Information to Identify Agenda Item Themes (verbal)**

The Board reflected that patient impact had been appropriately considered throughout the discussions.

Non-executive Director, Stephen Radford, noted that the discussion had triangulated several aspects of the Reset Programme.

The Deputy Chief Executive highlighted the links between the Winter Plan and Trauma & Orthopaedic Recovery Plan and recognised that the complexity of the issues would require difficult decisions.

P26/09/J3 **Board Effectiveness & Demonstrating the DBTH Way**

The Board reflected that the discussions had been appropriate and had enabled the matters presented to be fully considered.

P26/09/K1 **Minutes of the meeting held on 07 July 2026 (Enclosure J1)**

The Board:

- ***Approved the minutes of 07 July 2026.***

P26/09/K2 **Pre-submitted Questions regarding the business of the meeting (verbal)**

The pre-submitted questions were addressed during the meeting, and a formal written response would be provided.

P26/09/K3 **Board of Directors Work Plan (Enclosure F6)**

The Board:

- ***Noted the Board of Directors work plan***

P26/09/K4 **Any other business (to be agreed with the Chair prior to the meeting)**

There were no items of other business.

P26/09/K5 **Date and time of next meeting (verbal):**

Date: 03 November 2026
Time: 9:30am
Venue: Boardroom, Montagu Hospital

P26/09/K6 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

P26/09/L **Close of meeting (Verbal)**

The meeting closed at 13:31

2611 - A3 MATTERS ARISING AND ACTIONS FROM THE PREVIOUS MEETING

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

10 minutes

REFERENCES

Only PDFs are attached

A3 - BoD Action Log - 01 September 2026.pdf

Action notes prepared by: Anneleisse Siddall
Updated: 30 September 2026

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	01 September 2026

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	P26/07/B2	**Non-executive Director Oversight of National Reports / Guidance** To support increased awareness of national reports / guidance	ZJ	September 2026	**Update 12/8/2026 -** non-executive director colleagues to sign up to NHSE's The Week bulletin. **Action Closed.**
2.	P26/09/C1	**Sepsis Deep Dive** As there had been deterioration in Emergency Department Sepsis performance, it was proposed that a Deep Dive on Sepsis be presented to the Board.	NM	TBC	**Update 13/10/2026 –** to be carried forward and incorporated into December 2026 Board Development Session. **Action to be closed.**
3.	P26/09/D1	**Learning From Deaths** As Board and Quality Committee Assurance did not align, further work was required on Learning from Deaths which required further scrutiny. Improved reporting was also required to include impact, learning, and reoccurring themes Quality Committees meeting in October 2026. To return to the Board in November.	NM/Quality	November 2026	**Update 13/10/2026 –** to be carried forward and incorporated into December 2026 Board Development Session. **Action to be closed.**

Action notes prepared by: Anneleisse Siddall
Updated: 30 September 2026

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	P26/09/D4	**2026/27 Winter Plan** Exec Team to explore prioritisation of reserves, ahead of the winter plan.	Execs	October 2026	**Update 16/09/26 –** presented to the Executive Team, with further review carried out. **Update 22/09/26 –** Winter Plan was presented and approved within the Finance and Performance Committee. **Action to be closed.**
5.	P26/09/D4	**2026/27 Winter Plan – Board Assurance Statement** Subset of the Board to approve the winter plan Board Assurance Statement. To include Interim Chair, Interim Chief Executive, Chair of Quality Committee or Chair of Audit.	RJ/MB/TBC	October 2026	**Update 13/10/2026** – Board Assurance Statement submitted. **Action to be closed**.
6.	P26/09/D5	**Trauma & Orthopaedic Recovery Plan** To include tackle of demand including musculoskeletal demand and Patient-Reported Outcome Measure scores. Further Executive Review Required prior to final Approval.	DS	TBC	**Update 13/10/2026 –** work continues on the recovery plan
7.	P26/09/H2	**Constitution, Scheme of Reservation and Delegation & Standing Financial Instructions** Review the Constitutional documents including approval limits, and bring back to the next Board of Directors	SW/BT	November 2026	**Update 14/10/2026** – received by the Audit & Risk Committee on 15/10/2026. **Included on November's Board of Directors agenda.**
8.	P26/09/J1	**Board Assurance Framework including Trust Risk Register** To review the financial risk assessment. To ensure Sepsis was adequately captured on the Trust Risk Register.	SW NM	January 2027	**Update 13/10/2026** – to be considered by the Risk Management Group on 16/11/2026

2611 - BOARD REFLECTION & LEARNING

09:40

2611 - B1 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

B1 - Chair's Report including Partnership Update.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Chair's Report including Partnership Update**			
Sponsor:	Mark Bailey, Interim Chair			
Authors:	Adam Tingle, Deputy Director of Communications & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1-5			

Executive Summary – Key messages and Issues
This report provides the Board of Directors with an insight into the Chair's reflections, focusing on priorities for the Trust, its patients, people and partnership working since the last Board report in September 2026.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	The report acknowledges that patient experience, safety and quality of care remain a central focus of the Trust.
People	The report recognises colleagues' contribution, reinforces collaborative working, accountability, listening and speaking up for patient safety.
Partnerships	The report acknowledges the importance of working with partners to provide joined-up pathways, shared expertise, research and innovation to improve patient care.
Pounds	The report recognises the focused work of the Reset and Turnaround Programmes to focus on improving services while using public resources effectively and securing financial sustainability.
Health Inequalities	Addressing health inequalities is a strategic ambition of the Trust and ongoing work to bring services closer to the communities served supports this ambition.
Legal/ Regulation:	
Partner ICB strategies	

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

Chair's Report November 2026

Since my last report, Richard Jenkins, Interim Chief Executive, has completed his first two months at Doncaster and Bassetlaw Teaching Hospitals (DBTH), sharpening our work on improving services and our financial position. I thank Richard and all colleagues across the Trust for their leadership and commitment during this transition.

I'm pleased to advise in this report that I have accepted an invitation to extend my term as Interim Chair for a further six months from the end of this year, providing continuity as the Trust progresses arrangements to appoint a substantive Chair.

As referenced in the Chief Executive report, we are now in a focused period of Turnaround, bringing greater pace and scrutiny to our improvement work. The Board will continue to guide, support and provide constructive challenge where delivery falls short, and be ready to help address the barriers colleagues face; patient safety and quality of care remain paramount.

The experience of patients receiving care or waiting to receive care must remain central to our purpose. There is encouraging progress in some areas, including cancer care, but we know that access to emergency care, planned treatment and diagnostics needs to improve.

Our Three-Year Plan and supporting Reset Programme remain the foundation for a sustainable future, guiding changes to organise services well, support our workforce and use public resources wisely. These improvements must last beyond the immediate period of Turnaround.

I recognise what this asks of colleagues managing busy services and preparing for Winter. Clear expectations and prioritisation are important and equally for us all to succeed we need in all our roles to listen to each other and listen to understand and then act when facing our opportunities and our challenges.

Supporting improvement- partnership and innovation

Winter brings into focus how closely our services depend on one another and on our partners. Helping people move safely through hospital and return home with the right support requires shared responsibility across hospital, community and social care services. The relationships we build should help colleagues work through those boundaries in practice.

It is always good to take time to recognise our successes and as I hope we acknowledge together there are many instances 'day by day' where DBTH does 'extraordinary service'.

Two recent examples, also referenced in the Chief Executive Report, have particularly reinforced for me the value of partnership and innovation in improving care. Both demonstrate what can be achieved when colleagues combine their expertise around the needs of patients and are supported to develop their services over time.

The completion of our 500th day-case minimally invasive parathyroidectomy at Doncaster Royal Infirmary is a significant achievement. The service has developed over two decades through collaboration across clinical specialties, supported by sustained audit, research and shared learning. It is a reminder of the commitment behind clinical progress and the importance of creating the conditions for that work to continue.

Its day-case protocol has been adopted as a national model by Getting It Right First Time (GIRFT), and specialist input from Sheffield continues to support its development. I congratulate Mr Shahed Quraishi and

the whole team. Their work demonstrates how improving the experience of patients and using hospital capacity effectively go hand in hand.

The new kidney transplant assessment clinic offers another practical example. Nicola Beavers and transplant surgeons from Sheffield Teaching Hospitals have brought specialist assessment closer to home, reducing the travel and disruption experienced by patients preparing for a transplant. For patients and families managing a complex period in their lives, these changes will make a real difference.

These examples strengthen my conviction that our partnerships should be judged by the benefits they create for patients. Sharing expertise, developing research and joining up pathways give us opportunities to offer better care than any one organisation however well intended can achieve alone.

In this spirit, I am now having regular discussions with fellow Chairs in our region and beyond. There is much good will and a drive to clearly understand each other's strengths and where opportunities may present to further develop our respective services together. Our Boards and Executive Teams all have stated an intent to help one another, join up patient pathways and develop research and innovation across South Yorkshire and beyond. Our task is now to turn that into prioritised improvements that patients and colleagues can see and experience.

Our members and governors

Our Annual Members' Meeting on 23 September provided an opportunity to reflect on the year, share our progress and challenges, and hear from members about the services we provide. I thank everyone who attended and contributed to the discussion.

The relationship between the Board, our Governors and our members is particularly important as we take forward changes to the organisation. Governors bring the perspectives of the communities we serve and the colleagues who work here, helping us connect to their experiences and priorities.

Follow recent elections, I would also like to welcome our new governors and look forward to working with them.

Recognising our colleagues

Our annual Star Awards at Doncaster Dome on 8 October provided a welcome opportunity to recognise colleagues and teams from across the Trust.

I congratulate all our winners and nominees and thank everyone who took the time to put someone forward. A nomination tells a colleague that their contribution has been noticed and valued. Each year, the awards bring forward different teams and individuals, helping us recognise the breadth of talent, care and commitment across our hospitals and services.

That recognition matters particularly during a demanding period of change. The awards also give us examples to learn from: colleagues working together, taking responsibility and listening to those around them to improve care.

This connects directly with the messages of Line in the Sand: Collaborative relationships, personal accountability and speaking up for patient safety. These behaviours matter in the everyday decisions and conversations through which care improves. Every voice matters, and we need to make it easier for colleagues to contribute ideas, raise concerns and know that they will receive a thoughtful response.

My thanks go to the organisers and sponsors who made the Star Awards possible and helped us celebrate the contribution of our colleagues.

Working with Doncaster on our shared future

A recent visit by Ros Jones, Mayor of Doncaster, and Damian Allen, Chief Executive of City of Doncaster Council, to see the ongoing works within our Department of Critical Care provided an opportunity to reflect on how investment at Doncaster Royal Infirmary connects with the city's wider regeneration.

The development of our sites and services through the Shape pillar of Reset forms part of this shared opportunity. Our hospitals support local health, employment and training, while regeneration can help our communities and services thrive.

Our Health on the High Street ambitions also offer opportunities to improve access by bringing appropriate services closer to communities. I welcome the continuing dialogue with the Council on how we can develop these plans together, with a clear understanding of priorities and available resources.

Looking ahead

The examples in this report show the strengths we can build on: Clinical expertise, committed colleagues and partnerships that improve care. As we address our service performance and financials and head into winter, we need to ensure these strengths inform how we make the right choices and enable the improvements we all wish to see for our communities. It will always be front of mind that we understand the combined impact of any change on patients and colleagues, ensure that improvements last, and remain open to opportunities to achieve more with our partners.

We will keep listening to colleagues and communities, act positively to recognise achievement and constructively face into situations where progress is not where it needs to be.

Together we will succeed and in doing so we will make an even greater difference to the lives of anyone and everyone who needs our care.

2611 - B2 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Chief Executive's Report including Partnership Update**			
Sponsor:	Dr Richard Jenkins, Interim Chief Executive			
Authors:	Emma Shaheen, Director of Communications & Engagement			
Appendices:	N/A			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1-5 & 7			

Executive Summary – Key messages and Issues
This report provides an overview of the Trust's operational performance, identifies progress against its strategic priorities, and confirms associated risks and key areas of focus going forward.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	The report highlights clinical innovation and improved local access to joined up care. There remains a focus on ensuring patients receive timely care, recognising current challenges in urgent and emergency care, elective and diagnostic pathways.
People	The report highlights the Trust's commitment to recognise, support and develop its people.
Partnerships	The report demonstrates the value of working in partnership for the benefit of our patients.
Pounds	The report sets out the need for financial sustainability and the approach taken to increase scrutiny and improve the pace of delivering change.
Health Inequalities	The report identifies positive improvements to support access and the provision of specialist services.
Legal/ Regulation:	
Partner ICB strategies	

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

Chief Executive Report, November 2026

1. Operational performance

Performance remains mixed across our key access standards. Cancer pathways continue to perform strongly against plan and there are areas of improvement in ambulance handovers, theatre utilisation and reductions in some long-wait cohorts. However, four-hour urgent and emergency care performance, referral-to-treatment performance and diagnostic access remain below trajectory.

In September, 73.3% of patients attending Type 1, 2 and 3 emergency departments were admitted, discharged or transferred within four hours against a trajectory of 76.0%. Doncaster remains the principal driver of underperformance, particularly for admitted pathways. Average ambulance handover time was 18 minutes against a 20-minute plan, although performance against the 15-minute handover measure remained below standard. The proportion of patients spending more than 12 hours in the Emergency Department was also above trajectory. A new urgent and emergency care improvement programme will launch in November, focusing on SDEC, clinical decision-making, specialty pathways, streaming and stronger real-time operational oversight.

Elective performance remains behind plan. September referral-to-treatment performance was 63.9% against a 67.1% trajectory, while 1,467 patients were waiting more than 52 weeks. Trauma and Orthopaedics and ENT continue to account for the majority of these longest waits with significant numbers of patients waiting over 65 weeks. Weekly oversight and specialty recovery plans remain in place, with additional operational capacity focused on the most challenged specialties. Additional focus on the longest waiting patients and a recovery trajectory for Referral-To-Treatment is rapidly being developed.

Diagnostic performance was 75.3% of patients receiving their test within six weeks, against a trajectory of 82.4%. MRI and Audiology account for the majority of patients waiting over six weeks. Additional capacity is in place for both services, including seven-day MRI working and additional Paediatric Audiology capacity, with recovery plans focused on improving the position by December 2026.

Cancer performance remains a relative strength. The latest reported position was ahead of plan for the Faster Diagnosis Standard, the 31-day decision-to-treatment standard and the 62-day referral-to-treatment standard. The priority is to sustain this performance while accelerating recovery in the other access standards.

2. Progress against our strategic priorities

Patients

A specialist team at Doncaster Royal Infirmary has completed DBTH's 500th minimally invasive parathyroidectomy as a day-case procedure. The procedure allows eligible patients to have the affected parathyroid gland(s) removed through a small incision in the neck and return home on the same day without an overnight stay. The team reports the largest series of its kind in the country. This is an important national milestone for DBTH and a strong example of clinical expertise improving the experience of patients while supporting effective use of hospital capacity.

In October, DBTH also delivered its first endoscopic ultrasound list, establishing this activity at the Trust for the first time. This represents another positive development in the clinical services available locally and reflects the expertise and ambition of the teams involved.

Two further specialist clinics have also launched, improving access to more joined-up care for patients. A new kidney transplant clinic at Doncaster Royal Infirmary enables patients preparing for transplant to receive specialist surgical assessments locally, working in partnership with Sheffield Teaching Hospitals and reducing the need to travel to Sheffield. A new Epilepsy in Pregnancy Clinic has also brought maternity and epilepsy specialists together at Doncaster Royal Infirmary, working with Rotherham Doncaster and South Humber NHS Foundation Trust to provide more coordinated specialist care and support for women throughout pregnancy.

People

In October, we celebrated colleagues from across DBTH at our annual Star Awards, attended by more than 400 people following over 500 nominations from colleagues and members of the public. The awards recognised individuals and teams for their contribution to patient care, teamwork, teaching, health equality, fundraising, sustainability and improvement. Congratulations to all those nominated and recognised, and thank you to everyone involved in making the event possible.

We are also progressing our response to the new NHS Staff Standards and Leadership and Management Framework. These set clearer national expectations for colleague experience and effective leadership and management. Much of this aligns with work already under way through the DBTH Way, We Care values, our People Plan and Culture and Leadership work, and we are now mapping our existing arrangements against the new requirements and identifying any areas where further action is needed.

The national staff survey is underway. At the time of writing, DBTH's response rate was above the sector average. Thank you to colleagues who have already taken the time to complete it. We continue to encourage everyone who receives the survey to share their views, with the ambition of achieving a higher completion rate than last year and ensuring that as many colleague voices as possible inform our improvement work.

Our seasonal flu vaccination programme has also started well, with more than 30 per cent of our frontline colleagues vaccinated at the time of writing. We continue to encourage eligible colleagues to take up the vaccination offer as part of our preparations for winter and our shared commitment to protecting patients, colleagues and services.

Partners

Partnership working remains an important part of our improvement approach, particularly in urgent and emergency care and discharge. DBTH has successfully joined the NHS England Discharge Improvement Programme, with work focused on reducing Pathway Zero delays, improving patient tracking and escalation, and supporting improved bed occupancy ahead of winter. Progress across other discharge pathways will continue to depend on close working with community, social care and intermediate care partners.

Over the past month, we have also continued discussions with partners across Doncaster to progress our 'Health on the High Street' ambitions, with a shared focus on moving this work forward at pace and exploring how services can be brought closer to the communities we serve.

In October, DBTH also launched new detailed access guides to help patients, visitors and colleagues plan their visits with confidence. Developed in partnership with AccessAble, the UK's leading provider of detailed accessibility information, and funded by Doncaster and Bassetlaw Teaching Hospitals Charity, the guides provide practical accessibility information across our hospital sites and services.

Pounds

Financial sustainability is a key focus for the Trust and central to delivering the ambitions set out in our Three-Year Plan and supporting Reset programme. We face a significant financial challenge, with further detail on our current position provided in the Chief Finance Officer's report. We have entered a period of Turnaround to bring spending into line with our income and put services on a more sustainable footing. Patient safety and the quality of care remain paramount throughout this work.

Turnaround brings greater pace and scrutiny to our immediate financial improvement work, linked to the longer-term changes in delivery needed for sustainability. This includes tighter controls on spending, recruitment and temporary staffing, alongside improvements in how we organise services and use our resources. The Executive Team has overall oversight, supported by our Turnaround Director, with weekly meetings to monitor delivery, address risks and hold leaders to account. Accountability at every level will be essential, and all proposed changes will be assessed for their impact on patient safety, quality of care and colleagues.

The Trust's Mutually Agreed Resignation Scheme (MARS) closed on 16 October, with 187 applications received from colleagues. These are now being assessed to identify where changes can support sustainable workforce structures and longer-term financial improvement. Applications will only be supported where safe staffing and high-quality patient care can be maintained.

3. Looking ahead: risks and priorities

3.1 Key risks

- Delivering recurrent financial improvement at the pace and scale required, including closing the gap between the efficiency plan and the current risk-adjusted forecast.
- Operational performance remaining below trajectory across urgent and emergency care, elective care and diagnostics, with particular pressure from long waits in Trauma and Orthopaedics and ENT.
- Winter pressures increasing emergency department crowding, inpatient flow and discharge delays.
- Improvement actions not translating into sufficiently consistent and sustained recovery across all services and sites.
- Capacity and capability to deliver significant operational, financial, workforce and digital transformation simultaneously, including preparation for the Electronic Patient Record.

3.2 Key priorities

- Accelerate Turnaround, moving schemes to full maturity and identifying further recurrent opportunities.
- Launch and embed the new urgent and emergency care improvement programme, with particular focus on Doncaster, patient flow and operational grip.
- Continue specialty-level elective recovery, validation and productivity work, particularly in Trauma and Orthopaedics and ENT.

- Deliver diagnostic recovery plans for MRI and Audiology while sustaining strong cancer pathway performance.
- Embed the NHS Staff Standards and Leadership and Management Framework through existing DBTH culture, leadership, appraisal and development arrangements.
- Maximise staff survey participation and seasonal flu vaccination uptake as part of our focus on colleague experience and winter resilience.

4. Board takeaways

- Performance remains mixed but overall adverse to agreed trajectories. Cancer pathways and some productivity measures are positive, but urgent and emergency care, elective access and diagnostics require sustained improvement.
- The Month 6 financial position remains significantly adverse to plan and recurrent efficiency delivery must accelerate.
- Clinical innovation continues alongside the improvement challenge, including the 500th day-case parathyroidectomy and the Trust's first endoscopic ultrasound list.
- The NHS Staff Standards and Leadership and Management Framework provide a further opportunity to strengthen and evidence work already under way through the DBTH Way, People Plan and Reset.
- As we approach winter, organisational grip, flow, financial delivery and support for colleagues remain central to maintaining safe and sustainable services.

2611 - B3 SHIRLEY'S STORY (DIGITAL)

Information Item | Karen Jessop, Chief Nurse | 10:00

10 minutes

2611 - C ASSURANCE - PATIENTS, PEOPLE, PARTNERSHIP & POUNDS

10:10

2611 - C1 IMPERATIVES REPORT - MONTH 6

Discussion Item | Michael Wright, Interim Deputy Chief Executive | 10:10

15 minutes

REFERENCES

Only PDFs are attached

C1 - Imperatives Report.pdf

C1 - Appendix 1 - Imperatives Report - M6.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	03 November 2026
Report Title/ Ref:	**Imperatives Report 2026/27 – Month 6**			
Sponsor:	Michael Wright, Interim Deputy Chief Executive			
Authors:	James Tabor, Associate Director of Planning, Performance & Improvement			
Appendices:	Appendix 1 - Imperatives Report 2026/27 – Month 6			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	**Information**	~~Discussion~~
Proposed assurance Level	N/A			
Assurance Rationale	N/A, the report is provided for information and oversight of delivery against the Trust's agreed 2026/27 plans.			
Impacts on Strategic Risks (BAF 1-7)	Supports oversight of strategic risks relating to finance, workforce, patient access and operational performance.			

Executive Summary – Key messages and Issues

The Imperatives Report is a new report that brings together the Trust's most important financial, workforce and operational performance measures in a single framework. It tracks actual performance against agreed plans and trajectories throughout 2026/27, highlighting progress and emerging variances.

The latest available data are used for each measure. Reporting periods vary in line with national submission and validation timetables, including the Provider Finance Return (PFR), Provider Workforce Return (PWR) and other national returns.

Recommendations

The Board of Directors is asked to note the Month 6 Imperatives Report and the position against agreed plans and trajectories.

Healthier together – delivering exceptional care for all	
Patients	Provides oversight of patient access and operational performance measures.
People	Includes workforce measures and their performance against plan.
Partnerships	Supports oversight of delivery against relevant system priorities.
Pounds	Includes financial performance against the agreed 2026/27 plan.
Health Inequalities	No direct impact arising from this information paper.
Legal/ Regulation:	No direct legal or regulatory decision is requested.
Partner ICB strategies	Supports the monitoring of Trust delivery against relevant national and system priorities.

Assurance Route	
Previously considered by - including date:	Finance and Performance Committee, 27 October 2026.
Any outcomes/next steps / time scales	The Imperatives Report will be refreshed monthly as new data becomes available and reported through the governance processes.

DBTH Imperatives Report 2026/27 - Month 6

Based on the national planning submission, focusing on the key metrics NHSE would expect the Board to be sighted on and those where NHSE have set targets

Definitions and Escalations

£ - information from the monthly NHSE Provider Finance Return (PFR).

Surplus/(deficit) and income exclude Non-Recurrent Deficit Support Funding (DSF)

Efficiency - scheme-level risk profile from the PFR.

Cash status compares revenue cash with the four-day minimum requirement.

Orange status cells require escalation.

September RTT figures are currently unvalidated.

52+ and 65+ week waits include all incomplete pathways exceeding those thresholds.

WTE figures are contracted WTE from the monthly NHSE Provider Workforce Return (PWR), not worked WTE.

£ - information from the monthly PFR.

Month 6 Provider Workforce Return is currently still in development

Sickness actuals are from the DBTH monthly workforce report not NHSE published data.

Previous year comparison derived from the FY2025/26 Month 12 PFR.

		1 Actual Apr-26	2 Actual May-26	3 Actual Jun-26	4 Actual Jul-26	5 Actual Aug-26	6 Actual Sep-26	7 Forecast Oct-26	8 Forecast Nov-26	9 Forecast Dec-26	10 Forecast Jan-27	11 Forecast Feb-27	12 Forecast Mar-27	Total
Finance	*Income excluding DSF - in Month Actual (£k)*	51,910	52,254	51,866	51,797	52,990	53,047							313,864
	Pay - in Month Actual (£k)	(36,586)	(36,656)	(35,399)	(36,693)	(36,997)	(37,357)							(219,688)
	Non Pay (inc non-op + adj.) - in Month Actual (£k)	(17,821)	(17,361)	(18,582)	(17,722)	(18,852)	(19,300)							(109,638)
	I&E (Deficit)/Surplus excl. DSF - in Month Actual (£k)	(2,497)	(1,763)	(2,115)	(2,618)	(2,859)	(3,610)							(15,462)
	I&E (Deficit)/Surplus excl. DSF - in Month Plan (£k)	(2,164)	(2,098)	(2,118)	(1,636)	(1,245)	(1,092)	(966)	(1,031)	(1,087)	(627)	(644)	(992)	
	On Track/Off Track	Off Track	On Track	On Track	Off Track	Off Track	Off Track							
	I&E (Deficit)/Surplus - in Month Actual Underlying (£k)	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	
	I&E (Deficit)/Surplus excl. DSF - YTD Actual (£k)	(2,497)	(4,260)	(6,375)	(8,993)	(11,852)	(15,462)							(15,462)
	I&E (Deficit)/Surplus excl. DSF - YTD Plan (£k)	(2,164)	(4,262)	(6,380)	(8,016)	(9,261)	(10,353)	(11,319)	(12,350)	(13,438)	(14,065)	(14,709)	(15,700)	(15,700)
	On Track/Off Track	Off Track	On Track	On Track	Off Track	Off Track	Off Track							
	I&E (Deficit)/Surplus - YTD Actual Underlying (£k)	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	
	Efficiencies - Low Risk (£k)	2,523	2,818	2,284	1,495	1,660	1,222	1,431	1,318	1,371	1,266	1,287	1,774	20,448
	Efficiencies - Medium Risk (£k)	190	(78)	(48)	20	33	7	782	480	506	596	616	665	3,771
	Efficiencies - High Risk (£k)	-	-	484	-	(0)	75	3,585	3,585	3,585	3,585	3,585	3,585	22,072
	Efficiencies - Unidentified (£k)	-	-	-	-	-	-	-	-	-	-	-	-	-
	Efficiencies - YTD Forecast (£k) (Risk Adjusted)	2,712	5,452	8,173	9,688	11,382	12,687	15,256	17,537	19,888	22,201	24,536	27,337	27,337
	Efficiencies - YTD Plan (£k)	2,712	5,452	8,172	11,377	15,386	19,546	23,841	28,071	32,245	36,939	41,616	46,290	46,290
	On Track/Off Track	On Track	On Track	On Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	
	Capital Cash - in Month actual/forecast - closing balance (£k)	18,059	9,492	6,248	7,145	5,061	10,990	22,432	20,064	18,625	17,594	13,846	7,617	7,617
	Revenue Cash - in Month actual/forecast - closing balance (£k)	13,013	9,406	1,893	4,930	5,261	(3,881)	1,678	2,897	4,195	9,403	10,727	16,513	16,513
	Total Cash - in Month actual/forecast - closing balance (£k)	31,072	18,898	8,141	12,075	10,322	7,109	24,111	22,962	22,821	26,997	24,574	24,130	24,130
	Four-day minimum cash requirement (£k)	6,970	6,666	6,885	6,709	6,797	7,211	6,600	6,832	6,617	6,556	7,257	6,600	6,600
	On Track/Off Track - Revenue Cash vs 4-day minimum	On Track	On Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	On Track	On Track	On Track	
Operational	RTT Performance - Actual	61.6%	62.6%	64.1%	63.6%	63.5%	63.9%							
	RTT Performance - Plan	64.2%	64.8%	65.3%	65.9%	66.5%	67.1%	67.7%	68.3%	68.8%	69.4%	70.0%	70.6%	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	RTT - PTL WL Size Actual	53,490	54,205	54,327	54,941	55,386	55,981							
	RTT - PTL WL Size Plan	52,916	52,885	53,263	54,276	54,963	55,267	55,700	55,185	54,487	53,631	53,463	52,809	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	4 Hour Performance - Actual	74.6%	71.2%	71.3%	73.3%	74.6%	73.3%							
	4 Hour Performance - Plan	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	80.0%	80.7%	76.7%	77.8%	81.6%	82.0%	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	RTT 52+ Week Waits - Actual	1,165	1,330	1,445	1,626	1,553	1,467							
	RTT 52+ Week Waits - Target	485	441	399	362	321	276	232	184	136	223	312	0	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	RTT 65+ Week Waits - Actual	106	59	69	150	210	268							
	RTT 65+ Week Waits - Target	0	0	0	0	0	0	0	0	0	0	0	0	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
Workforce	*Contracted WTE - Substantive, actual*	6,265.3	6,232.4	6,276.6	6,253.3	6,303.8	6,275.2							
	Contracted WTE - Bank, actual	306.1	330.4	322.4	326.6	335.2	320.8							
	Contracted WTE - Additional Sessions, actual	TBC	TBC	TBC	TBC	TBC	TBC							
	Contracted WTE - Agency, actual	52.0	61.5	50.0	64.1	65.0	71.2							
	Contracted WTE - Total, Actual	6,623.4	6,624.2	6,649.1	6,644.0	6,704.0	6,667.2							
	Contracted WTE - NHSE Plan	6,704.7	6,700.5	6,713.7	6,690.8	6,702.8	6,709.2	6,675.8	6,680.6	6,686.8	6,554.5	6,554.5	6,300.9	
	On Track/Off Track	On Track	On Track	On Track	On Track	Off Track	On Track							
	Agency Spend - in Month Actual (% reduction, -% increase vs prior ye	18.9%	21.3%	30.3%	16.0%	4.6%	-2.5%							
	Agency Spend - YTD Actual (% reduction, -% increase vs prior year)	18.9%	20.2%	23.2%	21.2%	18.1%	15.3%							
	Agency Spend - YTD Actual (£k)	826	1,808	2,472	3,525	4,488	5,402							
	Agency Spend - YTD NHSE Cap (£k)	680	1,360	2,041	2,721	3,401	4,081	4,761	5,441	6,122	6,802	7,482	8,162	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	Bank Spend - in Month Actual (% reduction, -% increase vs prior year	-1.4%	-6.8%	-11.9%	-33.5%	23.5%	-1.9%							
	Bank Spend - YTD Actual (% reduction, -% increase vs prior year)	-1.4%	-4.1%	-6.6%	-12.2%	-2.2%	-2.2%							
	Bank Spend - YTD Actual (£k)	1,457	3,025	4,496	6,000	7,594	9,099							
	Bank Spend - YTD NHSE Cap (£k)	1,383	2,766	4,149	5,532	6,915	8,299	9,682	11,065	12,448	13,831	15,214	16,597	
	On Track/Off Track	Off Track	Off Track	Off Track	Off Track	Off Track	Off Track							
	Sickness - Actual (%)	5.5%	5.7%	5.7%	5.8%	5.8%	6.0%							
	Sickness - Plan (%)	5.8%	5.8%	5.7%	5.6%	5.6%	5.5%	5.5%	5.5%	5.5%	5.6%	5.5%	5.5%	
	On Track/Off Track	On Track	On Track	On Track	Off Track	Off Track	Off Track							

2611 - C2 FINANCE & PERFORMANCE COMMITTEE CHAIR'S ASSURANCE LOG

Discussion Item | Non-executive Director | 10:25

5 minutes

REFERENCES

Only PDFs are attached

- C2 - Finance and Performance Committee Chair's Assurance Log - 22.09.2026.pdf
- C2 - Finance & Performnce Committee Chair's Assurance - 27.10.2026.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Finance & Performance Committee - Chair's Highlight Report to Trust Board		
Subject:	**Finance & Performance Committee**	**Board Date:** 03 November 2026
Prepared By:	Stephen Radford, Non-executive Director & Finance & Performance Committee Chair	
Approved By:	Finance & Performance Committee Members	
Presented By:	Stephen Radford, Non-executive Director & Finance & Performance Committee Chair	
Purpose	The paper summarises the key highlights from the Finance & Performance Committee meeting held on **22 September 2026**	

Matters of Concern (***Moderate, Limited,*** **or** ***Weak*** **Assurance)**	**Work Underway / Major actions commissions**
Operational Performance / Access Standards – August 2026 – Moderate Assurance **Emergency Care:** • Emergency Department (ED) 4 hours performance was 74.6%, against a trajectory of 76%. A 2.7% improvement compared to July, but performance remains off plan • The performance is driven by underperformance at the Doncaster site. Maintaining effective grip and control of the non-admitted pathway over a 24/7 period is key. **Elective Care:** • Trust performance for percentage of patients waiting less than 18 weeks from referral to treatment improved slightly month on month to 63.1% (unvalidated) against a target of 66.5% • Over 52 week waits - 2.8% (unvalidated) of patients were waiting >52 weeks against the trajectory of 0.6%. An increase of 0.1% month on month. • The most significant risk to >18 week & 52-week performance targets are Trauma and Orthopaedics speciality and Ear Nose Throat. Substantive improvements are required or both targets are likely to be missed by the Trust. **Cancer:** • Performance was ahead of plan for Faster Diagnosis Standard, 31 day and 62 day waiting time standards, reflecting effective pathway management • There was a detailed discussion on the level of assurance with some members of the F&P Committee feeling there was not sufficient evidence of recovery or sustainability in operational performance. They felt that Limited Assurance should be accredited and not Moderate.	

- The F&P Committee however as a majority assigned Moderate Assurance feeling on balance that there was sufficient evidence of improvement.

Board Assurance Framework Risk 3 - Demand, Capacity & Flow - Moderate Assurance

- The F&P Committee received an update on the Board Assurance Framework 3 - Demand, Capacity & Flow
- The Committee noted the remains rated 16, against a target rating of 12 by March 2028.
- Limited assurance has been reported through the internal audits of cancer data quality and patient flow, with a focus on discharge.
- The timetable for implementing frailty and surgical Same Day Emergency Care has been revised to November 2026
- As with Operational Performance, some members of F&P felt that Limited and not Moderate assurance should be accredited given issues with sustainability and ongoing performance challenges.
- The Committee however as a majority assigned a Moderate level of assurance based on the report provided.

Getting It Right First Time and Elective Productivity Update Q1 2026/27 - Moderate Assurance

- The F&P Committee received the report on the Getting It Right First Time priorities: Further Faster, theatres and outpatients for Q1 2026/27
- The Committee noted that gaps remain in theatre utilisation and estate use, and outpatient Did Not Attends (DNA), Patient Initiated Follow-up and remote delivery measures and in particular, the need to improve our DNA performance.
- Given the progress made to-date in Further Faster compliance, theatre throughput and implementation of delivery controls that had been achieved, the Committee assigned a level of Moderate assurance

Trust Reset Programme – Limited Assurance

- The F&P Committee received the month 5 update on the Reset programme and the 6 pillars within the programme.
- Year-to-date delivery is £11.4m against £15.4m, giving a £4m shortfall.
- Cost Improvement Programme (CIP) development is behind schedule and off plan. The pace of CIP programme needs to be enhanced, or this will invariably have a detrimental impact on Debt Support Funding.

• Workforce and Organisational Design remains the principal delivery challenge and remains significantly under-budget and off plan. • The Committee noted that 'plan B' potential savings had been developed but even with these a shortfall was still being projected. • The immediate focus is converting the existing forecast into in-year delivery and reduce reliance on later-year phasing. • Given delays to the programme and the amount off plan the F&P Committee assigned only Limited Assurance to the Reset Programme **Financial Performance - Month 5 – Limited Assurance** • For month 5, the Trust reported a £7.9m year to date deficit, which is £5.2m adverse to plan due to Deficit Support Funding (DSF) not being achieved for Q2, unachieved efficiencies, offset by non-recurrent technical benefits. • An application for DSF for Q2 is due to made but will be lower than budget. • The financial position is being significantly affected by shortfall in the Reset Programme • The underlying forecast deficit exit rate for 26/27 exit rate remains at £10.1m which is in line with the Medium-Term Plan. • In the year to-date, Trust Improvement Development Programme schemes implemented in the year will yield recurrent full year savings of £17.1m. Year to date in-year savings which also includes non-recurrent are £11.4m but are off plan by £4.0m. • Agency costs reduced month on month to £0.9m but are off plan. Bank costs increased month on month to £1.5m and are also off plan. • Cash balance is £10.3m and has reduced by £1.7m owing to the timing of the receipt of quarterly Education monies. An application for additional funding to NHSE is in-progress. • A deep dive is planned again in October 2026 on agency/bank with a special focus on Medical and Allied Health Professionals staffing. The results from this will be shared with the People Committee and to perform further follow-up where required. • The F&P Committee assigned Limited Assurance. This aligns with the assurance position on the Reset Programme.	

Substantial, Significant, Assurances	Decisions Made
Procurement Enabling Plan 2025-28 – Significant Assurance • The F&P Committee received the update on Year 1 of the Procurement Enabling Plan 2025-2028 • The Committee noted the positive progress that made against the 69 deliverables, recognising that some had been updated as required. • The Committee approved the changes to the plan and assigned Significant Assurance based on the progress made to-date. **Board Assurance Framework Risk 7- Digital/Cyber- Significant Assurance** • The F&P Committee received an update on BAF 7. • The Committee noted that good progress has been made against BAF Risk 7. This included Board oversight and operational governance arrangements for the Electronic Patient Record (EPR) programme and the work continuing to achieve full clinical safety assurance for existing systems by April 2027 and ahead of EPR go-live in November 2027. • The Committee assigned a significant level of assurance based on the report provided.	**Business Case – Replacement X-Ray Room 4 & Fracture Clinic At DRI** • The F&P Committee received the business case for the replacement of X-Ray equipment that had reached the end of life. • The equipment replacement had been provisioned for in the Trust capital budget and would be procured under an existing framework contract. • After discussion around the recommended option and possible additional costs, the F&P Committee recommended the business case to the Board for final review and approval. **Winter Plan 2026/27** • The F&P Committee received the updated Winter Plan 2026/27 for review and after discussion around the changes that had been made since the last draft, the plan was approved for implementation. • The Committee noted that the proposal reflected previous years' experience and expected demand. • The F&P Committee noted that the plan would now be staggered with defined escalation points and that the maximum outlay would be £1.1m. **Quarter 2 – Deficit Support Funding Assurance Statement** • The F&P Committee received the draft Quarter 2 DSF Assurance Statement for review and approval. • The Committee noted that receipt of the DSF allocation is conditional on sustained delivery of the approved financial recovery plan • The Trust has not been able to deliver a fully compliant assurance statement and as such the Trust is planning on receipt of a reduced level of DSF support for the quarter 2 2026. **Application For Revenue Cash Support** • The F&P Committee received the draft Application for Revenue Cash Support for review. • The Trust's liquidity position has reached a point where it is prudent and appropriate to apply to receive revenue cash support. • Cash injection into the Trust is being requested from NHSE for November & December 2026. Further cash injections may be required and will in part be dependent on delivery of cash releasing CIP savings and the payment of Deficit Support Funding. • The Committee approved the Request.

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent, and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Subject:	**Finance & Performance Committee Meeting**	**Board Date:** 3 November 2026
Prepared By:	Jo Gander, Non-Executive Director & Committee Chair	
Approved By:	Finance & Performance Committee Members	
Presented By:	Jo Gander, Non-Executive Director & Committee Chair	
Purpose	The paper summarises the key highlights from the Finance & Performance Committee meeting held on 27th October 2026	

Matters of Concern (*Moderate, Limited,* or *Weak* Assurance)

- **Financial Performance Month 6** **Limited Assurance**
  The Trust remains under significant financial pressure despite some improvement in overall risk position. Savings delivery and financial sustainability remain major concerns.

  - YTD deficit £11.5m, £9m adverse to plan due to a £6.9m shortfall on efficiency delivery and £3.9m Quarter 2 Deficit Support Funding (DSF) not being earned, partially offset by non-recurrent technical benefits.
  - Savings delivery £12.7m, £6.9m adverse to plan
  - Underlying deficit estimated at £50.5m an updated method of calculating the underlying deficit has been prepared, which aligns to the PAM.
  - Outpatient New, Outpatient Follow up, and day case activity were below plan in September. Elective was above plan; however, ERF activity is below plan. Year to date, outpatient new and outpatient follow up are behind plan and day case and elective are above plan.

- **Agency & Bank Optimisation Deep Dive** **Moderate Assurance**
  Temporary staffing expenditure remains a material risk. Stronger governance and controls are now in place but delivery of financial improvements are dependent on reduction of vacancies, shorter recruitment
  times and improved sickness rates.

Work Underway / Major actions commissions

- **South Yorkshire Diagnostic Pathology Improvement Trajectory** – Deputy CEO to discuss histology performance with a specific emphasis on Doncaster next week and to provide a further update following the meeting at next Board.
- **Winter Plan Business Case** to be presented at next FPC following consideration at Corporate Investment Group.
- **Provider Assurance Model Month 6** noted

Previous FPC recommended the deep dive findings to be shared with the people committee. Following recent feedback from QC regarding increased sickness rates and lowering staff morale, request updated to ask People Committee for additional insight and recommendations on how the position can be improved.

- **Reset Programme Oversight inc. IDP Programme** **Limited Assurance**
  Month 6 recovery position remains significantly behind plan. Savings delivery, workforce reductions and recurrent sustainability continue to present material risk despite turnaround governance. Recovery programme and governance proposal in development for discussion at next board. Further, current saving projections are not expected to deliver in line with plan.

- **Digital & Data Progress Report incl. Progress on the Electronic Patient Record (EPR)** **Moderate Assurance**
  EPR on track for Nov 2027, key risk related to capability of chosen supplier of the Single Cancer Management System

- **Local Security Management Bi Annual Report** **Moderate Assurance**
  Whilst significant assurance is provided that effective management controls are in place and proactive efforts are taken to manage security effectively, incident data confirms an increased prevalence of violence and aggression incidents and examples of multiple security incidents posing a risk to the organisation.

- **Board Assurance Framework (BAF) Risks 4 & 5 and Trust Risk Register** **Moderate Assurance**
  Estate risks remain high until funding formally confirmed for key works. Agreed to review financial controls as despite current controls being enacted some risks score at 25. Updated BAF 5 controls to be presented to Board in due course.

Substantial or *Significant,* Assurances	Decisions Made
• **Capital Infrastructure Programme** **Significant Assurance** NHS England has committed to fund a revised £250m Preferred Way Forward option for the East Ward Block, with formal confirmation expected in early November 2026. In addition, £14.9m of Estates Safety Funding has been secured. Major schemes progressing include: Critical Care relocation, MRI upgrade, Urgent & Emergency Care redevelopment and Montagu Community Diagnostic Centre	• Contracting & Procurement Update/Significant High value contract recommended to Board for approval ➢ Managed Print services • High Value Business Cases recommended to Board for approval ➢ Replacement of Angiography Systems at DRI ➢ Replacement Pharmacy Robot at Bassetlaw

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
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Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2611 - C3 QUALITY COMMITTEE CHAIR'S ASSURANCE LOG

Discussion Item | Helen Best, Non-executive Director | 10:30

5 minutes

REFERENCES

Only PDFs are attached

C3 - Quality Committee Chair's Assurance Log.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Committee Meeting - Chair's Highlight Report to Trust Board

Subject:	**Quality Committee**	**Board Date: 3 November 2026**
Prepared By:	Jo Gander, Non-executive Director & Quality Committee Chair	
Approved By:	Quality Committee Members	
Presented By:	Jo Gander, Committee, Non-executive Director & Quality Committee Chair	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on **8 October 2026**	

Matters of Concern (Limited or Weak)	**Work / Major actions commissions**
• **Audiology Lessons Learnt Report – Limited assurance** **Paediatrics** Continued investment is required to ensure that all staff are signed off as competent and the service continues to improve DM01 performance and reduce the size of waiting lists. Recruitment to date for 2 x B6 Paediatric Audiologists/B5 developmental role has been unsuccessful to date. Adherence to National Standards will be essential to achieving full assurance and IQIPs accreditation in the near future. Current average length of wait is 34 weeks. While the waiting list is growing and we do not have Paediatric staff signed off, assurance meetings with the Integrated Care Board will not be stood down. **Adults** DM01 continues to rise and sits at 85% for August 2026. Average wait for new patients has reduced from 52 weeks to 3.5 weeks. However, to date the focus has been on new referrals but now needs to switch to patient reviews. Review patients stood at 6,500 in Dec '25 and now stands at 4,600. We do not have adequate available capacity to facilitate seeing all these patients within this financial year. We are currently insourcing and providing additional review capacity, but the waiting list will still be above 2,000 at the end of this financial year. While the review list remains this high assurance meetings with the ICB will not be stood down.	Items brought to the Quality Committee for information. • Leaning for improvement and Digital Patient Story – the committee noted the progress made and that governance and oversight arrangements are in place to monitor implementation, effectiveness, and overall improvement. • Mental Health Act Compliance Annual Report – Executive team to review report to identify elements for future presentation at Quality Committee vs elements where DBTH Mental Health Service provider requires contractual management via operational management structure. • Quality priorities progress update • Getting It Right First Time • Urgent and Emergency Care - Care Quality Commission (CQC) Action Plan update. • Workplan review

Substantial Significant or Moderate Assurances	Decisions Made
• **Perinatal Quality & Safety report** - **Significant Assurance** The report was received and demonstrated significant assurance from the detail provided within the report. Concerns were raised regarding current staff sickness levels, which appear to be linked to the impact of ongoing escalating demands and scrutiny which is beginning to affect staff morale and wellbeing. In addition, the Committee recognised the increasing resource requirements needed, to maintain the current reporting demands, including those to sustain compliance with the NHS Resolution Maternity Incentive Scheme. • **Quarterly Patient Experience Report inc. Picker Impatient Survey results – Moderate Assurance** The report demonstrated that arrangements to capture, respond to and to learn from patient feedback are strengthening along with improvements in engagement activity, accessibility initiatives, and governance oversight. Challenges remain in complaint timeliness, consistency of organisational learning and achieving Friends and Family Test (FFT) response rates. • **Safeguarding Accountability and Assurance Framework – Moderate Assurance** From the 16 areas reviewed, 4 areas of review were identified as requiring further strengthening. 1. Safeguarding Training 2. Safeguarding supervision 3. CP-IS (Child protection information Sharing 4. Embedding Safeguarding at every level of the organisation The Committee were significantly assured of the process and governance structure, however, due to the recent reduction in safeguarding compliance the committee felt they could only be moderately assured that these arrangements were enough. without evidence of a positive upturn in safeguarding compliance. • **Patient Safety Report including Martha's rule implementation – Moderate Assurance** The Committee took assurance that robust patient safety governance, incident review and organisational learning processes are in place. Whilst DBTH has been identified as an outlier in national benchmarking for Learn from Patient Safety Events reporting timeliness, this relates primarily to delays in submission to the national system arising from current DATIX system limitations and the Trust's data validation processes, rather than deficiencies in incident reporting, investigation, learning or oversight. Improvement actions remain in place	The Committee on behalf of the Trust Board took significant assurance from the detail provided within the Perinatal Quality & Safety report and recorded in the Committee minutes to provide evidence for the Maternity Incentive Scheme the following. • Perinatal Quality Oversight measures (PQOM) Data & Maternity Metrics (Appendix 1) • Perinatal Mortality Review Tool (PMRT) Q1 compliance (Appendix 2) • Thematic review (Appendix 3) • Neonatal Nursing Staffing Action Plan (Appendix 4) • Perinatal Culture Improvement Plan (Appendix 5) • Q4 25-26 DBTH – Local Maternity and Neonatal System (LMNS) Assured position (Appendix 6) • Maternal Care Bundle (Appendix 7) • Progress to achieve NHS Resolution Maternity Incentive Scheme Year 8, 6 safeties. Actions (appendix 8) The Committee was further asked to record that the Quality Committee, on behalf of the Trust Board, has been sighted on: • The number of perinatal deaths • The number of Maternity and Newborn Safety investigations (MNSI) and Early Notifications Scheme (ENS) cases reported within required timescales. • Evidence that parental feedback is routinely sought, received, and used to inform PMRT Reviews • Assurance that families receive appropriate information in a timely manner; and • Assurance that meetings with parents following a perinatal death are routinely offered. • The Maternal Care Bundle quarter one progress update has been reviewed and approved on behalf of the trust board. • The Board Safety Champions continue to meet bi-monthly with the Perinatal Leadership Team, and any support required from the Trust Board has been identified and is being progressed. • Level 1 Maternity Operational Support System (MOSS) signal was received on the 18 September 2026. • The Quality Committee has reviewed and discussed any exceptions, concerns and risks identified within this report and has agreed any matters requiring escalation to the board.

- **Clinical Audit progress inc. National Clinic Audit Alerts relevant to DBTH – Moderate Assurance**
  Several outstanding overdue actions linked to access to treatment and performance against national measures.

  National Audits
  National Clinical Audit of Seizures and Epilepsies for children and Young People (Epilepsy 12).
  The trust exceeded the national benchmark across all four reported measures, including specialist nurse involvement, appropriate Tertiary referral, mental health screening, and communication regarding care planning.

  National Early Arthritis Audit/ National Early Inflammatory Autoimmune Audit
  The trust achieved 62.3% remission at 3 months, compared with the national value of 34%, performance against access and treatment measures remains below the national benchmark, patients seen within 3 weeks and treated within 6 weeks of referral. The rheumatology service has been identified as an outlier and has undertaken a comprehensive review, with actions implemented to address the factors contributing to the current performance. Assurance level applied due to the current position and lack of evidence supporting impact of implemented actions on trajectory.

- **Quality of Care Trends via review of IQPR metrics – Moderate Assurance**
  There is evidence of sustained performance in several indicators including CHPPD (Planned vs Actual Care hours per patient day) delivery, Duty of Candour compliance, patient experience, and the absence of MRSA bacteraemia during the reporting period.
  However, several key indicators remain outside agreed trajectories, notably Clostridioides Difficile, MRSA colonisation, E Coli bacteraemia and Pseudomonas infections demonstrating that whilst mitigating actions are established further improvement is required to deliver sustained performance recovery.

- Board Assurance Framework (BAF) Risk 1, including Trust Risk Register discussion triangulated to the assurances provided by the reports on the agenda, which linked to the required actions in progress. The Committee recommend this updated BAF version to the Board of Directors.

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
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Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2611 - C4 PEOPLE COMMITTEE CHAIR'S ASSURANCE LOG

Discussion Item | Lucy Nickson, Non-executive Director | 10:35

5 minutes

REFERENCES

Only PDFs are attached

C4 - People Committee Chair's Assurance Log.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board		
Subject:	**People Committee**	**Board Date: 3 November 2026**
Prepared By:	Lucy Nickson, Non-Executive Director & People Committee Chair	
Approved By:	People Committee Members	
Presented By:	Lucy Nickson, Non-Executive Director & People Committee Chair	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 20 October 2026	

Matters of Concern (*Moderate, Limited,* or *Weak* Assurance)	**Work Underway / Major actions commissions**
Workforce Supply and Demand Advanced Practitioner Workforce – split assurance - **Moderate /Limited** Moderate assurance was agreed in relation to actions taken to meet the annual planning requirements for 2027/28– detailed national guidance is not yet available. Limited Assurance was agreed against year 1 of the Medium-Term Plan and actual and planned WTE reduction. The MARs scheme is expected to improve the scale of the WTE reductions needed, which may improve the assurance position going forward. **Education Report** – **Moderate Assurance** Although the recent 360 audit provided significant assurance on governance and controls, the committee heard that trust-wide SET compliance remains below the 90% target at 85.99%, and SET+ at 86.65%. It was agreed a recovery plan is needed. Work is underway for transition to the new NHS England statutory and mandatory training framework. Placement capacity remains sufficient despite reductions in nursing, medical and midwifery learner numbers. However, reductions in nursing, medical and midwifery learner numbers were noted and increases in AHPs. The supply of graduates nurses and midwives may not match demand in coming years, and more work needs to be done on the workforce plan to better understand supply and demand. Work continues to strengthen supervision, placement opportunities, and the Safe Learning Environment Charter. AHP placements have increased, and work continues to strengthen supervision, placement opportunities, and the Safe Learning Environment Charter. The 2026 GMC National Training Survey demonstrates significant improvement	**NHS Staff Standards & Leadership and Management Framework**. NHSE has published two new frameworks which relate to employee experience and leadership practice. The committee heard about current relevant activity aligned to the new national frameworks, evidenced though the DBTH Way, 'We Care' values, the People Plan 2023–27 and the Culture and Leadership pillar. Initial analysis has not identified any significant competency gaps although there will be areas for further focus. A more detailed mapping exercise against the Staff Standards is in progress, and the committee will retain oversight.

overall, particularly in Paediatrics, Obstetrics and Gynaecology and Intensive Care Medicine. Targeted improvement and monitoring continue for Urology, Vascular Surgery and Acute Internal Medicine. CPD investment. Resident Doctors 10-point plan – **Moderate Assurance** Of 19 rated key lines of enquiry, 16 are compliant and three are partially compliant, with no non-compliance. Improvements and progress is evidenced across key areas, including in annual leave reform. Rota-coordinator training has moved from non-compliant to partially compliant. Strong evidence continues across rota transparency, board-level leadership, mandatory training, exception reporting, and expense reimbursement. The remaining partially compliant areas are workplace wellbeing, rota-coordinator training, and monthly payroll error reporting, with mitigating actions to address being put in pace to move these areas to full compliance. People Committee retains oversight but the gaps in control in relation to BAF reporting have now been addressed.	
***Substantial & Significant* Assurances**	**Decisions Made**
Engagement & Leadership – Significant Assurance The committee was provided with an update on the four schemes contained within the Trust's Culture and Leadership pillar (Reset programme). Progress is reported as being on track against agreed actions. The committee also received an overview of the current position in relation to the national staff survey, which opened on 18 September 2026. There was a detailed discussion about culture, governance, and oversight of it. The committee has good oversight of many of the current measures regarding culture but agreed that the longer-term impact of the changes being implemented will also need to be measured through future survey results and wider cultural indicators over time. **Health and Wellbeing Report – Significant Assurance** The Committee took significant assurance that comprehensive Health and wellbeing offer continues to be in place based on engagement data, feedback, and	**Health and Wellbeing Report** On the basis that there is separate reporting on the PNA and PMA activity, the committee agreed to take a more detailed look at this activity at a future meeting, with a view to deciding on ongoing reporting as a standalone item, or to continue with it being embedded into the HWB report. **Designated Body Annual Report Statement of Compliance** Recommend submission to NHS England by 31 October 2026, following completion of the Trust's approval and sign-off process

measurable outcomes. Robust plans are in place for the 2026/27 flu vaccination campaign – the committee recognises the target for flu vaccination is a stretching one at 60%. 45.6% was achieved in 2025/26.

The Professional Nurse Advocate (PNA) and Professional Midwifery Advocate (PMA) offer provides colleagues at DBTH with access to restorative clinical supervision, reflective support, facilitated debriefing, career conversations, professional development, and quality improvement support. Overall, evidence indicates the PNA/PMA offer is becoming embedded in DBTH's health and wellbeing infrastructure, providing accessible restorative support to colleagues, while contributing to attendance, retention, learning, quality improvement, and a healthier workplace culture.

Nursing Workforce Bi-annual Report – Significant Assurance

The Committee heard evidence that robust arrangements are in place to review, monitor and determine nursing workforce requirements across the Trust. Establishment recommendations are informed through triangulation of nationally recognised workforce tools, patient acuity and dependency data, quality indicators, workforce metrics, and structured professional judgement. Effective governance processes are in place to identify, escalate and mitigate workforce risks, with clear action plans to address areas requiring further investment or review. Whilst operational pressures and workforce challenges remain, there is evidence that these risks are understood and actively managed, providing confidence that appropriate controls are operating effectively to support safe, high-quality patient care.

Safe Staffing Compliance -Significant Assurance

The period May to August 2026 was discussed. The Trust has remained compliant with national nursing and midwifery workforce reporting requirements and continues to maintain robust systems and processes to support safe staffing, risk escalation, workforce deployment, and patient safety. Agency usage has now been eliminated across nursing, midwifery, and theatre services, with strengthened controls in place regarding bank and overtime utilisation. For Sep and November 2026, recruitment activity remains robust, with 77 newly qualified nurses commencing in post and a continued focus on healthcare support worker recruitment and workforce transformation initiatives. Midwifery services remain fully recruited against funded establishment, although sickness absence continues to require targeted management.

Research & Innovation Bi-annual Report – Significant Assurance

Reporting provided evidence of Good Clinical Practice regulatory compliance. R&I activity is on track to deliver both contractual obligations and the R&I delivery plan. The Committee noted that effective processes and short-term mitigations are in place to deliver against the new 150-day clinical trial set up target, with work underway to identify long-term sustainable mitigation to address the limitations in Pharmacy and clinical research delivery. An external bid for in-year funding has been successful to support in these areas.

Phase 2 of the Clinical Research Hub, (to add two bedded day bays) is on track commenced 5 October 2026 with Phase 2 planned to be fully operational in early 2027. It is intended that the enhanced provision will provide better facilities and care for patients recruited to clinical trials requiring more intensive treatments.
Work is underway to develop plans for growing capabilities and capacity in earlier phase clinical trials.

Designated Body Annual Report Statement of Compliance

The committee noted the Medical Appraisal and Revalidation Annual Board Report and Statement of Compliance for 2025/26. Significant Assurance taken from evidence presented in the report noting effective systems and controls in place to support the Trust's statutory responsibilities for medical appraisal, revalidation, and professional standards.

Committee noted the achievement of 100% medical appraisal compliance, with no unapproved missed appraisals, no late revalidation recommendations and no doctors failing to revalidate during the reporting period. The committee approve the annual report and endorsed the Statement of Compliance - subject to any final amendments, for onward organisational approval and signature. The committee noted the improvement priorities for 2026/27

Board Assurance Framework (BAF) Risk 2 and Risk Register- Significant Assurance

There were no new gaps in controls recognised and clear evidence of gaps in controls being closed since last committee meeting.

It was agreed that it is important to look at the principle risks again to ensure that current activities and targets regarding workforce reduction and any subsequent impact on people and culture are clearly articulated in BAF 2.

The committee is able to recommend the current actions and controls to the board

and agreed a rating of significant assurance based on current reporting. There was a good discussion around all of the evidence presented in the risk report, the inherent and target risk scores, and the new format reporting for the BAF. Committee was satisfied the committee business was appropriately relevant to and aligned with the articulated risks and controls. **Flexible Working Annual Report** The committee received and noted the annual report. Delivery of the Flexible Working is aligned to the three success measures in the People Plan 2023–2027: delivery of the action plan; growth in the range and accessibility of opportunities; and improvement in staff survey measures. This report presented to committee reviews progress over the past 12 months, including analysis of data between 1 September 2025 and 31 August 2026. Manager engagement with data quality work is required to ensure records are accurate, as only 37.9% of flexible working requests submitted during the reporting period had a final outcome recorded at the point of capture. However, requests that did have a recorded final outcome show a positive picture with 95% of these requests accepted or an alternative being accepted. **Appraisal Season** The committee received a report providing a detailed overview of the 2026 appraisal season, The Trust achieved 91.63% completion in the 2026 appraisal season exceeding the 90% standard for a third consecutive year, although performance reduced from 93.28% in 2025. A quality assurance process is in place to help review and ensure the quality of appraisal conversations.	

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2611 - C5 AUDIT & RISK COMMITTEE CHAIR'S ASSURANCE LOG

Discussion Item | Kath Smart, Non-executive Director | 10:40

5 minute

REFERENCES

Only PDFs are attached

C5 - Audit & Risk Committee Chair's Assurance Log.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Audi & Risk Committee (ARC) - Chair's Highlight Report to Trust Board

Subject:	**Audit & Risk Committee**	**Board Date: 3 November 2026**
Prepared By:	Kath Smart, Committee Chair & Non-Executive Director	
Approved By:	ARC Committee Members	
Presented By:	Kath Smart, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the Audit & Risk Committee meeting held on 15 October 2026	

Matters of Concern (*Limited,* or *Weak* Assurance)	**Work Underway / Major actions commissions**
a) Internal Audit Report – SYB Pathology Network Benefit Realisation review – Split opinion with 'Limited Assurance' for assurance flows within SYBP and to partners. IA concluded that individual governance forums in SYBP largely meet their TOR's, however there were variances in the structures operating in practice, versus those articulated in the Business case. DBTH had previously some performance concerns with SYBP and noted Recommendations should improve the situation.	k) Constitution review – • ARC requested the Board had oversight of the plans to ensure compliance with para 25.11 "Independence: at least half of the Board (excluding the Chair) are to be independent non-executive directors" (para 25.11 of the Constitution); • Tenure – ARC noted that Board and NHSE will need to note the clarification of NED/ Chair Tenure requirements as outlined in 28.1 and 28.2, and any impact upon Chair/ NED recruitment • Compliance and self assessment on the Code of Governance to be brought back to February's ARC • ARC Terms of Reference in relation to the newly developed Corporate Governance Manual to be reviewed l) 360 Assurance work on Provider License compliance – Scope to be agreed before February ARC. Agreed this would sit outside of the audit programme m) Declarations of Interest – Follow up with a small number of decision makers which have not yet made a declaration of interest n) Losses/ Compensations report - Triangulation with a Quality Committee report & recent ED/NED Ward visit identifies ongoing losses with respect to Patient Hearing Aids. ARC requested response on where oversight of new process would be reported into and impact.

	o) BAF – Work to bring BAF 2 to reflect current position to be carried out by next People Committee; Overdue actions to be reviewed by BAF owners and BAF actions review to be completed by Finance Committee actions due to cycle of BAF review
***Moderate, Substantial, Significant,* Assurances**	**Decisions Made**
p) Internal Audit :- Progress report including Audit Recommendations closure rate for high & medium risks -100% which remains very positive significant assurance q) Internal Audit Report – SYB Pathology Network Benefit Realisation review – Split opinion with significant assurance on the performance oversight role of STH. r) CounterFraud – Quarter 3 26/27 demonstrated significant assurance in the arrangements for fraud prevention, detection and investigation. Lower than normal Fraud survey response has resulted in actions to improve for next year and training compliance is being monitored following a small dip s) Patient Flow – Internal Audit Actions update – Moderate assurance opinion was assigned, as although progress is positive and 1 recommendation (1/7) has been implemented, risks remain to achievement of the other actions. t) Single Tender Waivers and Losses & Compensations reports – These were agreed to provide significant assurance. u) Risk Management & the Board Assurance Framework – This report was given significant assurance with some clear actions agreed in relation to overdue actions; cross referencing to Reset challenge/ delivery and People Committee review next week in relation to Culture work. Key message to BAF owners in understanding the actions which are overdue and updating in a timely way. v) Emergency Planning Resilience and Response (EPRR) Assurance Statement - ARC took significant assurance from the update, reporting 94% compliance rate in relation to the Trusts arrangements for EPRR	o) The Trust Constitution, Standing Financial Instructions; & Scheme of Reservation & Delegation – There were all reviewed and recommended to the Board for approval with additional actions (listed above). p) Audit Committee approved the External Quality Assessment for 360 Assurance and will receive the results of the review q) Audit Committee supported the re-appointment of 360 Assurance as internal auditors and Counterfraud Plus as the counter-fraud service provider for 2026/27.

(improved from 82% previous year). Validation to be carried out & reported back. w) Register of Interest – This presented a significant assurance to the Committee, albeit ARC requested follow-up of a small (4) number of decision makers x) SBS System Annual Assurance Statement – A moderate opinion was assigned, as PWC gave an unqualified opinion, with a number of actions which needed progressing with SBS.	

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2611 - C6 BOARD ASSURANCE FRAMEWORK COMPLIANCE & RISK REGISTER

Decision Item | Brenda Thomas, Interim Company Secretary | 10:45

Executive Directors
10 minutes

REFERENCES

Only PDFs are attached

C6 - Board Assurance Framework Complaince & Risk Register.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**03 November 2026**
Report Title/ Ref:	**Board Assurance Framework Compliance and Risk Register**			
Sponsor:	Richard Jenkins, Interim Chief Executive			
Authors:	Brenda Thomas, Interim Company Secretary Tracy Evans -Philips, Trust Risk Manager			
Appendices:	Appendix 1: Risk Report and Trust Risk Register Appendix 2: BAF Risk 1 - 7			
Purpose of the report	**Assurance**	**Approval/decision**	~~Information~~	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	All BAF risks are effectively managed and monitored via the appointed committees and the Board of Directors.			
For decision papers only: Is this in line with Current risk appetite NO	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested			

Avoid	Minimal	Cautious	Open	Seek	Mature
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

This report presents the Board Assurance Framework (BAF), incorporating reviews completed up to 21 October 2026, and the Trust Operational Risk Register extracted on 12 October 2026. The Board is asked to discuss and approve the current BAF risk content and note the operational risk position.

Board Assurance Framework

Revised format of the Board Assurance Framework

This is the first time the Board has received the BAF in its revised format. The presentation has been redesigned, drawing on good practice at other trusts, so that the key messages and the strength of assurance are easier to see. The content of each risk has been carried over from the previous format. The main changes from the previous structure are:

- **Summary dashboard:** previously a score-history table and a list of the principal risks with their linked operational risks. The BAF now opens with a one-page summary showing, for each risk, the lead committee and executive lead, the inherent, current and target scores, movement since the last report, risk appetite, linked operational risks, open gaps, action status and the lead committee's assurance level.
- **Heat map and key messages (new):** each risk's current position is plotted against its March 2028 target, alongside the key messages for the Board.
- **Score trend and linked risks:** the score history and the principal risks with their linked significant operational risks are retained, now colour-coded and placed after the summary.
- **Risk pages:** previously a header table, a controls and assurance table with the line of assurance shown as (1), (2) or (3) after each source, and actions table. Each risk now has its own page with a title band and risk statement, a key facts and scores panel, a new section setting out the rationale for the current score and the key changes this period, sources of assurance in separate columns for the first, second and third lines, and an action plan showing the status of each action.
- **Assurance levels (new):** each lead committee records an overall level of assurance for its BAF risks, using the Trust's assurance levels (Substantial, Significant, Moderate, Limited and Weak).
- **Method and keys:** the methodology, the three lines of assurance and the assurance level definitions have moved to the end of the BAF as a reference key.
- **Committee reporting:** each Board committee now receives its BAF risks in the same format, with each risk presented separately with its own summary page.

The Audit and Risk Committee reviewed the revised format at its meeting on 15 October 2026 and recommended it to the Board for approval. As this is the first reporting cycle in the new format, some new elements are still to be completed and will be in place for the next report - these are in red text.

Key changes by BAF risk

BAF 1: Care Quality (Quality Committee) Score unchanged at 16 (4 × 4).
Updated to reflect maternity and neonatal assurance requirements, including the Maternity Incentive Scheme, national 10-point plan and Thirlwall Inquiry. CQC urgent and emergency care actions continue with strengthened executive oversight, while the clinical policy action is agreed for closure following improvements in policy management. The Learning from Deaths Manager is now in post and GC5 is proposed to close, and the due dates for GA1 (SHMI (Summary Hospital-level Mortality Indicator) data quality), GC4 (structured judgement reviews) and GC11 have moved to January 2027. BAF 1 was discussed at the Quality Committee before the revised BAF format was introduced. The assurance level, the rationale for the risk score and the key changes are new features of the format; these are shown in red and will be completed and presented at the next Quality Committee meeting.

BAF 2: People and Culture (People Committee, 20 October 2026) Score unchanged at 16 (4 × 4).
Progress continues across attendance, leadership and culture actions, with the Supporting Attendance at Work action completed and further actions proposed for closure. A new assurance gap has been added for Internal Audit Statutory and Essential Training actions, alongside additional independent assurance through Freedom to Speak Up and workforce planning activity. The People Committee assessed the level of assurance as Moderate.

BAF 3: Access (Finance and Performance Committee, September 2026) The overall risk position remains unchanged at 16 (4 × 4). The Urgent Treatment Centre First model remains suspended following Care Quality Commission (CQC) feedback, while the frailty and surgical Same Day Emergency Care (SDEC) implementation date has moved to November 2026, with the proposal progressing through the Executive Team.

BAF 4: Estates and Environment (Finance and Performance Committee, 27 October 2026) The estates risk remains unchanged at 20 (4 × 5). Site evacuation planning actions are complete and proposed for closure, while additional maintenance funding is not currently available and the related action (GC1a) is proposed to close. Site development planning continues, with the target moved to March 2027, alongside ongoing progress on capital investment and external funding. A new action records successful bids for Estates Safety Fund (£24m over four years) and Return to Constitutional Standards urgent and emergency care (£32m) funding, alongside a £100m pre-commitment for the East Ward Block.

BAF 5: Financial Sustainability (Finance and Performance Committee, 27 October 2026) The most significant change is the escalation of the current financial sustainability risk from 16 to 25, reflecting significant shortfalls in savings delivery affecting the deficit and cash position. The inherent score has also been re-scored from 20 to 25. The risk statement has been updated, several actions have completed or closed, and work continues on savings delivery, medical rostering and resolution of the £6.5m contract misalignment with South Yorkshire Integrated Care Board (ICB). The contract misalignment has been escalated to chief executives, who met on 20 October 2026 and agreed actions; the revised date is November 2026. With the inherent and current scores now the same, this indicates that the existing controls are not currently reducing the risk, driven by significant shortfalls in Reset Programme savings delivery affecting both the deficit and the cash position. The inherent and current scores now the same indicates that the existing controls are not currently reducing the risk, driven by significant shortfalls in Reset Programme savings delivery affecting both the deficit and the cash position.

BAF 7: Digital and Cyber (Finance and Performance Committee, September 2026) Score unchanged at 15 (3 × 5). Progress continues on digital and cyber resilience, with Board oversight, Electronic Patient Record (EPR) partnership arrangements and unsupported system actions completed. Remaining activity focuses on EPR interoperability and third-party cyber assurance, aligned to the November 2027 EPR go-live, alongside implementation of IT service management improvements. GC9 is proposed to close as a duplicate of GA2. The changes made before the Committee are shown in red or struck through in Appendix 2.

Overall: The principal material movement is the escalation of BAF 5, financial sustainability, from 16 to 25 because of significant shortfalls in savings delivery and the resulting impact on the deficit and cash position. The Committee did not assess the level of assurance, but requested a further review of the controls, setting which controls are not

working, the additional controls and actions being taken. The revisions made should be presented to the next Committee meeting.

Other BAF risk scores remain unchanged.
Across the BAF, there is evidence of actions completing and moving into established governance, alongside continued focus on access, estates, digital/EPR and quality assurance gaps. No BAF actions are reported as overdue; one (BAF 3 GC9) is at risk.

The clean BAF is provided at Appendix 2.

Trust Operational Risk Register

The operational risk profile continues to reduce. Active risks fell from 344 in August 2026 to 319 in October 2026 and are 80 lower than in October 2025, a reduction of 20%. In October 2026, the register comprised 42 extreme, 167 high, 100 moderate and 10 low risks. Between August 2026 and October 2026, 11 new risks were added, four were escalated, 13 were downgraded and 41 were reported as archived; most risks remained at the same rating.
Risk review compliance improved materially. Overdue risks reduced from 25 in September 2026 to five in the October 2026 report, representing 1.6% of the register and within the 5% target. No risks rated 15 or above were overdue, and divisional assurance compliance for risks rated 12 and below reached 98.4%. This provides evidence of stronger and more timely review arrangements.

Further improvement is required in two areas. Action-plan compliance for risks rated 15 and above was 74%, with 29 of 39 actions on schedule, and risk management e-learning compliance was 88.25% against the 90% target. Both remain subject to targeted follow-up through the Risk Management Group.
The Risk Management Group continues to provide structured oversight through monthly moderation, review of long-standing risks, alignment with the BAF and targeted deep dives. Finance and Medicine deep dives provided additional challenge and identified where further evidence of control effectiveness and delivery is required. The generator fuel storage risk was escalated to the Hospital Leadership Team in September 2026. A new Trust risk concerning the postponed replacement of the risk management system and limitations of DatixWeb is due for review in November 2026 and may be escalated if unresolved.

The Trust Operational Risk Register is provided at Appendix 1.

Overall assurance
The report provides significant assurance that strategic and operational risks are subject to established review and escalation arrangements. This assurance is balanced by the material financial risk escalation and the remaining gaps in action-plan and training compliance, which require continued Board and committee oversight.

Recommendations

The Board is asked to:

- Approve the revised format of the Board Assurance Framework, as recommended by the Audit and Risk Committee on 15 October 2026, noting the elements still to be completed;
- Approve the increase in BAF 5 (financial sustainability) risk score from 16 to 25 and note that the controls, assurance and gaps in assurance will be reviewed further ahead of the next Finance and Performance Committee;
- Note that the BAF and Trust Risk Register are live documents, which will be reviewed and updated regularly throughout the year.

Healthier together – delivering exceptional care for all

Patients	Regular review and assessment of the risks support the delivery of safe and effective services.
People	Regular review and assessment of strategic risks, support our people to deliver safe and effective care.

Partnerships	Regular review and assessment of strategic risks, supports the identification of partnership and collaboration risks and opportunities as part of a triangulated approach to risk management.
Pounds	Regular review and assessment of strategic risks, support delivery of the strategic priority to be sustainable and spend money wisely. Regular review may identify areas of financial or resource risk and opportunities as part of a triangulated approach to risk management.
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities
Legal/ Regulation:	It is a regulatory requirement as part of the NHS Code of Governance for the Board of Directors to have mechanisms in place to manage and address risk throughout the organisation.
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies.
Assurance Route	
Previously considered by - including date:	Audit and Risk Committee: 15 October 2026 - recommended the revised BAF format to the Board for approval) Quality Committee: 8 October 2026 (not in the new format) People Committee: 20 October 2026 Finance and Performance Committee: 27 October 2026.
Any outcomes/next steps/ time scales	Further discussion at Board Committees.

Appendix 1 - Trust Operational Risk Register

Summary of data extracted from Datix Risk Management System 12 October 2026
Author: Tracy Evans-Phillips, Trust Risk Manager

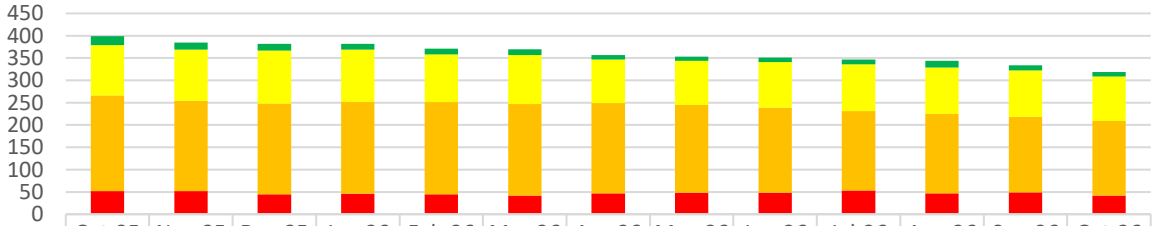
Introduction

This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the continued efforts of the Risk Management Group to assess and moderate risks, including escalations and any new developments in risk management practices.

Please note: The information provided is based on the date the reports were compiled. Specific figures are subject to change throughout the month as live updates occur within the risk management system.

Risk Activity August 2026 to October 2026

The overall number of risks recorded on the Trust Risk Register continues to reduce, falling from 344 in August 2026 to 319 in October 2026. This reduction is reflected across all risk levels, with extreme risks decreasing from 47 to 42, high risks from 178 to 167, moderate risks from 104 to 100 and low risks from 15 to 10. The longer-term trend also remains downward, with 319 risks recorded in October 2026 compared with 399 in October 2025, representing a reduction of 80 risks (20%).



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Low	20	16	15	13	13	13	10	9	10	11	15	12	10
Moderate	113	115	119	117	107	110	98	99	102	105	104	104	100
High	214	202	203	206	206	205	202	197	191	178	178	169	167
Extreme	52	52	45	46	45	42	47	48	48	53	47	49	42

Overview of Risk Numbers and Changes (August 2026 to October 2026)

- Risks archived: 41
- New risks added: 11
- Risks escalated (risk rating increased): 4
- Risks downgraded (risk rating decreased): 13
- Risks with no change in rating: 285

Between August 2026 and October 2026, there were 354 risk register movements or reviews. Most risks (285) remained at the same rating, while 41 were archived and 13 were downgraded. Four risks were escalated and 11 new risks were added. Overall, the data shows that most risk ratings remained stable during the period, alongside continued activity to review, reduce and close risks.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	**5**	
Moderate	**13**	
High	**20**	Fit testing implemented, trauma backlog reduced, access to specialist palliative care in Bassetlaw, increase in switchboard colleagues
Extreme	**3**	Electronic solution to paper-based documentation, electronic prescribing in ED
Total	**41**	

Risk Management Group (RMG) Update

RMG oversight and assurance

The Risk Management Group (RMG) continues to provide structured oversight of the Trust Risk Register, including review and moderation of new and existing risks, monitoring of long-standing risks and actions, alignment with the Board Assurance Framework (BAF), and consideration of emerging risks. The October 2026 meeting also reviewed an enhanced BAF dashboard incorporating risk appetite, linked operational risks, score trends and three lines of assurance.

Performance highlights

Improved risk review compliance

Risk review compliance improved significantly between September 2026 and October 2026. Overdue risks reduced from 25 in September 2026 to five in the October 2026 report, representing 1.6% of the register and within the 5% target. By the October 2026 meeting, only one divisional risk remained overdue. Divisional risk assurance compliance for risks rated 12 and below reached 98.4%.

The overall operational risk profile also reduced, with active risks decreasing to 319 and extreme risks reducing from 49 to 42 in October 2026. No risks rated 15 or above were overdue.

Continued improvement in risk management capability

RMG continues to strengthen risk management through monthly risk moderation, scrutiny of long-standing risks and targeted follow-up where assurance requires improvement. Risk management e-learning compliance was 88.25% in October 2026 against the 90% target, with targeted improvement work continuing.

Action-plan compliance for risks rated 15 and above was 74% in October 2026, with 29 of 39 actions on schedule. RMG agreed follow-up of overdue and missing actions to support further improvement.

Enhanced assurance deep dives

The deep-dive programme continued during September 2026 and October 2026, with focused reviews of Finance and Medicine risks. These reviews provide RMG with additional challenge and assurance over controls, mitigating actions, risk scores and areas requiring further attention.

Key evidence from the deep dives

The Finance deep dive found established governance and oversight across the financial risk portfolio, while recognising that significant challenges remain around recurrent savings, productivity, income, workforce and delivery of the financial plan. Assurance across the risks reviewed ranged from Limited to Significant, enabling RMG to identify where further evidence of delivery remains necessary.

The Medicine deep dive reviewed five operational risks. Evidence included improving stroke four-hour assessment performance, which increased from 61% to 73%, alongside established clinical controls. The review also identified areas requiring further work, including a digital visibility gap affecting some patients, the clinical environment for dermatology patients, and capacity associated with liver surveillance. Assurance was assessed as Moderate or Limited where an assurance level was recorded, with further actions identified.

Overall impact

The September 2026 and October 2026 meetings demonstrate continued strengthening of risk oversight, particularly through improved review compliance, systematic challenge of risk scores and controls, enhanced BAF reporting, and targeted deep dives. Areas not yet meeting expected standards, including action compliance and risk management learning, remain under active RMG oversight with targeted follow-up in place.

Risks escalated to Hospital Leadership Team (HLT)

HLT escalation and further review

In September 2026, RMG agreed to escalate the risk relating to insufficient generator fuel storage to HLT. Following consideration, HLT directed Estates and Facilities to explore modification and use of existing fuel storage at Doncaster, with an options appraisal required for Bassetlaw.

No new escalation to HLT was agreed in October 2026. RMG did, however, support creation of a Trust risk relating to the postponed replacement of the risk management system and limitations of DatixWeb. This will be reviewed in November 2026 and may be escalated to HLT if unresolved.

Appendix 1 Trust Risk Register

Following review of the Board Assurance Framework, some risks previously recorded as overarching risks are now linked directly to the relevant BAF strategic risk. As a result, more risks are shown individually on the Trust Risk Register. The register table has also been updated to provide clearer information about each risk.

Risks with extended duration are reviewed through a scheduled Deep Dive at Risk Management Group on a rolling basis.

BAF	Risk ID	Risk Owner	Title	Review date	Regular Review	Rating (current)	Rating (Target)	Risk score requires review	Time at current risk rating (months)	Duration requires review	Number of Dependent Extreme Risks	Action Status
BAF 1	1517	Chief Pharmacist	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	30/03/2027	✓	15	6	No	26 Months	RMG Deep Dive ✓	0	✓
BAF 1	3209	Chief Operating Officer	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	30/11/2026	✓	8	6	No	14 Months	No	0	✓
BAF 1	3246	Deputy Chief Nurse	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	30/01/2027	✓	12	9	No	6 Months	RMG Deep Dive ✓	0	✓
BAF 1	3290	Chief Nursing Officer	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	01/12/2026	✓	10	6	No	38 Months	RMG Deep Dive ✓	0	✓
BAF 1	3454	Chief Medical Officer	Insufficient governance and service gaps risk failure to meet guidance, leading to harm, regulatory action, and reputational damage	18/12/2026	✓	16	8	No	29 Months	RMG Deep Dive ✓	4	✓
BAF 1	3883	Chief Operating Officer	Incomplete Emergency Response Plans Risk EPRR Non-Compliance and Delayed Incident Response (Domain 3)	31/10/2026	✓	6	3	No	5 Months	No	0	✓
BAF 1	3884	Chief Operating Officer	Insufficient On-Call Training Risks Delayed Incident Command and Non-Compliance with EPRR Standards (Domain 4)	31/12/2026	✓	12	3	No	5 Months	No	0	✓
BAF 1	3887	Chief Operating Officer	Insufficient HAZMAT/CBRN Capability Risks Unsafe Incident Response and Non-Compliance with EPRR Standards (Domain 10)	30/11/2026	✓	8	4	No	5 Months	No	0	✓
BAF 2	16	Chief People Officer	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	30/11/2026	✓	9	6	No	12 Months	No	0	✓
BAF 2	19	Chief People Officer	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	30/10/2026	✓	9	6	No	7 Months	RMG Deep Dive ✓	0	✓
BAF 2	3507	Director of Education and Research	Failure to meet MHRA research inspection standards	08/12/2026	✓	12	4	No	25 Months	RMG Deep Dive ✓	0	✓

BAF 3	3890	Deputy Chief Operating Officer	Timely access to diagnostic services - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	5 Months	No	2	✓
BAF 3	3891	Deputy Chief Operating Officer	Timely access to elective care - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	5 Months	No	0	✓
BAF 3	3892	Deputy Chief Operating Officer	Timely access to cancer services - Demand, Capacity & Flow	30/10/2026	✓	12	12	RMG	5 Months	No	1	✓
BAF 3	3893	Deputy Chief Operating Officer	Timely access to emergency care - Demand, Capacity & Flow 2026/27	30/10/2026	✓	16	12	RMG	5 Months	No	0	✓
BAF 4	12	Director of Infrastructure	Failure to maintain estates to standards may cause compliance breaches, service disruption, and reputational harm.	30/11/2026	✓	25	10	No	17 Months	RMG Deep Dive ✓	10	✓
BAF 4	1083	Operational Director of Estates and Facilities	Non-compliant, aging electrical systems may fail, increasing risk of incidents and reducing operational resilience.	02/11/2026	✓	15	10	No	97 Months	RMG Deep Dive ✓	1 RMG Deep Dive ✓.	✓
BAF 4	1412	Operational Director of Estates and Facilities	Failure to maintain estates to fire safety standards may lead to enforcement, service disruption, and reputational harm.	31/12/2026	✓	15	10	No	65 Months	RMG Deep Dive ✓	7 RMG Deep Dive ✓.	✓
BAF 4	1807	Operational Director of Estates and Facilities	Aged lifts may fail beyond repair, reducing patient transfer capacity and impacting safety and care.	31/12/2026	✓	16	8	No	17 Months	RMG Deep Dive ✓	3	✓
BAF 4	3348	Chief Medical Officer	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/10/2026	✓	12	8	No	22 Months	RMG Deep Dive ✓	0	✓
BAF 5	3880	Chief Finance Officer	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust	11/12/2026	✓	9	9	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3895	Chief Finance Officer	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3896	Chief Finance Officer	Failure to redesign services leads to failure to improve implied productivity at the required rate	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3897	Chief Finance Officer	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3898	Chief Finance Officer	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity	18/10/2026	✓	20	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3899	Chief Finance Officer	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels	18/10/2026	✓	20	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3900	Chief Finance Officer	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3901	Chief Finance Officer	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3902	Chief Finance Officer	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓.
BAF 5	3903	Chief Finance Officer	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow	18/10/2026	✓	16	6	No	5 Months	RMG Deep Dive ✓	0	✓
BAF 5	3920	Chief Finance Officer	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm	11/12/2026	✓	9	9	No	4 Month	RMG Deep Dive ✓	0	✓
BAF 7	1410	Head of Digital Operations	[Cyber] Failure to protect digital assets, risk of a cyber attack which may result in the Trust being non-operational	30/10/2026	✓	10	10	No	13 Months	RMG Deep Dive ✓	0	✖ Overdue
BAF 7	1663	Head of Digital Operations	[Infrastructure - Network] Failure of the HSCN, Internet, or VOIP telephony external network connections	30/11/2026	✓	8	4	No	20 Months	No	0	✓
BAF 7	2727	Digital Infrastructure Manager	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	31/12/2026	✓	6	3	No	27 Months	RMG Deep Dive ✓	0	✓
BAF 7	2736	Head of Digital Operations	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & DR	30/12/2026	✓	9	6	No	52 Months	RMG Deep Dive ✓	0	✓
BAF 7	3184	Head of Digital Operations	[Infrastructure - Network] Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	30/12/2026	✓	8	4	No	20 Months	RMG Deep Dive ✓	0	✓
BAF 7	3384	Chief Information Officer	Out of support software/hardware increase the risk of outage/unavailability of key Clinical/Corporate Systems	17/03/2027	✓	8	4	No	5 Months	No	0	✓

Appendix 2: Board Assurance Framework (BAF)

BAF Summary as at October 2026

The Board Assurance Framework enables the Board to identify and understand the principal risks to achieving its strategic objectives. Our 'Healthier Together – Delivering Exceptional Care for All' Strategy is structured around four key priorities, and these are mapped against each of the risks on the BAF.



1. BAF at a glance - October 2026

One line per principal risk. Scores are likelihood × consequence (L × I). Colours follow the 5 × 5 matrix bands: 1-3 low, 4-6 moderate, 8-12 high, 15-25 extreme.

BAF	Principal risk	Strategic priority	Lead committee	Executive lead	Inherent	Current	Target March 2028	Movement since last report	Current score unchanged since	Risk appetite	Linked TRR risks (of which 15+)	Open gaps control / assurance	Action status	Assurance level (lead committee)
BAF 1	**Learning and listening to support delivery of excellent patient care**	Patients	Quality Committee	Chief Nurse / Chief Medical Officer	**20** 5 × 4	**16** 4 × 4	**12** 4 × 3	↔ No change	Dec 2024	Quality: Cautious Regulatory: Cautious	8 (2)	5 / 1	■ 4 on track ■ 2 closed / proposed to close	To be confirmed at the next Quality Committee
BAF 2	**An open, inclusive culture that supports a skilled workforce**	People	People Committee	Chief People Officer	**20** 5 × 4	**16** 4 × 4	**12** 4 × 3	↔ No change	**Dec 2025 (12 → 16)**	People: Seek (4)	3 (0)	3 / 2	■ 3 on track ■ 3 proposed to close	**Moderate (People Committee)**
BAF 3	**Timely access to care**	Patients	Finance & Performance Committee	Chief Operating Officer	**20** 5 × 4	**16** 4 × 4	**12** 4 × 3	↔ No change	Nov 2024	Quality: Cautious Regulatory: Cautious	4 (1)	3 / 2	■ 1 at risk ■ 4 on track	To be confirmed at the next Finance and Performance Committee
BAF 4	**A safe and welcoming care environment for all**	Patients People Pounds	Finance & Performance Committee	Chief Finance Officer	**25** 5 × 5	**20** 4 × 5	**16** 4 × 4	↔ No change	Jul 2023	Regulatory: Cautious (2) Quality: Cautious (2) Finance: Open (3) People: Seek (4)	5 (4)	4 / 1	■ 3 on track ■ 3 proposed to close	**Moderate (Finance and Performance Committee)**
BAF 5	**Delivery of financial plans and address the underlying deficit**	Pounds	Finance & Performance Committee	Chief Finance Officer	**25** 5 × 5	**25** 5 × 5	**12** 4 × 3	↑ **Increased**	**Changed Oct 2026 (16 → 25)**	Finance: Open Regulatory: Cautious	11 (9)	4 / 0	■ 3 on track ■ 3 proposed to close ■ 1 deleted	To be confirmed at the next Finance and Performance Committee
BAF 7	**Digital and cyber resilience**	Patients People	Finance & Performance Committee	Chief Finance Officer	**25** 5 × 5	**15** 3 × 5	**12** 3 × 4	↔ No change	Not recorded (15 since at least Jul 2025)	People: Seek (4) Quality: Cautious (2)	6 (0)	2 / 1	■ 2 on track ■ 4 proposed to close	To be confirmed at the next Finance and Performance Committee
BAF 6	Partnerships and collaboration to transform and enhance services	Closed – integrated with remaining risks												

Action status key: ■ overdue / date passed ■ at risk ■ on track ■ complete, closed or proposed to close

2. Heat map - current position and March 2028 target

Almost certain (5)	5	10	15	20	**BAF 5**
Likely (4)	4	8	*Target: 1, 2, 3, 5*	**BAF 1, 2, 3** *Target: 4*	**BAF 4**
Possible (3)	3	6	9	*Target: 7*	**BAF 7**
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5
Likelihood ↑ / Consequence →	**Negligible (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**

BAF n = current score (October 2026). Target: n = March 2028 target.

Key messages

Key messages for the Board
• BAF 5 (financial sustainability) has increased from 16 to 25 (5 × 5), reflecting significant shortfalls in the delivery of savings in the Reset Programme, affecting both the deficit and the cash balance. Its inherent score has also been re-scored to 25. It is now the highest-rated BAF risk.
• The other five risks are unchanged: BAF 4 at 20, BAF 1, 2 and 3 at 16, and BAF 7 at 15. All six live risks are extreme (15+), and none is yet at its March 2028 target.
• Of the 36 actions, 19 are on track, 1 is at risk (BAF 3 GC9, the Urgent Treatment Centre First model, which remains suspended), 15 are complete or proposed to close and 1 has been deleted (BAF 5 GC1). No actions are reported as overdue.
• 16 of the 37 linked operational risks are extreme, including all nine savings and productivity risks on BAF 5; three of these (RISK 3896, 3901 and 3903) are now rated 25.
• Assurance levels: - BAF 1 - to be confirmed at the next Quality Committee. - BAF 2 - Moderate (People Committee). - BAF 3, 5 and 7 - to be confirmed at the next Finance and Performance Committee. BAF 5 required further work on the controls, gaps in controls and assurance for the Committee to discuss the assurance level. - BAF 4 - Moderate (Finance and Performance Committee).

3. Score trend - August 2025 to October 2026

BAF	Strategic priority	Oversight	Description	Target score March 2028	Target score March 2026	Current (L × I)	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26
BAF 1	Patients	Quality	Learning and listening to support delivery of excellent patient care	12	12	4 x 4	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
BAF 2	People	People	An open, inclusive culture that supports a skilled workforce	12	12	4 x 4	12	12	12	12	16	16	16	16	16	16	16	16	16	16	16
BAF 3	Patients	F&P	Timely access to care	12	12	4 x 4	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
BAF 4	Patients / People / Pounds	F&P	A safe and welcoming care environment for all	16	20	4 x 5	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
BAF 5	Pounds	F&P	Delivery of financial plans and address the underlying deficit	12	12	5 x 5	16	16	16	16	16	16	16	16	16	16	16	16	16	16	25
BAF 7	Patients / People	F&P	Digital and cyber resilience	12	15	3 x 5	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
BAF 6	Partnership	Board	Partnerships and collaboration to transform and enhance services	6	6	2 x 4	8	8	8	8	8	8	8	8	8	Closed – integrated with remaining risks					

4. Principal risks and linked significant operational risks

Ref	Risk description	Rating
Patients	**Quality Committee Oversight**	
BAF 1	**If learning from incidents, patient experience, clinical outcomes and workforce insight is not effectively triangulated and translated into sustainable quality care, patients could experience avoidable harm, leading to deteriorating outcomes and potential regulatory action for DBTH.**	**16**
RISK 1517	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	**15**
RISK 3209	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	**8**
RISK 3246	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	**12**
RISK 3290	Risk of harm to patient due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	**10**
RISK 3454	Insufficient governance & service gaps risk failure to meet guidance, leading to harm, regulatory action, & reputational damage	**16**
RISK 3883	Incomplete Emergency Response Plans Risk EPRR Non-Compliance and Delayed Incident Response (Domain 3)	**12**
RISK 3884	Insufficient On-Call Training Risks Delayed Incident Command and Non-Compliance with EPRR Standards (Domain 4)	**12**
RISK 3887	Insufficient HAZMAT/CBRN Capability Risks Unsafe Incident Response and Non-Compliance with EPRR Standards (Domain 10)	**12**
People	**People Committee Oversight**	
BAF 2	**If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.**	**16**
RISK 16	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	**9**
RISK 19	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	**9**
RISK 3507	Failure to meet MHRA research inspection standards	**12**
Patients	**Finance and Performance Committee Oversight**	
BAF 3	**If demand for clinical services exceeds the capacity available including where discharge capacity is dependent on partners, we are unable to deliver timely access to care, resulting in long waiting times and potential patient harm**	**16**
RISK 3890	Timely access to diagnostic services - Demand, Capacity & Flow	**12**
RISK 3891	Timely access to elective care - Demand, Capacity & Flow	**12**
RISK 3892	Timely access to cancer services - Demand, Capacity & Flow	**12**
RISK 3893	Timely access to emergency care - Demand, Capacity & Flow	**16**
Patients & People	**Finance and Performance Committee Oversight**	
BAF 4	**If DBTH cannot maintain and improve the care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and / or regulatory actions.**	**20**
RISK 12	Failure to maintain estates to standards may cause compliance breaches, service disruption, and reputational harm.	**25**
RISK 1083	Non-compliant, aging electrical systems may fail, increasing risk of incidents and reducing operational resilience.	**15**
RISK 1412	Failure to maintain estates to fire safety standards may lead to enforcement, service disruption, and reputational harm.	**15**
RISK 1807	Aged lifts may fail beyond repair, reducing patient transfer capacity and impacting safety and care.	**16**
RISK 3348	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	**12**
Pounds	**Finance and Performance Committee Oversight**	
BAF 5	**If DBTH does not remain on track to deliver the medium-term financial plan and tackle its underlying deficit over a reasonable timeframe, then the Trust may face regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.**	**25**
RISK 3880	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust	**9**
RISK 3895	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate	**16**
RISK 3896	Failure to redesign services leads to failure to improve implied productivity at the required rate	**25**
RISK 3897	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate	**16**

RISK 3898	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity	**20**
RISK 3899	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels	**20**
RISK 3900	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan	**16**
RISK 3901	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings	**25**
RISK 3902	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme	**16**
RISK 3903	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow	**25**
RISK 3920	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm	**9**
Patients & People	**Finance and Performance Committee Oversight**	
BAF 7	**If we fail to develop robust and resilient digital, data and technology systems and services that includes cyber resilience and interoperability dependencies with system partners and third-party suppliers, we increase the risk of key system failure, disruption to services and negatively impacting patient care.**	**15**
RISK 1410	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	**10**
RISK 1663	Failure of the HSCN, Internet, or VOIP telephony external network connections	**8**
RISK 2727	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	**9**
RISK 2736	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & Disaster Recovery	**9**
RISK 3184	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	**8**
RISK 3384	Failure to update software/hardware may lead to increase cyber-attack exposure and general failure of digital services	**8**

BAF 1 Learning and listening to support delivery of excellent patient care

Strategic priority: **Patients**

Strategic objective: We deliver safe, exceptional, person-centred care

Risk statement (cause – event – effect): ***If learning from incidents, patient experience, clinical outcomes and workforce insight is not effectively triangulated and translated into sustainable quality care, patients could experience avoidable harm, leading to deteriorating outcomes and potential regulatory action for DBTH.***

						Inherent	Current	Target Mar 2028	Risk target score	Linked significant risks on Trust Risk Register
Lead committee	Quality Committee	**Risk type**	Strategic	**Initial assessment**	July 2023	**20** 5 × 4	**16** 4 × 4	**12** 4 × 3	**10**	1517, 3209; 3246; 3290; 3454; 3883; 3884; 3887
Executive lead	Chief Nurse / Chief Medical Officer	**Risk appetite**	Quality: Cautious Regulatory: Cautious	**Last reviewed**	October 2026					
Treatment	Treat	**Movement**	↔ No change this period	**Score last changed**	December 2024					

Rationale for current score and key changes this period

Rationale: [Executive Lead to add two or three lines explaining why the risk remains at its current score and what must happen to reach the target]. To be provided for the next Quality Committee meeting.

Key changes:

- GC11 (Ockenden and Amos) closed; new GC11 added for the Maternity Incentive Scheme, the national 10-point plan and the Thirlwall Inquiry.
- GC10 widened to include the CQC final report on urgent and emergency care (UEC), with a revised date of March 2027.
- GC9 (clinical policies): action complete; propose to close.
- GA1, GC4 and GC11 updated with due dates extended.
- GC5 - Learning From Deaths Manager in place. Action closed.

Controls and assurance

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
Learning Opportunities					
• Chief Nurse Oversight Framework – which includes ongoing monitoring of quality metrics, peer reviews, expert reviews, and the ward accreditation process.		• Divisional performance monitored at Performance Review Meetings with Exec oversight, (monthly) • CARE Accreditation Process review oversight update to QC • Maternity, Neonatal Quality and safety Group	• Integrated Performance Report • CQC Action plan completion assurance paper • Safeguarding Annual Report at board • Annual Director of Infection Prevention and Control Report at board (September 2025)	• CQC Quarterly Engagement Meetings • Section 11 Safeguarding return provided to Safeguarding Partnership board	
• Mortality Overview	**GC4** Insufficient structured judgement reviews (SJRs) in line with best practice guidelines completed to contribute to Learning from Deaths and overview of mortality rates at DBTH **GC5** No substantive Learning from Deaths manager in post	• Structured Judgement Review • Perinatal Mortality Review Tool • Maternity Outcomes Signal System • The National Maternity and Newborn Safety Investigations	• Mortality (and DQ) report to Quality Committee • Compliance with Quarterly reporting of perinatal mortality review tool outcomes • Mortality Report presented to Quality committee	• SANDS review of bereavement care • *Planned Internal Audit Plan 2026-27 Q3/4 - Learning from deaths* • *Planned Internal Audit Plan 2026-27 Q1/2 - Mortality data quality assurance*	**GA1:** SHMI data remains within confidence levels although at the upper limits within this, despite the ongoing projects to reduce this.
• Patient safety incident response plan		• Never event and PSII tracker at internal meetings • Divisional and Trust LFPSE panels	• Patient experience Annual reports to Trust Board • Never Event Exception report to QC • Trust Executive Patient Safety Oversight Group • Patient Safety report to QC	• Internal Audit of Patient Safety Incident Response Framework 25/26 plan **(Significant Assurance)**	
• Listening to patients (Patient forum) Primary listening forums: Citizens Panel Digital Stories Patient Surveys Friends and Family Test Range of engagement forums		• Caring Assurance group reports • Patient Experience Annual Report	• Quality Committee		
Preventing avoidable harm and poor patient outcomes					
• Compliance with Developing workforce safeguards including use of Safer Nursing Care Tool and biannual workforce reviews (BR+ for Midwifery)		• Trust wide safe staffing meetings • Established use of safe care • Evidence of escalation in incident reporting	• Biannual establishment review reporting for Nursing to People Committee		

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
• Establishment changes via Chief Nurse approval.			• Monthly compliance with safe staffing care hours per patient day reporting via unify • AHP Biannual workforce report presented to People Committee • Biannual Midwifery Workforce report to Trust Board of Directors		
Ensuring regulatory compliance and sustainable quality					
Clinical policies, processes and clinical guidelines	**GC9:** Significant numbers of Clinical policies are out of date **GC10:** CQC 29a notice issued which outlines regulatory breaches	• Infection Prevention Control Steering Group • Risk Management Group	• Risk Management Group assesses and moderates significant risks and presence of valid action plans monthly	• CQC unannounced visit to DRI ED • *Planned Internal Audit 2026-27 Q1/2 – Medical Devices Management (+ BAF 4 and BAF 7)*	
Clinical Audit Programme and monitoring.		• Monday.com dashboard outputs reviewed at Audit and effectiveness forum	• Report to Quality Committee		
Maternity Incentive Scheme • National 10-point plan for maternity and neonates	**GC11:** Awaiting immediate recommendations from the Thirlwall Inquiry.	• NHSE North-East and Yorkshire Maternity & Neonatal Assurance Visits • Maternity Incentive Scheme divisional oversight group highlight reports	• Paediatric and Perinatal Quality and Safety Group • Maternity safety champions visits and meeting	• Maternity and Neonatal report to QC	
The shape of DBTH Programme Pillar		• Reset Board	• Board of Directors • QPIAs to Quality Committee (where criteria met)		

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GA1	SHMI review of the data quality reporting and individual cases	CMO	January 2027	**On Track**	Currently, Bassetlaw SDEC activity is not coded within the admitted dataset, as per national guidance. Work has commenced to rectify this position to gain parity with Doncaster SDEC recording and further improve Trust-wide clinical coding quality. Increase in cadence of mortality review meetings from 3 monthly to monthly. Current focus SJRs on high SHMI areas of breast cancer and contusion/bruising. Audit of coding to look at order of codes as well as department. Due date extended to January 2027.
GC4	SJR plan in place to address current gaps	CMO	January 2027	**On Track**	Q1 25-26 reported 7% SJR completion, rising to 14% in Q4 25-26. Best practice guidance is 15 - 20% completion. Current dip in SJRs due to change in Learning From Deaths Manager plan to improve again from Q2 with a minimum of 91 SJRs to be requested per quarter. Due date extended to January 2027.
GC5	Recruitment to Learning From Deaths Manager	CMO	September 2026 Complete	**Propose to close**	Learning From Deaths Manager in place. Action closed. The team has been reviewed and structured to increase the dedicated time and resource available for this function. Initial recruitment was not successful; however, the roles have been re-advertised, which will delay implementation and the impact of the roles.
GC9	Implement and embed processes to ensure Trust wide clinical policies are reviewed in a timely fashion	Company Secretary	September 2026 Complete	**Propose to close**	Recruitment to support with the policy role is now in place to provide management and monitoring internally against review dates and the APD process. Report taken through to the Hospital Leadership Team (HLT) evidencing reduction in overdue policies (14) with plans in place for all these to be reviewed and or signed off before September 2026.
GC10	Action plan to address the CQC 29A Notice and CQC final report of UEC.	CNO	March 2027	**On track**	Monthly updates via executive team and HLT with oversight at the quality committee. Programme of unannounced executive assurance visits fortnightly to check on embedding of the improvements outlined in the plan.
GC11	Maternity Incentive Scheme - National 10-point plan for maternity and neonates	CNO & CMO	January 2027	**On Track**	Assurance for the 10-point plan went to Board on 1 September and was submitted to NHSE by 25 September 2026. Awaiting national Gap analysis tool and review against the 10-point action plan from NHSE prior to oversight at Board. Currently reviewing Thirlwall and awaiting anticipated national guidance for Thirlwall. Due date extended to January 2027.

BAF 2 An open, inclusive culture that supports a skilled workforce

Strategic priority
People
Partnerships

Strategic objective
We are supportive, positive, and welcoming
We work together to enhance our services with clear goals for our communities

Risk statement (cause – event – effect)	*If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.*

Lead committee	People Committee	Risk type	Strategic	Initial assessment	July 2023	Inherent	Current	Target Mar 2028	Risk target score	Linked significant risks on Trust Risk Register
Executive lead	Chief People Officer	Risk appetite	People: Seek (4)	Last reviewed	September 2026	20 (5 × 4)	16 (4 × 4)	12 (4 × 3)	15	16; 19; 3507
Treatment	Manage	Movement	↔ No change this period	Score last changed	December 2025					

Rationale for current score and key changes this period

Rationale: [Executive Lead to add two or three lines explaining why the risk remains at its current score and what must happen to reach the target.] To be provided for the next People Committee.

Key Changes:

- GC1 (attendance): Supporting Attendance at Work Policy launched; action closed.
- GC5 (resident doctors' 10-point plan) and GA2 (culture and leadership programme) proposed to close.
- New GA3 added to implement the Internal Audit Statutory and Essential Training actions (due December 2026). The external Freedom to Speak Up peer review has been added as a source of assurance.
- Partnerships strategic objective removed: BAF 6 (Partnerships) has closed and has not been incorporated into BAF 2.

Controls and assurance

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
Listening engaging and supporting colleagues Equality, Diversity and Inclusion Improvement Plan Education Quality Framework and Safe Learning Environment Charter People Engagement Strategic Approach Speaking Up Process and partnering activities 2025-26 Internal Audit report Equality Diversity and Inclusion **(Significant Assurance)** Oversight of the People metrics Partnership working across place/ICS to align and share best practice on multiple areas including inclusion, education and Freedom to Speak Up (e.g., joint learning and benchmarking) Culture and Leadership Reset Programme Pillar Workforce and Organisational Design Reset Programme Pillar	**GC5:** National initiative 10-point plan for improving working lives of Resident Doctors **GC6)** System-wide workforce pipeline and learning pipeline, are not yet consistently developed and delivering	• EDI Forum • Operational Delivery Groups and Networks • Data triangulation group • Reset Board • Feedback to executive team on the 'line in the sand' • TLT and other leadership workshops on 'Line in the sand' impact	• Reports to People Committee • Progress reporting to People Committee • Board of Directors • RESET Delivery plans	• WRES and WDES data reporting to Board • Diversity and Inclusion 2025-26 Audit Plan • External Annual Quality Visits • Learner Feedback and Surveys • Annual National Staff Survey • Peer Review of DBTH Speaking up Process • Education partners quality reviews and placement / learner feedback surveys • Internal Audit Statutory Essential Training 2025 - 26 Audit plan **(Significant Assurance)** • Internal Audit Workforce Planning and Establishment Control -Terms of Reference agreed on 16 September • NHSE meetings	**GA3:** Implement actions from Internal Audit SET.
Embedding the DBTH way for an open and inclusive culture The People Plan Delivery Plans HR Policies and support resources Health and Wellbeing activities and resources Leadership Development Offer and Organisational Development activities Exit Interview process and management Partnership arrangements with universities/education providers Culture and Leadership Reset Programme Pillar	**GC1:** Additional actions identified to support return to work and reduce sickness absence. **GC4:** Further work required to articulate the DBTH leadership framework for different levels of leadership role.	• Chief People Officer Senior Leadership meeting • Operational Delivery Groups	• Reports to People Committee • IPR to Board	• Annual National Staff Survey • Learner Feedback and Surveys • Externally Commissioned Review of the DBTH Way in Action • Anti-racism Accreditation Bronze award • External Freedom to Speak Up Peer Review	**GA2:** the Trust wide Culture and Leadership programme to include the recommendations and actions following external cultural review of DBTH Way in Action.

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GC1	The Workforce workstream reviewing identified actions for improvements in return to work and sickness absence, deep dive reporting to Executive team	Chief People Officer	July 2026 Complete	**Propose to close**	Supporting Attendance at Work Policy approved and formally launched, supported by training. Actions in relation to attendance management continue with oversight through the Bank and Agency Optimisation Steering Group reporting into Reset Board. Complete. Action closed.
GC4	Design of holistic leadership development modules into an overarching leadership programme	Chief People Officer	March 2027	**On track**	The culture and leadership prospectus redesign aligned with wider cultural work includes development of new managers' competency packages for aspiring and established leaders. Due to launch Q3. Mapping to new national leadership and management framework underway with plans for implementation of the self-assessment tool.
GC5	Implementation of the 10-point plan for the national initiative of 'improving working lives of resident doctors	Chief Medical Officer	July 2026 Complete	**Propose to close**	Progress report being presented to People Committee in October. Propose to close.
GA2	Development of Trust Wide Culture and Leadership Programme	Chief People Officer	March 2027 Complete	**Propose to close**	Culture and leadership pillar activities on track monthly reporting to Reset Board and at every People Committee meeting through the engagement and leadership report. Detailed action plans in place to support delivery. Propose to close and move to ongoing monitoring through established governance.
GC6	System-wide workforce pipeline and learning pipeline plans are not yet consistently developed and delivered	Chief People Officer	March 2027	**On track**	There is a SYB education group established, with plans to develop further with the acute trusts. Group remains in place, with potential to explore further opportunities with new shared leadership arrangements.
GA3	Internal Audit SET actions	Chief People Officer	December 2026	**On track**	Actions on track in line with deadlines.

BAF 3 Timely access to care

Strategic priority: **Patients**

Strategic objective: We deliver safe, exceptional person-centred care

Risk statement (cause – event – effect): *If demand for clinical services exceeds the capacity available* including where discharge capacity is dependent on partners, *we are unable to deliver timely access to care, resulting in long waiting times and potential patient harm*

						Inherent	Current	Target Mar 2028	Risk target score	Linked significant risks on Trust Risk Register
Lead committee	Finance and Performance Committee	**Risk type**	Strategic / Regulatory Quality	**Initial assessment**	July 2023	**20** 5 × 4	**16** 4 × 4	**12** 4 × 3	**10**	3890; 3891; 3892; 3893
Executive lead	Chief Operating Officer	**Risk appetite**	Quality: Cautious Regulatory: Cautious	**Last reviewed**	September 2026					
Treatment	Treat	**Movement**	↔ No change this period	**Score last changed**	November 2024					

Rationale for current score and key changes this period

Rationale: [Executive Lead to add two or three lines explaining why the risk remains at its current score and what must happen to reach the target.] To be provided for the next Finance and Performance Committee.

Key changes:

- GC10 (frailty and surgical SDEC): date moved from July to November 2026; SDEC proposal going to Executive Team in October.
- GC9 (UTC First model) remains suspended following CQC feedback.

Controls and assurance

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
Waiting time standards Access Policy Cancer Access policy Capacity and flow policy Trust validation Programme Patient Tracking List management Consistent across all Trust services Cancer Patient Tracking List management Clinical Prioritisation Access and Flow Reset Programme Pillar		• Performance Review Meetings monthly report • Reset Board	• National Data Submission of Trust performance • Access Standards Reports to F&P Committee • IQPR report to Board • Operational Delivery & Improvement Group (monthly) now in progress • Progress reporting to F&P Committee • Board of Directors • Trust Access Group: Elective • Trust Access Group: UEC & Patient Flow	• Doncaster Place UEC board (monthly) • NHSE / ICB / Place Tier 2 meeting (fortnightly) • Model Health reporting system • SYB Cancer performance meeting • Internal Audit of Data Quality, Cancer metrics 25/26 Plan **(limited Assurance)** • External review of PTL arrangements by GIRFT Elective • System discharge / flow partnership oversight reporting • Internal Audit Report 25/26: Patient flow: focus on discharge **(limited assurance)**	GA7) **Limited assurance** on partner-delivered elements of access recovery plans (e.g., community and social care capacity, diagnostic network capacity) and the impact of mutual aid **GA8)** Implementation of Internal Audit recommendations from the Patient flow Audit **(Limited Assurance)**
Demand management Doncaster Place UEC improvement programme Patient initiated Follow-up (PIFU) policy Advice and Guidance policy Diagnostic improvement programme Virtual ward System partnership demand and capacity planning (ICB/place/provider collaborative), including agreed mutual aid triggers for elective, diagnostics and UEC	**GC9)** Implement Urgent Treatment Centre First model **GC10)** Implement frailty and surgical SDEC **GC11)** Formal mutual aid / capacity-sharing agreements and escalation triggers with system partners are not yet consistently in place across key pathways	• Performance Review Meetings monthly report • Outpatient improvement programme meeting • Diagnostic Improvement Programme meeting	• National Data Submission of Trust performance	• Doncaster Place UEC board (monthly)	
Efficiency GIRFT Programme Outpatient improvement programme Theatres improvement programme Urgent Emergency Care improvement programme		• Performance Review Meetings monthly report • Outpatient improvement programme meeting • Theatre improvement programme meeting	• Deep dive reports to F&P	• Doncaster Place UEC board (monthly) • Model Health reporting system	

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GC9	Urgent Treatment Centre First model to be implemented at all sites	COO	October 2026	**At risk**	Phase 1 had been implemented at DRI, now paused following the CQC feedback and is under review pending this. This remains suspended.
GC10	Frailty and surgical SDEC implementation plan	COO	November 2026	**On track**	Paper for SDEC proposal going through Executive team in October.
GC11	Develop and implement formal mutual aid and escalation arrangements with system partners for elective, diagnostics and UEC pathways (with agreed KPIs and triggers)	COO	March 2027	**On track**	Mutual aid options being explored for a number of pathways to support with the access and waiting time standards. Initial clinical conversations held at Hospital Leadership Team
GA7	**Limited assurance** on partner-delivered elements of access recovery plans	COO	March 2027	**On track**	Commence review of enabling partnership arrangements and plans to address key aspects of these on DBTH access plans.
GA8	Internal Audit of Patient Flow: Focus on Discharge **(limited assurance)**	COO	March 2027	**On track**	Review of Internal Audit recommendations and commence implementation plan

BAF 4 A safe and welcoming care environment for all

Strategic priority
Patients
People
Pounds

Strategic objective
-We deliver safe, exceptional person-centred care
-We are supportive, positive and welcoming
-We are efficient and spend public money wisely

Risk statement (cause – event – effect)	***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.***

Lead committee	Finance and Performance Committee	**Risk type**	Quality / Financial / Regulatory	**Initial assessment**	July 2023	**Inherent**	**Current**	**Target Mar 2028**	**Risk target score**	**Linked significant risks on Trust Risk Register**
Executive lead	Chief Finance Officer	**Risk appetite**	Regulatory: Cautious (2) Quality: Cautious (2) Finance: Open (3) People: Seek (4)	**Last reviewed**	October 2026	**25** 5 × 5	**20** 4 × 5	**16** 4 × 4	**10**	**12; 1412; 1807; 3348; 1083**
Treatment	Manage	**Movement**	↔ No change this period	**Score last changed**	July 2023					

Rationale for current score and key changes this period

Rationale: Estates position remains unchanged.

Key changes:

- Action GC1a is proposed to close, as the funding is not available.
- Action GC2 is proposed to close - action is complete.
- Action GC3 - due date changed to March 2027.
- Action GA2 is proposed to close - action is complete.

Controls and assurance

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
DRI Development Master Plan 2024 and long-term capital investment plan.		• Review of incidents on Datix via Quality and Safety Group	• Department of Critical Care (DCC) relocation project due to complete March 2027, this project is an enabling project to the full East Ward Block refurbishment project	• East Ward Block Strategic Outline Case for £442m submitted to DoH and NHSE 25th November 2025 following approval at F&P and BoD • Bids submitted to NHSE on 13th January for funding via Return to Constitutional Standards (RtCS) which includes a large £25m project co-located UEC/UTC/SDEC at DRI • Bids have also been submitted against the Estates Safety Fund (ESF) in January for schemes to the value of £24m over 4 years, £6m each year, in addition to two £25m main theatre bids to first expand by two theatres and then to refurbish the 8 existing theatres • Board Development Session BAF 4 & DRI Development Master Plan and accompanying bids to accelerate Backlog and Critical Infrastructure Risk eradication at DRI on 3rd February. • Confirmation of £100m precommitment of Estates Safety Fund monies over next 4 years to progress East Ward block refurbishment, next stage of business case now progressing to Outline Business Case (OBC) with a new Preferred Way Forward that achieves 100% refurbishment of the EWB with internal decant rather than new decant build reducing the cost from £442m to £250m. NHSE currently assessing route to funding for remaining £150m requirement which it is suggested with be years 4-9 of 10 year national capital deal. Request received from NHSE 17th July 26 to cashflow the full £250m.	

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
Planned Preventative Maintenance (PPM) program.	**GC1**: The Trust's current maintenance strategy focuses on statutory compliance and minimum essential maintenance requirements. An estates maintenance review indicates that circa £1m of additional resource (the majority at DRI) is required (£690k pay/£317k non-pay) to deliver an effective maintenance strategy that aims to improve preventative maintenance measures in line with industry guidance as a control against estates infrastructure risks.	• Premises Assurance Model (PAM) Self-Assessment • PPM KPI data reviewed weekly by Estates Management Team to monitor performance and ensure effective prioritisation of resource • Ongoing monitoring of maintenance reactive	• PPM data included within KPI's reviewed during quarterly corporate PRM's with Executive Team. • Bi-annual Report to F&P Committee • Ongoing monitoring of maintenance reactive. • PPM completion data also reviewed monthly at internal Estates and Facilities Performance Review Meetings (PRM's) providing departmental oversight. • Relevant PPM performance data routinely reported to technical safety groups for assurance including Fire Safety Group, Water Safety Group and Ventilation Safety Group.	• Programme of external audit for Authorising Engineers (AE) and enforcing authorities.	
Doncaster Royal Infirmary Site Evacuation Plans	**GC2**: Work is currently in progress to establish effective site evacuation plans for DRI, supported by a System response.		• EPRR response approved by Board of Directors • Review through Capital Monitoring Committee • Report to Audit and Risk Committee		**GA2:** Complete the internal and system wide evacuation response plan
5 year Annual Capital Investment Programme CDEL – focus on backlog eradication Trust wide	**GC3:** Site Development Master Plans required for Bassetlaw and Montague sites. **GC4:** Annual CDEL investment alone is unable to keep up with level of backlog within the Trust, as evidenced in annual ERIC returns	• Annual 6 facet surveys to monitor risk profile changes	• Annual report to Board of Directors • Capital programme delivery monitored via Estates Capital Committee. • Capital programme delivery also monitored via corporate PRM's with Executive Team.	• ERIC return	**GA3:** 6 facet survey and ERIC data indicate that backlog values are increasing annually at a rate that exceeds the amount by which they reduce from capital investment due to deterioration and inflation, suggesting current levels of investment are insufficient to eradicate or significantly reduce the Trust's backlog position.
Policies, procedures and Standard operating procedures		• Efficacy monitored through incident and risk in Datix at divisional management meetings	• Policies and procedures subjected to formal review and approval processes in line with Trust policy. • Efficacy monitored through incident and risk in Datix at organisational forums such as the Health and Safety Group and Risk Management Group. • Health and Safety reports to F&P committee	• HSE Audit Outcomes • ROSPA accreditation Gold Accreditation	
Robust Health and Safety Management System		• Efficacy monitored through incident and risk in Datix at divisional management meetings • Datix incident data • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Data • Annual Internal Health and Safety Audit • Premises Assurance Model (PAM) Safety Domain Assessment	• Monitoring from Trust Health and Safety Group. • Biannual Health and Safety Report to F&P committee • Annual report to Board of Directors on PAM • Annual report to Board of Directors on Estates Return Information Collection (ERIC) • Efficacy monitored through incident and risk in Datix at organisational forums such as the Health and Safety Group and Risk Management Group	• Royal Society for the Prevention of Accidents (RoSPA) Gold accreditation • Annual submission of PAM data to NHS England • Annual ERIC Submission to NHS England	

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GC1a	Consider feasibility of funding the additional resource identified in the Estates review to enable a more preventative maintenance strategy during annual business planning.	CFO	March 2027	**Propose to close**	Funding not available. Propose to close. The Trust's current financial position means that it is not possible to support the additional funding required for the implementation of the Estates review findings. This position is unlikely to change in the immediate short term. The position will be reviewed annually during business planning to determine whether viability has increased.
GC2	Complete site evacuation plans for DRI	COO	Complete	**Propose to close**	The Trust's Inpatient Response Framework was approved by the EPRR Group in October 2025; this includes complete site evacuation plans for DRI. Exercises Blue Hammer (4 September 2025) and Blue Phantom (9 September 2025) tested Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's (DBTH) capability to evacuate the East Ward Block at Doncaster Royal Infirmary (DRI) and to coordinate safe patient dispersal across the system following an escalating fire at 05:00 on Level 6 (two Respiratory wards). Recommendations from the Exercises are incorporated into the Trust and System action plan. Next actions for the Trust are to: • ensure all staff / services based in the East Ward Block are familiar with the Inpatient Response Framework • ensure all staff with a designated role in the event of an incident are trained to undertaken this
GC3	Draft site development plans for BH and MH	Director of Infrastructure	March 2027	**On track**	Work currently paused to enable progression of Reset Shape pillar which will determine a clinical services site strategy to inform site development plans. Ongoing annual investment plans for Finance and Performance. Quotes obtained for site development plan. Director of Infrastructure drafting proposal for consideration by the Trust Executive Team. Funding approved by Trust Executive Team Q3. Work has now commenced to gather data to inform development plans. Outcomes from medium term planning currently underway will also inform the site development plans.
GC4	Review risk register and updated 6 facet survey data annually to inform capital planning process	Director of Infrastructure	March 2027	**On track**	Annual investment plans for F&P to be brought to committee and reviewed ahead of the following year Action completed for 25/26 & 26/27 – action is an ongoing annual requirement – updated target completion date to reflect requirement to complete for 27/28. In addition to annual planning requirements detailed above, the Trust is also submitting a 5-year capital plan to the ICB in January 2026 to inform the new multi-year capital investment regime utilising Estates Safety Fund and Return to Constitutional Standards Funding. Bids for ESF £24m (over 4 years) and RtCS UEC £32m (£7m enabling & £25m UEC) successful in addition to a pre-commitment of £100m for the EWB with further work confirmed by NHSE to identify additional £150m requirement for the new preferred way forward, total £250m. Strategic Outline Case (SOC) for EWB now in development using funding from an additional £3m ESF monies in 26/27.
GA2	Complete the internal and system wide evacuation response plan	COO	Complete	**Propose to close**	The Trust's Inpatient Response Framework was approved by the EPRR Group in October 2025; this includes complete site evacuation plans for DRI. Exercises Blue Hammer (4 September 2025) and Blue Phantom (9 September 2025) tested Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's (DBTH) capability to evacuate the East Ward Block at Doncaster Royal Infirmary (DRI) and to coordinate safe patient dispersal across the system following an escalating fire at 05:00 on Level 6 (two Respiratory wards). Recommendations from the Exercises are incorporated into the Trust and System action plan. Next actions for the Trust are to: • ensure all staff / services based in the East Ward Block are familiar with the Inpatient Response Framework • ensure all staff with a designated role in the event of an incident are trained to undertaken this
GA3	Explore opportunities for external funding to supplement CDEL to increase the rate of investment in backlog reduction/eradication to lower the level of critical infrastructure risk more expediently	Director of Infrastructure	Ongoing	**On track**	Bids for ESF £24m (over 4 years) and RtCS UEC £32m (£7m enabling & £25m UEC) successful in addition to a pre-commitment of £100m for the EWB with further work confirmed by NHSE to identify additional £150m requirement for the new preferred way forward, total £250m. Strategic Outline Case (SOC) for EWB now in development using funding from an additional £3m ESF monies in 26/27.

BAF 5 Delivery of financial plans and address the underlying deficit

Strategic priority: **Pounds**

Strategic objective: We are efficient and spend public money wisely

Risk statement (cause – event – effect): *If DBTH does not remain on track to deliver the medium-term financial plan and tackle its underlying deficit over a reasonable* **timeframe,** *then the Trust may face regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.*

						Inherent	Current	Target Mar 2028	Risk target score	Linked significant risks on Trust Risk Register
Lead committee	Finance and Performance Committee	**Risk type**	Reputational / Financial	**Initial assessment**	July 2023					
Executive lead	Chief Finance Officer	**Risk appetite**	Finance: Open Regulatory: Cautious	**Last reviewed**	October 2026	**25** 5 x 5	**25** 5 x 5	**12** 4 x 3	**10**	**3895; 3896; 3897; 3898; 3899; 3900; 3901; 3902; 3903; 3880; 3920**
Treatment	Treat	**Movement**	↑ Change this period	**Score last changed**	October 2026					

Rationale for current score and key changes this period

Rationale: Significant shortfalls in delivery of savings in Reset Programme impacting on both deficit and cash balance.

Key changes:

- Risk statement updated.
- Inherent and current risk scores changed from 20 (4 x 5) and 16 (4 x 5) to 25 (5 x 5) respectively.
- Risk statement updated to refer to the medium-term financial plan and the underlying deficit.
- Action GC1: deleted (refresh of the Medium-Term Finance Plan).
- Actions GC2: 2 of 3 actions closed (Local savings Plans produced and MARS Scheme launched/ weekly call bank and agency panels for medical spend established.
- GC2: month 3 risk-adjusted savings forecast shows a £26.1m (53.5%) recurrent gap and an £18.6m (40.2%) in-year gap; new local savings and contingency actions added.
- GC8: closed (Finance consultation has completed, and implementation of new structure has begun which includes the additional contract management capacity).
- GC9 rewritten: £6.5m full-year income misalignment with South Yorkshire ICB, to be resolved through a side letter to the contract. New due date proposed.

Controls and assurance

Key controls (RC)	Gaps in control (GC)	Assurance – 1st line (operational management)	Assurance – 2nd line (corporate oversight)	Assurance – 3rd line (independent)	Gaps in assurance (GA)
Annual, Medium- & Long-Term Planning Alignment to ICB/system financial plan, including governance of partner assumptions, risk share and cross-system recovery actions.	£6.5m full year income misalignment with South Yorkshire ICB with a process agreed to seek to resolve that through an agreed side letter to the contract	• Reset Board	• Annual Plan reviewed by the F&P Committee • Trust Board Approve the Annual Plan • Progress reporting to F&P Committee • Board of Directors		
Cost Improvement Plans within Reset Programme and Local Savings target system efficiency schemes (e.g., collaborative procurement, shared pathways and demand management) with named SROs and delivery governance	**GC2:** At the month 3 reporting point the risk adjusted savings forecast is: • £22.7M of recurrent FYE savings vs £48.8M plan, leaving a £26.1M (53.5%) gap • £27.7M of in-year savings vs £46.3M plan, leaving a £18.6M (40.2%) gap **GC5**: Embedding of Medical rostering		• Reset Programme reporting to Board and F&P committee • Local savings plans reviewed at Performance Review Meetings at divisional level monthly • Reset Board • Board of Directors	• HFMA Checklist Action Plan complete in April 2023. • NHSE IQIG Meeting	
BAU Financial Operating policies, procedures HFMA Getting the Basics Right and NHSE Strengthening Financial Management checklist processes Estates Contract management Commissioner and partner contract management, including contract variation governance and assurance over partner-delivered savings/income assumptions	**GC8:** Capacity within the contract management arrangements at DBTH (generally – not Estates specifically) have been identified by management as an opportunity for improvement.		• Bank and Agency Spend Control Follow Up Audit Review • Reports to Audit and Risk Committee • Counter fraud reports	• Internal Audit work plan • NHSE monthly finance and workforce submissions • External Auditors Annual Audit Letter • Internal Audit of Estates Contract Management 25/26 plan • ICB/system finance meetings and system plan sign-off • Provider collaborative finance recovery reporting and peer benchmarking	
Specific Financial expenditure control measures: • Executive vacancy approval Panel Weekly • Capital Investment Group and linked operational Control environments • CNO review of Nursing Agency and temp • Off framework protocol • Nursing rosters review • Weekly Non-pay review		• Reports to Executive team • Confirm and Support meetings with each division	• Reports to F&P Committee		

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GC1	Medium Term Finance Plan will be refreshed, reviewed by the CFO, aligned to capital plans and allocation of resources.	CFO	March 2026	**Deleted**	Draft plan submitted to NHSE in December. Final plan due to be submitted in February with Board approval.
GC2	Continue to drive each pillar of the reset programme to maximise savings delivery over the medium-term plan horizon.	DCEO/ Reset Director	March 2029	**On track**	Reset Board reporting now implemented. New PMO tool (Neon) procured that will allow us to correlate scheme actions to savings. Implementation with effect from the 19 August Reset Board.
GC2	Divisions and directorates to produce local savings plans and pipelines, to be managed through PRM escalation process.	Divisional and directorate management teams	September 2026 Complete	**Propose to close**	Local Savings Plans have been produced. Action complete. Latest plans reviewed at in person meetings with Reset Director and Executive team on 29th July. Plans being checked to reallocate any savings associated with Reset programme currently. Updated plans and pipelines to be reviewed at each PRM meeting going forward.
GC2	Executive Team to consider contingency options (difficult choices) and alternative benchmarking data to find further opportunity	Reset Director and Executive Team	September 2026 Complete	**Propose to close**	MARS Scheme has been launched and weekly call bank and agency panels for medical spend has been established. Action complete. The Hospital Leadership Team was briefed on 5th August including some ideas for difficult choices. Initial Executive discussion scheduled for 12th August in order to feedback to Reset Board on 19th August.
GC5	Medical rostering project, measured via reduction in locum medical use and expenditure	CFO / MD	February 2027 Ongoing	**On track**	Department of critical care are implementing from a next rota cycle which is early November. General anaesthetics is planned from the cycle after. Key project as part of the Pay Efficiency Workstream. Pay Efficiency Workstream Charter has now been signed off. UEC are fully live with the new system. Medicine and Women & Children's are partial. Anaesthetics are next with go-live planned at the end of September.
GC8	Review of contract management capacity within the procurement team	CFO	September 2026 Complete	**Propose to close**	Finance consultation has completed, and implementation of new structure has begun which includes the additional contract management capacity. Action complete. Invest to save business case approved by CIG in November 2025. Finance team structure approved by Executive Team in December 2025. Consultation with staff began in July 2026 and implementation of the approved business case will follow the end of the consultation.
GC9	Implement the process agreed in the side letter to the contract to seek to resolve the £6.5m contract misalignment with South Yorkshire ICB	CFO	November 2026	**On track**	Escalated to CEOs who met to discuss on 20 October and have agreed actions to move forward. The block contract review and rebasing exercise was completed and the analysis provided to the ICB in line with the agreed timeframe (end of May). However appropriate adjustments to the contract in light of that were not agreed by the end Q1 deadline when the then ICB CFO retired. The Trust is working with the new ICB CFO and her team on this matter, and a revised contract offer is expected in early September.

BAF 7 Digital and cyber resilience

Strategic priority
Patients
People
Partnerships

Strategic objective
-We deliver safe, exceptional, person-centred care.
-We are supportive, positive and welcoming
-We work together to enhance our services with clear goals for our communities

Risk statement (cause – event – effect)	***If we fail to develop robust and resilient digital, data and technology systems and services that includes cyber resilience*** **and interoperability dependencies with system partners and third-party suppliers*, we increase the risk of key system failure, disruption to services and negatively impacting patient care.***

Lead committee	Finance and Performance Committee	**Risk type**	Strategic	**Initial assessment**	January 2025	**Inherent**	**Current**	**Target Mar 2028**	**Risk target score**	**Linked significant risks on Trust Risk Register**
Executive lead	Chief Finance Officer	**Risk appetite**	People: Seek (4) Quality: Cautious (2)	**Last reviewed**	September 2026	**25** 5 × 5	**15** 3 × 5	**12** 3 × 4	**12**	1410; 3384; 2727; 3184; 1663;2736
Treatment	Treat	**Movement**	↔ No change this period	**Score last changed**	[to be completed]					

Rationale for current score and key changes this period

Rationale: [Executive Lead to add two or three lines explaining why the risk remains at its current score and what must happen to reach the target.] To be provided for the next Finance and Performance Committee.

Key changes:

- GA1 (board oversight of digital programme), GC1 (EPR partnership with STH) and GC6 (unsupported servers / Office 365) completed.
- GA2 date moved to November 2027, in line with EPR go-live; GC8 (IT service management) date moved to March 2027.

Controls and assurance

Key controls (RC)	**Gaps in control (GC)**	**Assurance – 1st line (operational management)**	**Assurance – 2nd line (corporate oversight)**	**Assurance – 3rd line (independent)**	**Gaps in assurance (GA)**
Digital Enabling Plan (including Analytics) Digital Business Plan (versions to be updated) ICS/Place digital and interoperability strategy (including shared care record integration) and associated delivery roadmap with partners		• Digital Data and Technology (DDaT) Meeting • Report to Trust Leadership team (a regular digital update is preferred)	• Report to F&P Committee		
Electronic Patient Record (EPR) Programme Board, overseeing EPR FBC and programme delivery. Intra-Trust Partnership Agreement in Place Interoperability and interface governance with partner organisations (including data sharing agreements and clinical safety assurance for integrations)				• DSPT Audit reports, external cyber security assessments such as penetration testing, and testing of information sharing agreements. • ICB/ICS Digital Board reporting on interoperability and cyber readiness	**GA2**: Limited independent assurance over third-party and partner cyber resilience and EPR interoperability risks, including clinical safety of interfaces
Digital policies and procedures and Standard Operating Policies and Procedures for all digital activities Compliance to the DSPT Toolkit 25/26				• Data Security and Protection Toolkit assessment	
Data quality improvement plan.	**GC9:** Consistent assurance over third-party supplier and system partner cyber resilience and integration dependencies (including EPR interfaces) is not yet fully in place			• Digital Maturity Assessment	
Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware) Cyber Assurance Framework actions implemented (**IA Significant Assurance)** Third-party/supplier cyber assurance (contractual requirements and compliance reviews) and joint cyber incident response exercises with system partners		• Results of business continuity / EPRR testing • Reporting into DDaT	• Report to Audit and Risk Committee	• NHS Cyber Assurance Framework results • Data Security and Protection Toolkit • Audit plan (internal audit) • Counter Fraud arrangements • Supplier assurance reports (e.g., ISO27001/SOC reports where available) and contract compliance reviews	
Digital EPRR and business continuity arrangements	**GC8:** Recommendations following on from the IT service management review report		• Reported to Audit and Risk Committee	• IT service Management review	
Information Asset Management Framework		• Reviewed by IG Group and SIRO			

Actions to address gaps in control and assurance

Ref	Action	Lead	Due date	Status (proposed)	Progress update
GA1	Potential gap in board assurance and strategic oversight of the digital programme delivery	CIO/CMO	April 2026 Complete	**Propose to close**	Board level engagement has been reviewed. The operational governance arrangements have been agreed and are in place, including the EPR Steering Group, EPR workstream and EPR Partnership Board between DBTH and STH.
GA2	Limited independent assurance over third-party and partner cyber resilience and EPR interoperability risks, including clinical safety of interfaces	CIO/CMO	November 2027	**On track**	Ongoing - and to be assessed as part of the EPR programme and will be a component part of the go-live checklist. A team has been employed to support the organisations drive to have 100% clinical system safety compliance by April 2027 (for existing systems). The EPR will have full clinical safety assurance (including interfaces) ahead of go-live in November 2027.
GC1	Development of Partnership relationships to support confidence based on evidence of effective EPR implementation	CMO	December 2026 Complete	**Propose to close**	Relationship established with STH via the EPR Partnership Board and agreement in place for STH resource to support the DBTH EPR Programme.
GC6	Unsupported and out of date core systems or systems running unsupported versions of Microsoft Server (2016 and below)	CIO	March 2026 Complete	**Propose to close**	Completed. **Microsoft Server 2016:** Versions of Microsoft Server on all internet facing servers have been upgraded, as planned. **Microsoft Office 365:** Fully upgraded and project complete.
GC8	IT Service management Report Recommendations	CIO	March 2027	**On track**	Interim Head of IT Service Management in place and delivery of the plan is underway. Procurement is underway for a new IT Service Management system.
GC9	Establish and implement a third-party/supplier and partner assurance framework for cyber resilience and interoperability (incl. EPR interfaces)	CIO	December 2026	**Propose to close**	Duplicate of GA2 - propose to merge and close.

5. How the BAF is constructed - method and keys

Aligning Controls and assurances

The BAF Template format presents the controls, assurances, gaps and actions together. This means that assurance can be provided over whether existing controls are working. Where they are not, query the action/s required to resolve this. Also able to clearly identify where additional controls and assurances are required and what actions are needed.

Three lines of assurance model

The Trust uses the three lines of assurance model. The assurance provided on the BAF is split by each of the three lines so that clarity is given on which part of the organisation is providing assurance and undertaking mitigating action. This also helps to identify and rectify any gaps.

Cause, risk and effect

The cause, risk and effect format allows to see controls, assurances and actions by the cause and effect of each risk, to be sighted on how the likelihood and the consequence are being reduced. Risk descriptors are written using the cause, risk, and effect model to help shape the way risk on the BAF is presented.

Clarity over scoring stages and methodology

Scoring terminology is defined as follows:

- **Inherent Score**. This is the score of a risk based on there being no controls in place. This would apply if the BAF were to identify that current controls are not working effectively.
- **Current score.** This is the score considering the controls currently in place, assuming that they are working. Some organisations call this the residual risk; to avoid confusion, the Trust does not use that term.
- **Target score**. This is the score once any new mitigating controls have been put in place; this will need to be within the Trust's risk appetite or will need to be tolerated and justified as such in the covering risk report.

The Trust uses the 5 x 5 multiplication scoring method of likelihood × consequence (each scored 1–5), giving scores from 1 to 25: 1–3 low, 4–6 moderate, 8–12 high and 15–25 extreme.

Column definitions used on the risk pages

- **Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC**
- **Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**
- **Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates) (Evidence that the controls/ systems which we are placing reliance on are effective)**
- **Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**
- **Actions SMART (specific, measurable, achievable, relevant, and time-bound) actions.**

Three Lines of Assurance		
First Line of Assurance - operational management, examples include:		
	Budgets; Risk assessments; Work programmes of groups / committees;	Planning exercises when, who, relevance; Training needs assessments.
Second Line of Assurance - Corporate oversight, examples include:		
	Performance/Quality monitoring in place and at what level, how and when; Action monitoring reports Complaints and Compliments / Incident monitoring;	National returns; Training compliance monitoring; Routine reporting of key targets together with any necessary contingency plans.
Third Line of Assurance - independent assurance, examples include:		
	External audit; External inspection bodies, such as the Care Quality Commission and Royal Colleges; Systems of accreditation	Mandatory reporting systems; Internal Audit; Health and Safety Executive.
Assurance Levels		
Trust Assurance Level	**What this means for Board**	**Descriptions that are supported by the evidence presented**
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.
External - Third Line of Assurance - Internal Audit (360 Assurance)		
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.	
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.	
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.	
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.	

BREAK 10:55 - 11:10

2611 - D PERFORMANCE

11:10

2611 - INTEGRATED PERFORMANCE REPORT (INCLUDING FINANCE REPORT)

Discussion Item | Michael Wright, Interim Deputy Chief Executive | 11:10

Executive Directors
15 minutes

REFERENCES

Only PDFs are attached

- D1 - Integrated Performance Report.pdf
- D1 - Appendix 1 - IPR.pdf
- D1 - Appendix 2 - Trust Board Finance & Activity Report 26-27 Month 6.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Integrated Performance Report**			
Sponsor:	Michael Wright, Interim Deputy Chief Executive			
Authors:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Chief Medical Officer Sam Wilde, Chief Financial Officer Denise Smith, Chief Operating Officer			
Appendices:	Appendix 1 - IPR Appendix 2 - Finance & Activity Report 26-27 Month 6			
Purpose of the report	**Assurance**	~~Approval/decision~~	~~Information~~	**Discussion**
Proposed assurance Level **(For assurance papers only)**	***Limited Assurance***			
Assurance Rationale	The Board is asked to take Limited Assurance that whilst some controls exist, they are not embedded and therefore objectives may not be fully met. An approved financial plan is in place but a significant level of risks remains at this point.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			

Executive Summary – Key messages and Issues

This paper provides a high-level view of the Trust's performance and the extent to which current plans are addressing the key challenges. The overall position remains one of Limited Assurance: actions and mitigations are in place, but improvement is not yet consistent or sufficiently embedded. The main issues are interconnected and require coordinated oversight.

Urgent and emergency care continues to be affected by pressures across the whole pathway, including ambulance handovers, emergency department crowding, inpatient capacity and delays in discharge. These challenges present a system-wide flow issue rather than addressed through isolated actions. A coordinated plan should connect operational recovery, discharge improvement and winter preparedness.

Elective and diagnostic backlogs remain a material access risk, particularly for patients waiting longest and in services with concentrated capacity constraints. There are signs of progress in some areas, but the overall pace of recovery is not yet sufficient. Assurance should be sought that specialty-level plans are deliverable, prioritise patients according to clinical need and are supported by clear capacity and productivity actions.

Quality and safety signals, alongside workforce pressures, limit confidence that improvements can be sustained without further action. Concerns include timely recognition and treatment of deteriorating patients, infection-related indicators, staffing capacity and sickness absence.

<u>1 Financial Risks</u>

The financial risks are updated on a monthly basis following the 26/27 plan submission. There has been an improvement of £23.5m in the gross risk since the planning submission (£45.7m to £22.1m). The main risk is centred around delivery the Improvement Delivery Programme (Reset). Mitigations have improved by £4.2m (£6.8m to £11.0m) since plan submission, with the main mitigations being related to contract negotiations with SY

ICB and increasing maturity of delivery plans for the Reset Programme. Since plan submission the net risk has reduced by £27.7m to £11.1m.
The financial risks associated with delivery of recurrent cash releasing savings at planned levels (risks 3895, 3901 and 3903) have all been increased to scores of 25 this month in light of the current status of the Reset programme.

2 Delivering financial sustainability by addressing our underlying deficit over time

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At month 6, the current underlying deficit is estimated at £50.5m. An updated method of calculating the underlying deficit has been prepared, using the PAM as a basis.

Latest published data (to March 2026) shows that Implied productivity is 0.2% (per £) **above** and 2.9% (per WTE) **above** pre-COVID levels, placing the Trust in the best quartile of performance nationally on each measure. There has not been a data refresh since the previous report.

Efficiency schemes implemented during the year to date will yield recurrent full year savings of £17.8m and a 72.1 WTE recurrent reduction in the funded establishment.

3 Delivering the 2026/27 committed plan

The Trust is reporting a £11.5m year to date deficit, which is £9.0m adverse to plan due to a £6.9m shortfall on efficiency delivery and £3.9m Quarter 2 Deficit Support Funding (DSF) not yet being earned, partially offset by non-recurrent technical benefits. Excluding the deficit support funding the Trust is £5.1m adverse to plan. Q2 DSF is being assessed at this point but no formal decision has been confirmed.

Outpatient New, Outpatient Follow up, and day case were below plan in September. Elective was above plan, however ERF activity is below plan. Year to date, outpatient new and outpatient follow up are behind plan and day case and elective are above plan.

Analysis of agency costs versus the required reduction is included within the pack. Agency costs in month were £0.9m, a £0.1m reduction from M5 mainly due to improved control. Bank costs in month are £1.5m, a £0.1m decrease from M5. Additional sessions were broadly in line with the previous month.

The funded establishment has reduced by 60.4 Whole Time Equivalents (WTE) in month 6 due to CIP profiling and is below (i.e. better than) plan and CDC workforce virements. Based on the number of contracted staff, there is a 'vacancy' rate of 2.8% gross (down from 3.2% last month) but a 3.3% over-establishment net of temporary staffing (3.0% over-establishment rate last month).

The most recently published data (June 26) shows an 1.0% **improvement** in implied productivity for DBTH in the first quarter of 26/27 in comparison to the first quarter of 25/26. This places the Trust in the 2nd quartile of performers nationally and is slightly behind the national median (+1.1%) but ahead of the median of the group of peer Trusts selected by NHS England (+0.1%).

Year to date in-year efficiency savings (which include non-recurrent efficiencies) are £12.7m (adverse to plan by £6.9m). Forecast full year in-year savings in the best case are £46.3m in line with plan, with a local gap of £13.7m, with a risk adjusted forecast of £30.6m.

The cash balance is £7.1m and has reduced by £3.2m as a result of cash outflows of PDC Dividend (£5.4m) and Capital payments (£4.2m), partially offset by cash inflow for PDC Capital monies of £2.4m. Revenue cash support from NHSE has been requested.

The capital programme has been increased to £64.9M following recent approval of £14.9M of Estates Safety Funding:
- £39.9M (57%) of the programme now has business case approval.

- £23.1M (33%) of the programme value has now been ordered; and - £3.1M (4%) of the programme has been spent.
Recommendations
The committee is asked to receive the report for assurance.

Healthier together – delivering exceptional care for all	
Patients	Regular review and assessment of Trust performance support the delivery of safe and effective services.
People	Regular review and assessment of Trust Performance, support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships.
Pounds	Regular review and assessment of Trust Performance, supports delivery of the strategic priority to be sustainable and spend money wisely.
Health Inequalities	Health inequality data is captured in the IPR.
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements
Partner ICB strategies	The document has no positive or negative impact on ICB Strategies.
Assurance Route	
Previously considered by - including date:	Contents shared with Finance & Performance Committee, Quality Committee and People Committee
Any outcomes/next steps / time scales	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

DBTH Integrated Performance Report

September 2026

Interpreting SPC charts

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

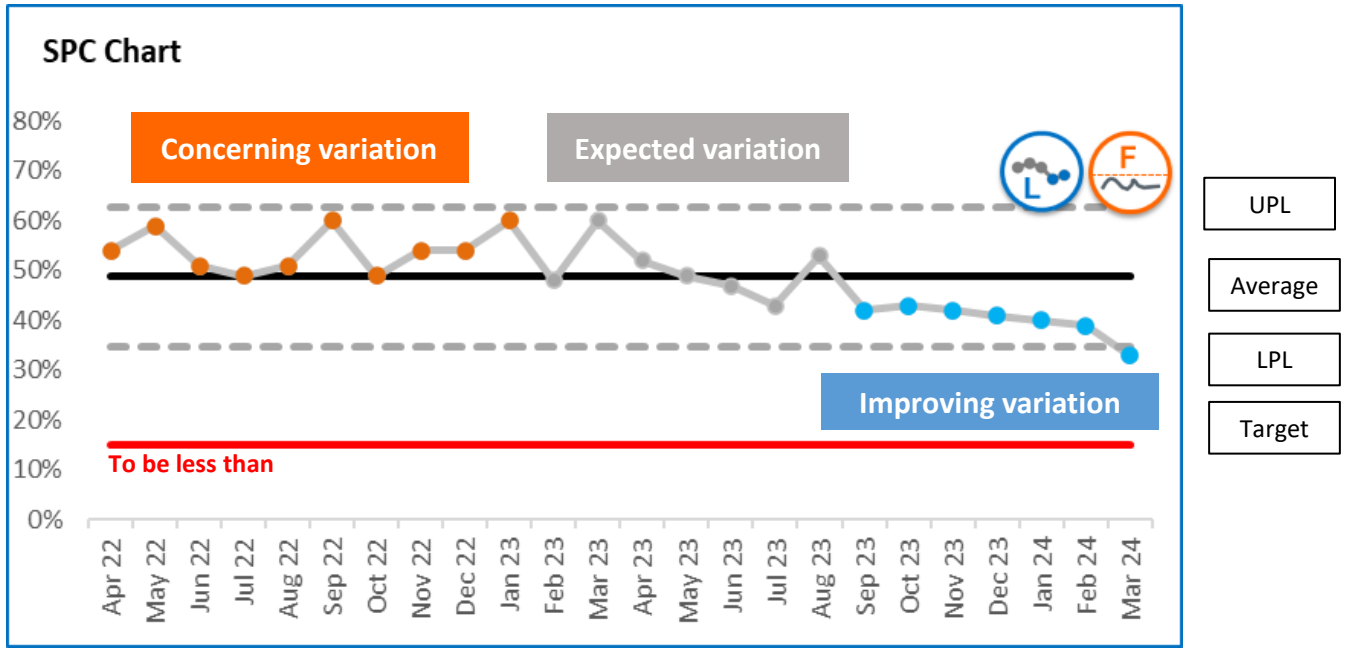
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



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

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

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

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

Interpreting summary icons

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Interpreting Data Quality rating icons

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with the metric. Each metric is scored using the prompt questions below, the combined score is calculated to give an overall KPI rating

S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

STAR scoring
0 points if no assurance at all, 1 point no robust assurance process in place, 2 points if some assurance but not seen as adequate
3 points if there are concerns but not major, 4 points if reasonable assurance
5 points if some concerns but not significant, 6 points if full assurance

Total Score	Overall KPI Rating Key
12 to 0	**No Assurance**
15 to 12	**Limited Assurance**
19 to 16	**Reasonable Assurance**
24 to 20	**Substantial Assurance**

NHS Oversight Framework 2026/27 KPIs - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Access to Services

9 Scoring KPIs Mean Score: 2.48

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q2 26/27	80.00%	**74.68%**			2.45
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q2 26/27	80.0%	83.0%			1.00
Community Services - Patients waiting less than 18 weeks	Aug 26	78.00%	**36.59%**			3.56
Community Services - Patients waiting over 52 weeks	Aug 26	-	0.00%			1.00
Diagnostics - 6 Week Standard	Aug 26	-	27.47%			3.32
ED - Attendances managed within 4 hours - Acute trust footprint QTD	Q2 26/27	82.00%	**73.94%**			3.01
ED - Attendances over 12 hours in department QTD	Q2 26/27	-	5.8%			1.84
RTT - Patients waiting 18 weeks or less	Aug 26	-	63.51%			3.02
RTT - Patients waiting over 52 weeks	Aug 26	0.00%	**2.80%**			3.84

Key performance indicators - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

				Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**2026/7 plan M12**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	26/27 NOF 26/27 Standard contract 26/27 MTP	Sep-26	82.00%	76.0%	13602	18561	73.3%	-2.7%	76.0%	80920	110794	73.0%	-3.0%
Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours.	26/27 MTP	Sep-26	76.85%	69.2%	9233	14143	65.3%	-3.9%	69.1%	54713	84337	64.9%	-4.3%
Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	26/27 MTP	Sep-26	96.48%	95.8%	3464	3598	96.3%	0.4%	96.3%	19348	20275	95.4%	-0.9%
12 hours in A&E department	26/27 NOF 26/27 Standard contract 26/27 MTP	Sep-26	2.50%	4.4%	1091	18561	5.9%	1.5%	5.0%	5341	110794	4.8%	-0.2%
Ambulance handovers within 15 minutes	26/27 Standard contract	Sep-26		65.0%	2005	3862	51.9%	-13.1%	65.0%	12581	23141	54.4%	-10.6%
Ambulance handovers over 45 minutes	26/27 MTP	Sep-26	0%	1.1%	85	3862	2.2%	1.1%	1.7%	614	23141	2.7%	0.9%
Average ambulance handover times	26/27 MTP	Sep-26	00:20:00	00:20:00	00:18:01	00:18:01	00:18:01	-00:01:59	00:20:00	00:17:50	00:17:50	00:17:50	-00:02:10
Overnight total general and acute bed occupancy %	26/27 MTP	Sep-26	95.18%	96.9%	668	708	94.3%	-2.6%	95.3%	652	706	92.4%	-2.9%
Non elective LOS – acute	26/27 MTP	Sep-26	7.06	7.08	20181	2696	7.49	0.41	7.12	124054	16632	7.46	0.33
Percentage of patients discharged on discharge ready date	26/27 MTP	Sep-26	82.40%	82.8%	2170	2696	80.5%	-2.3%	82.8%	13245	16632	79.6%	-3.2%
Average delay (exclude zero delay)	26/27 MTP	Sep-26	2.60	2.71	527	153	3.44	0.74	2.66	3388	1053	3.22	0.55
Mixed Sex Accommodation - nationally reported breaches in month	26/27 Standard contract	Sep-26		0	0	0	0	0	0	3	3	3	3
30 day readmission rate band	26/27 NOF	24/25		A1 = Significantly higher than the national average at the 99.8% level									
14 day readmission rate	26/27 NOF	Sep-26			9261	111256	8.3%			55453	662924	8.4%	

Key performance indicators - Access

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

				Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**2026/7 plan M12**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
Number of patients cared for in corridors - ED	26/27 NOF	Sep-26			-	-	155			-	-	648	
Percentage of patients waiting less than 18 weeks from referral to treatment	26/27 NOF 26/27 Standard contract 26/27 MTP	Sep-26	70.60%	67.1%	35756	55981	63.9%	-3.2%	65.7%	207542	328330	63.2%	-2.4%
Referral to treatment percentage waits over 52 weeks for incomplete pathways	26/27 NOF 26/27 Standard contract	Sep-26		0.5%	1467	55981	2.6%	2.1%	0.7%	8586	328330	2.6%	1.9%
Number of 52+ week RTT waits	26/27 MTP	Sep-26	0	276	1467	1467	1467	1191	276	1467	1467	1467	1191
Percentage of patients waiting no longer than 18 weeks for a first appointment	26/27 MTP	Sep-26	81.56%	78.1%	23789	32487	73.2%	-4.9%	76.7%	140582	189834	74.1%	-2.6%
RTT waiting list – total	26/27 MTP	Sep-26	52809	55267	55981	55981	55981	714	55267	55981	55981	55981	714
28 day Faster Diagnosis Standard	26/27 NOF 26/27 Standard contract 26/27 MTP	Aug-26	81.25%	78.4%	1555	1879	82.8%	4.4%	79.9%	7784	9823	79.2%	-0.7%
62 day referral to treatment for all cancer patients	26/27 Standard contract 26/27 MTP	Aug-26	80.31%	74.1%	136	181	75.1%	1.0%	72.7%	699	925.5	75.5%	2.9%
31 day decision to treatment for all cancer patients	26/27 NOF 26/27 Standard contract 26/27 MTP	Aug-26	94.16%	94.9%	172	175	98.3%	3.4%	95.2%	948	973	97.4%	2.3%
Diagnostic waiting times	26/27 NOF 26/27 Standard contract 26/27 MTP	Sep-26	81.57%	82.4%	9229	12259	75.3%	-7.1%	79.8%	9229	12259	75.3%	-4.5%
Cancelled operations not rebooked within 28 Days	26/27 Standard contract	Sep-26		0	7	7	7	7	0	36	36	36	36
Percent of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance	26/27 MTP	Sep-26	3.29%	3.3%	2110	49740	4.2%	1.0%	3.3%	2110	49740	4.2%	1.0%

Our Access domain matrix

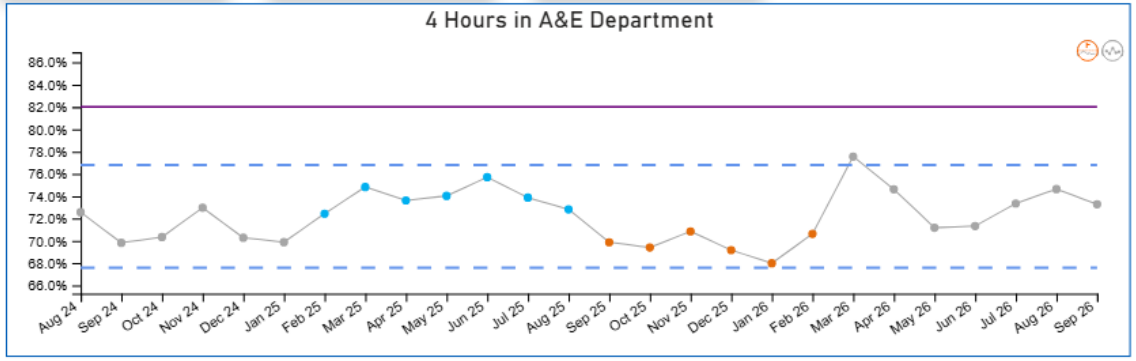
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

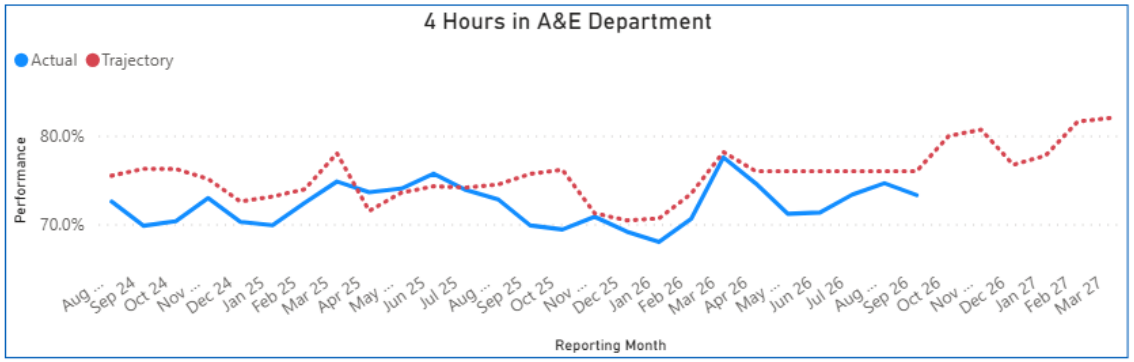
		Assurance			
	Icon	P	?	F	No Target
Variation	H		Percentage of patients waiting less than 18 weeks from referral to treatment	Ambulance handovers within 45 minutes	
	L		Average ambulance handover times	Ambulance handovers over 15 minutes	14 day readmission rate
		Overnight total general and acute bed occupancy %	12 hours in A&E department Percentage of patients waiting no longer than 18 weeks for a first appointment 28 day Faster Diagnosis Standard RTT total waiting list 62 day referral to treatment for all cancer patients Mixed Sex Accommodation Cancelled operations not rebooked within 28 Days Referral to treatment percentage waits over 52 weeks for incomplete pathways Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children Non elective LOS - acute Average delay (exclude zero delay) Percent of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance	Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours 31 day decision to treatment for all cancer patients Diagnostic waiting times Percentage of patients discharged on discharge ready date Number of 52+ week RTT waits	Number of patients cared for in corridors - ED
	H				
	L				

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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





Understanding the performance

In September, 73.3% of patients of patients were admitted, discharged or transferred within 4 hours of arrival at ED, against the trajectory of 76%. There were 18,568 attendances, against the plan of 18,281. The key driver of underperformance is at Doncaster, which sees 55% of all attendances and has 73% of all breaches. Performance at site level is as follows:

- **Doncaster**: 64.8%
- **Bassetlaw**: 78.6% performance
- **Mexborough:** 99.6% performance

Admitted pathway: Flow and capacity constraints following the decision to admit account a significant proportion of breaches at Doncaster and Bassetlaw. SDEC activity increased by 2 patients per day against a plan of 5.

Non-admitted pathway: ED delays and specialty discharges contributed to a significant proportion of breaches. EEMAC implementation has supported a 4% point improvement in Trust non-admitted performance year-on-year. The proportion of patients receiving an ED clinical assessment within 60 minutes increased to 62% in September vs 55% August.

Actions (SMART)

By March 2027, deliver the revised four-hour performance trajectory, assuming Bassetlaw and Mexborough performance remains constant, focusing improvement on Doncaster, through targeted interventions. A revised trajectory, to return to plan by January 2027, is being developed. Improvement actions are currently focussed on:

- **SDEC by default:** Increase combined new patient SDEC access for new patients by 6 patients per day.
- **Clinical decision-making:** Strengthen rapid assessment, management and discharge processes to reduce four-hour breaches by 210 per month.
- **Specialty pathways:** Reinstate specialty referral criteria and response-time standards to reduce specialty-related breaches by 25 per month.

A new UEC improvement programme will be launched in November 2026.

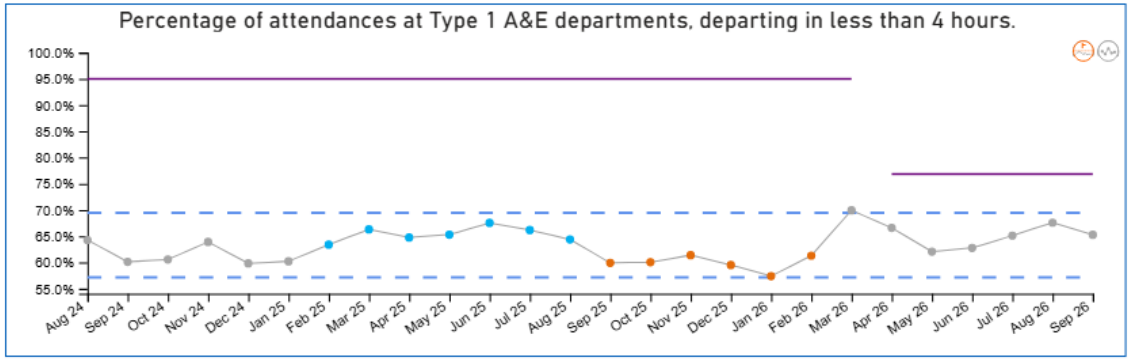
Risks

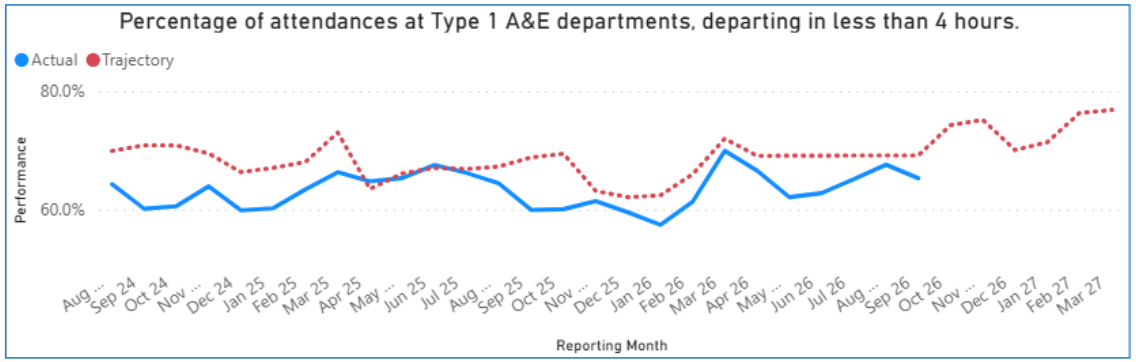
- **Patient flow and inpatient capacity:** Inpatient bed availability and delays to discharge (internal and external) may limit improvement in the admitted pathway.
- **Specialty pathways**: Inconsistent adherence to referral criteria and response-time standards, with ongoing delays in specialty review and discharge.
- **Clinical decision-making**: Delays in senior clinical review, diagnostics, treatment and discharge decisions limiting the reduction in breaches.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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





Understanding the performance

Type 1 performance was **65.3% (4,910 breaches)** against the trajectory of 69.2%. Performance at site level was:

- **Doncaster:** 58.7% performance
- **Bassetlaw:** 76.0% performance

The key drivers of underperformance are consistent with all type 4 hour performance. In addition:

- **UTC streaming:** Lower-than-expected streaming at Doncaster increased ED demand, reducing capacity for higher-acuity patients (14%).
- **EEMAC:** The full benefits of overnight capacity optimisation and implementation at Bassetlaw have yet to be realised.
- **Operational oversight:** a proportion of patients are admitted, discharged or transferred 4-5 hours from arrival, highlighting opportunities to strengthen real-time oversight and escalation to prevent avoidable breaches.

Actions (SMART)

By March 2027, deliver the revised four-hour performance trajectory, focusing improvement on Doncaster improvement through targeted interventions. A revised trajectory, to return to plan by January 2027, is being developed. Improvement actions are currently focussed on:

- **UTC streaming:** Increase streaming to UTC by 167 patients per month (5–6 per day**)** to reduce ED four-hour breaches by 50 per month.

- **Operational grip and control:** Strengthen real-time oversight by tracking patients approaching three hours and prioritising transfer to available inpatient beds. Reduce breaches occurring 4-5 hours from arrival by 50 patients per month.

A new UEC improvement programme will be launched in November 2026.

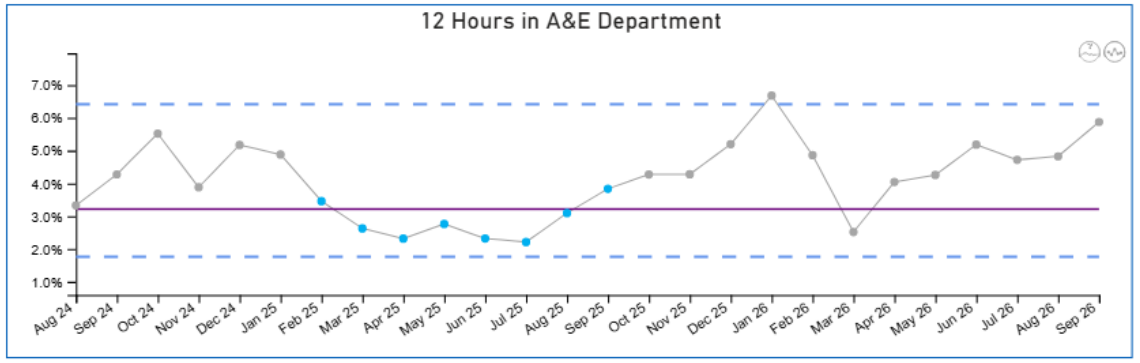
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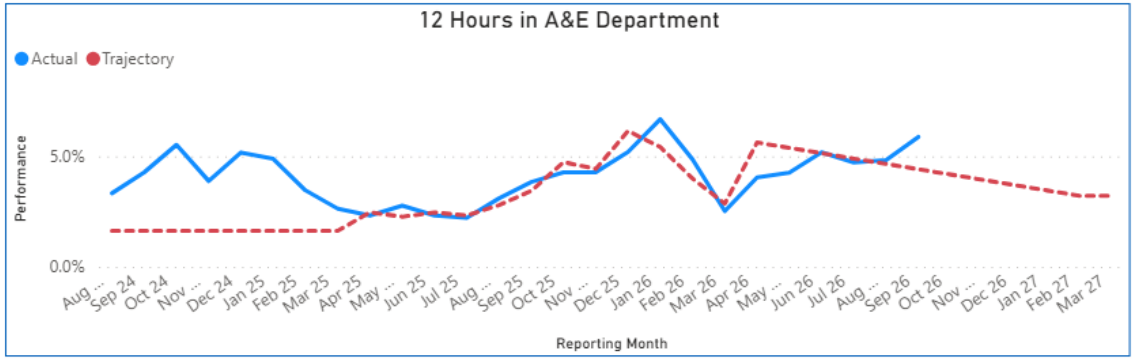
- **Operational oversight**: Inconsistent tracking at three hours, escalation and accountability may result in missed opportunities to prevent breaches.
- **Sustained demand and workforce pressures**: Fluctuating attendances, acuity and staffing may reduce the impact of interventions.
- **UTC streaming:** Insufficient UTC capacity, staffing or streaming compliance to achieve the additional 167 patients per month.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Percentage of patients spending over 12 hours in department





Understanding the performance

The percentage of patients spending over 12 hours in A&E was 5.9% against a trajectory of 4.4%.

Doncaster was the lower-performing site, with 8% of patients exceeding 12 hours. Key drivers of underperformance:

- **Admitted pathway and hospital flow:** 576 admitted patients waited over 12 hours, including 255 awaiting medical beds and 228 awaiting surgical beds.
- **Non admitted delays:** 240 patients were discharged from ED after 12 hours, including 71 Surgical, 54 Medicine, 44 Emergency, 22 Mental Health and 26 T&O.
- **Delayed transfers to inpatient beds:** Decision-to-admit-to-departure averaged seven hours, highlighting constraints in bed availability, specialty response and transfer processes.

Actions (SMART)

The key improvement actions are consistent with those required to improve 4 hour performance.

In addition:

- **NHSE Discharge Improvement Programme:** Successful bid to Participate in the Discharge improvement programme , with a focus on reducing Pathway 0 delays and achieving 85% occupancy ahead of Christmas-through improved patient tracking and escalation.

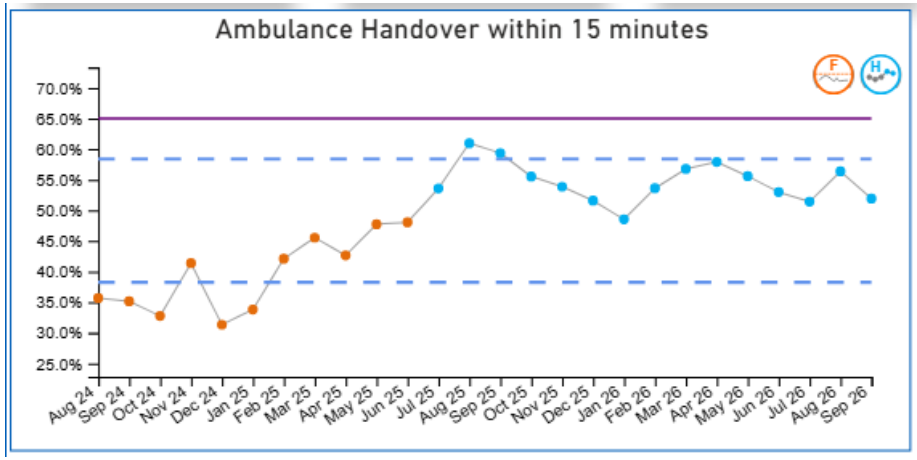
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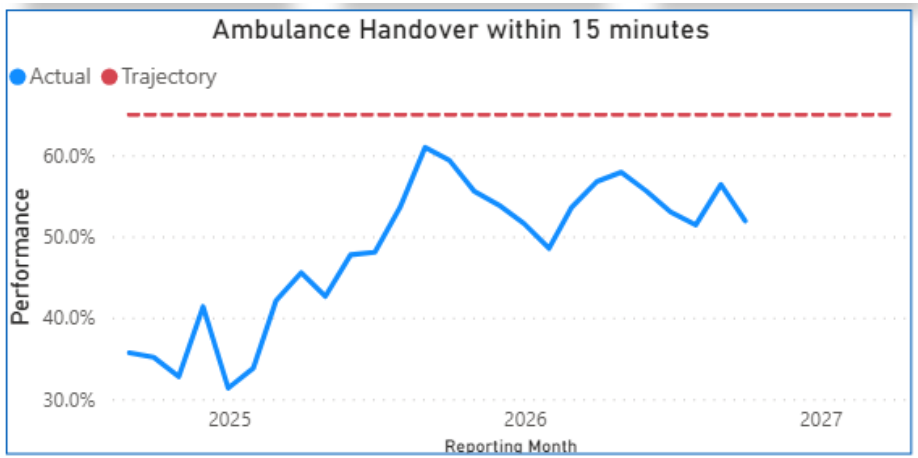
Risks

- **Bed capacity and specialty flow:** Limited bed availability, delayed discharges and pathway constraints may continue to increase DTA-to-admission times.
- **Discharge capacity:** Constraints in community and social care capacity may limit reductions in Pathway 1, 2, 3 delays and achievement of 85% occupancy ahead of Christmas.
- **Winter demand:** Higher-than-planned seasonal demand and acuity may reduce the Trust's ability to deliver planned improvements.
- **System dependencies:** Delivery of the Model Discharge requirements remains dependent on system partners and pathways outside the Trust's direct control.

Assurance report

Handovers between ambulance and hospitals within 15 minutes





Understanding the performance

In September 2026, 51.9% of handovers between ambulance and hospitals were within 15 minutes against the standard of 65.0%. Bassetlaw is the primary driver for underperformance, with 41.8% of handovers taking place within 15 minutes. At Doncaster, 54.7% of handovers took place within 15 minutes.

Average handover time was 18 minutes against the plan of 20:00 minutes. Bassetlaw average handover was 19:51, Doncaster 17:29.

Bassetlaw has improved by 3% September compared to August with average handover reduced by 2 minutes.

Actions (SMART)

- **Improved data quality – Bassetlaw:** Complete daily validation of ambulance handover timestamps, with EMAS actions agreed for all identified discrepancies and weekly review until sustained compliance is achieved.
- **Process consistency :** Embed the agreed escalation process, with daily monitoring of delayed handovers, documented actions and weekly review of compliance and performance.
- **Direct access to SDEC:** Implement agreed direct SDEC access pathways at Bassetlaw, with pathway delivery monitored monthly. At Doncaster, implement direct gynaecology access and YAS pre-conveyance navigation by December 2026, monitoring pathway activity and ED attendances avoided monthly by December 2026.

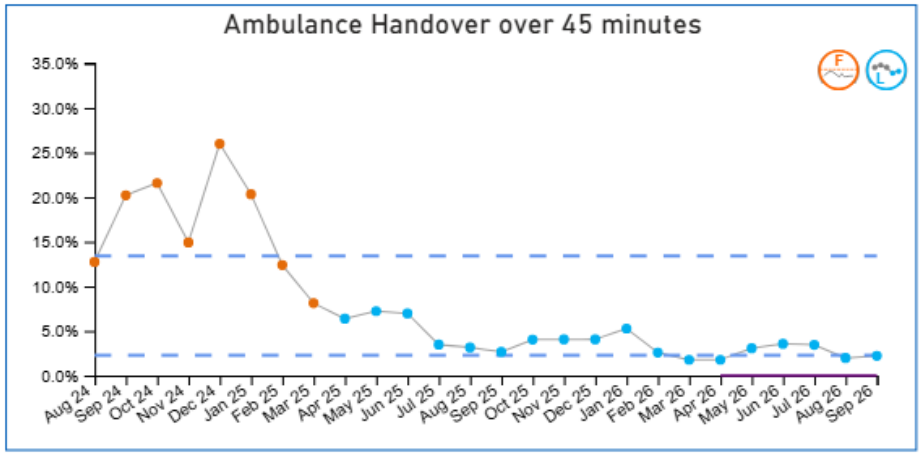
Risks

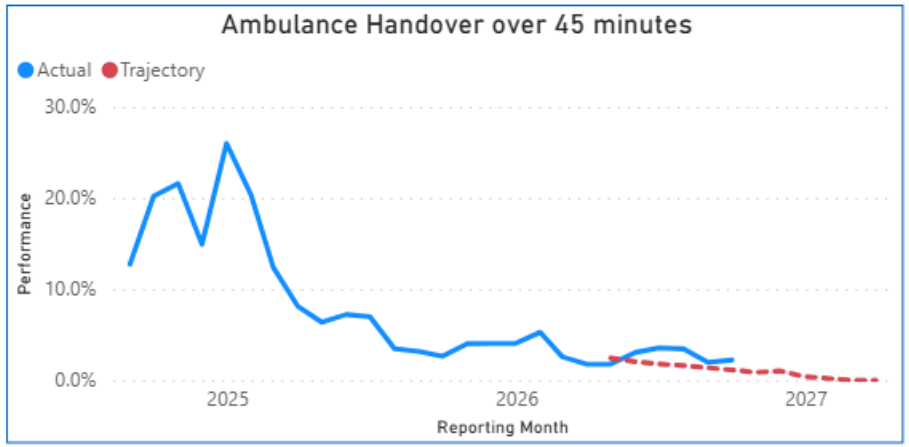
- **ED occupancy:** High occupancy may continue to restrict handover capacity.
- **Demand:** Increased ambulance conveyances may offset improvements.
- **Process variation:** Inconsistent practice between sites may limit improvement.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Handovers between ambulance and hospitals within 45 minutes





Understanding the performance

In September 2026, 2.2% of ambulance handovers took longer than 45 minutes against a trajectory of 1.1%.

Delays in handover at Bassetlaw are the primary driver of Trust underperformance with 4.65% exceeding 45 minutes compared to 1.52% at Doncaster.

Ambulance handover validation has demonstrated that 21 of the 39 reported were not at true 45- minute breach. Month on Month improvement observed since June – 4.8% improvement since commencement of targeted work.

Actions (SMART)

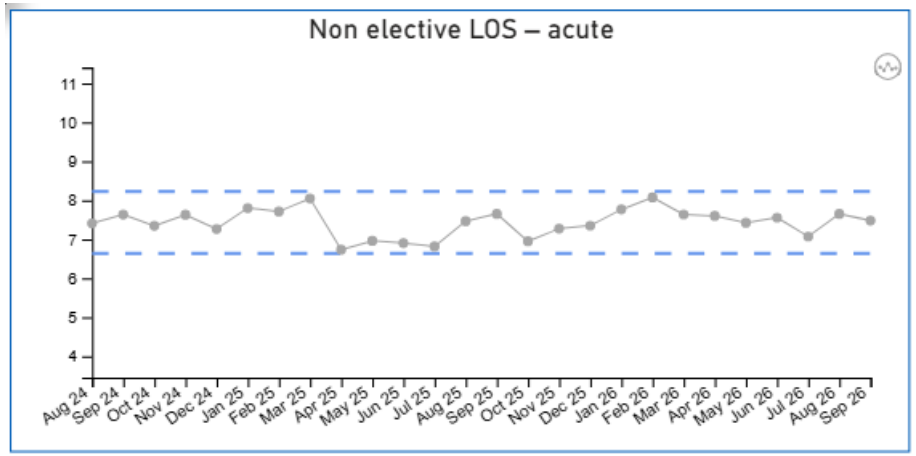
- **Improved data quality – Bassetlaw:** Complete daily validation of ambulance handover timestamps, with EMAS actions agreed for all identified discrepancies and weekly review until sustained compliance is achieved.
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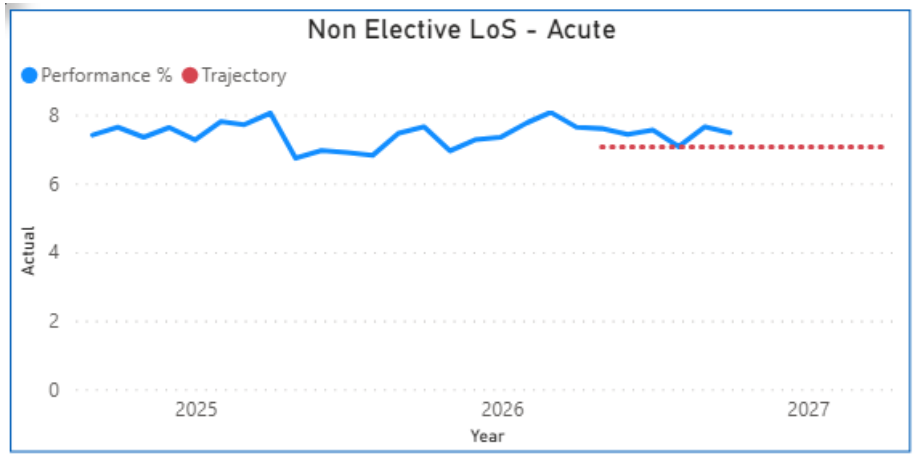
Risks

- **Capacity:** High ED occupancy may continue to limit timely handover and escalation capacity.
- **Process adherence:** Inconsistent adherence to the Handover/ ToC SOP, including timely pinning and timestamping, may sustain reported breaches.
- **Escalation Adherence**: inconsistent adherence to the agreed escalation process.

Assurance report

Non elective length of stay





Understanding the performance

In September 2026, non-elective LoS was **7.49 days against a trajectory of 7.08 days**. Emergency admissions remain broadly on plan.

- Reductions in 7- and 14-day LoS reflect improved consistency in Pathway 0 discharges through the identification and resolution of internal delays. Wards targeted through the UEC improvement programme achieved a one-day reduction in average LoS between August and September.
- Pathway 1 and 2 volumes have not increased, the length of stay associated with these pathways has risen, indicating ongoing delays in accessing onward care. Further improvement will focus on sustaining ward-level gains and addressing internal and external discharge barriers to close the gap against trajectory.

Actions (SMART)

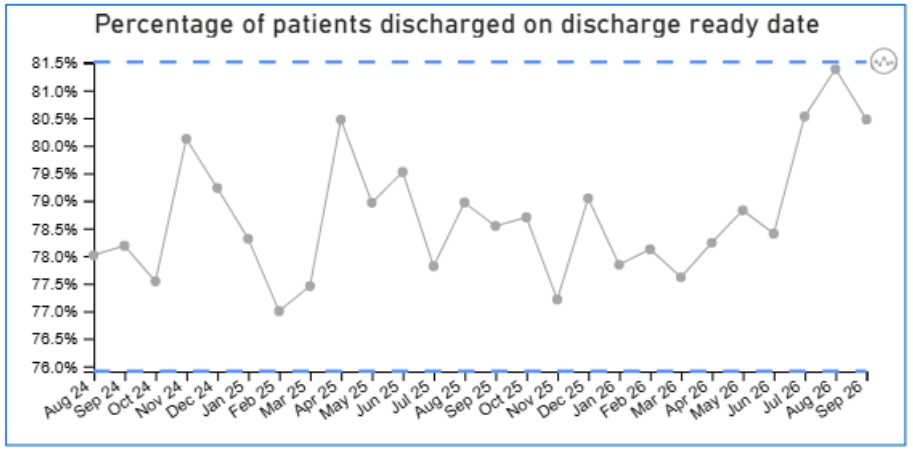
- **Ward processes:** Sustain and extend standardised ward processes across targeted medical wards, maintaining LoS improvements and monitoring performance monthly.
- **Flow and capacity**: Complete a review of the surgical pathway and bed model by the end of October 2026, with agreed actions to align capacity with demand.
- **Surgical Pathway redesign**: continue to progress virtual ward pathways for Surgery with a go live date of 2 November.
- **NHSE Discharge Improvement Programme:** Successful bid to Participate in the Discharge improvement programme , with a focus on reducing Pathway 0 delays and achieving 85% occupancy ahead of Christmas-through improved patient tracking and escalation.

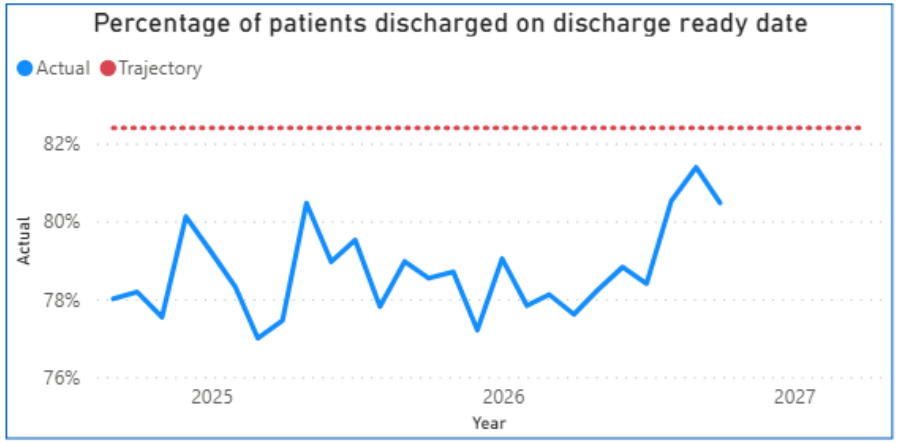
Risks

- **External pathway delays**: Increased LoS across Pathways 1 and 2 may offset improvements in Pathway 0 and delay delivery of trajectory.
- **Internal flow**: Bed capacity, delayed clinical decisions and inconsistent discharge processes may limit sustained LoS reductions.
- **Sustainability**: Inconsistent adoption of standardised ward processes may reverse improvements in targeted wards.
- **System capacity:** Limited community, intermediate care and social care capacity may delay onward transfers and increase LoS.

Assurance report

Patients discharged on discharge ready date





Understanding the performance

In September 2026, the percentage of patients discharged on discharge ready date was 80.5% against a trajectory of 82.8%.

Actions (SMART)

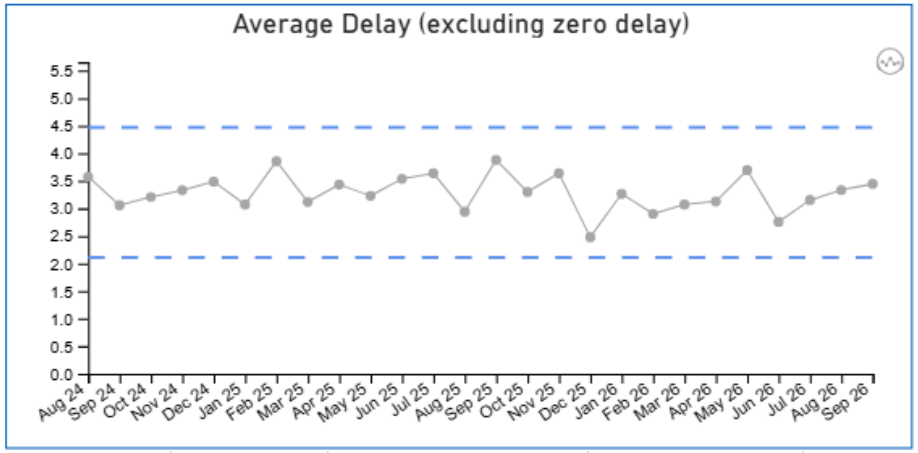
- **Ward processes:** Sustain and extend standardised ward processes across targeted medical wards, maintaining LoS improvements and monitoring performance monthly.
- **Simple discharges**: Standardise the simple discharge pathway (P0) to further improve discharge-ready performance by the end of Q3.
- **NHSE Discharge Improvement Programme:** Successful bid to Participate in the Discharge improvement programme , with a focus on reducing Pathway 0 delays and achieving 85% occupancy ahead of Christmas-through improved patient tracking and escalation.

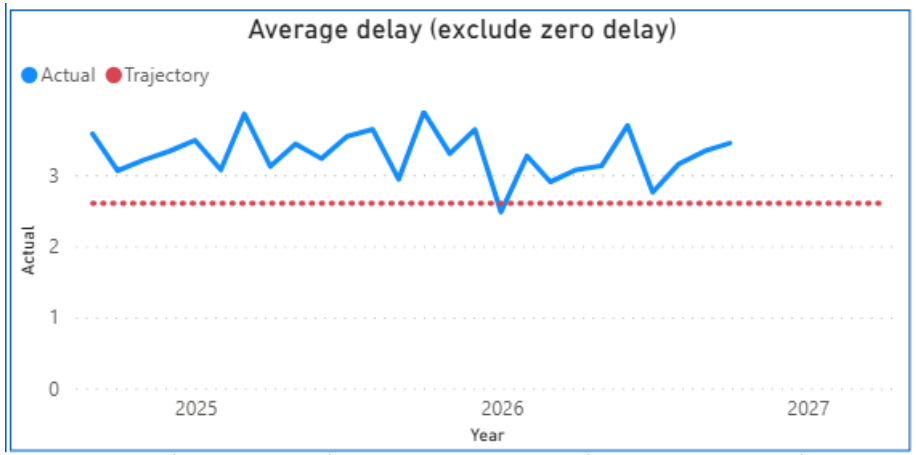
Risks

- **Process variation:** Inconsistent ward and discharge processes may limit improvement.
- **System capacity:** Limited community, intermediate care and social care capacity may delay onward transfers and increase LoS.

Assurance report

Average delay to discharge (exclude zero delay)





Understanding the performance

In September 2026, the average delay to discharge (excluding zero delay) was 3.44 days against a trajectory of 2.71.

Actions (SMART)

Internal actions are focussed on:

- **Ward processes**: Embed standardised ward processes across targeted wards, monitoring compliance and length of stay monthly.
- **Simple discharges**: Standardise the simple discharge pathway by the end of Q3 to improve discharge readiness.
- **Delayed discharge audit**: Identify internal delays and agree targeted improvement actions.

Improvement actions with system partners in Bassetlaw are focussed on:

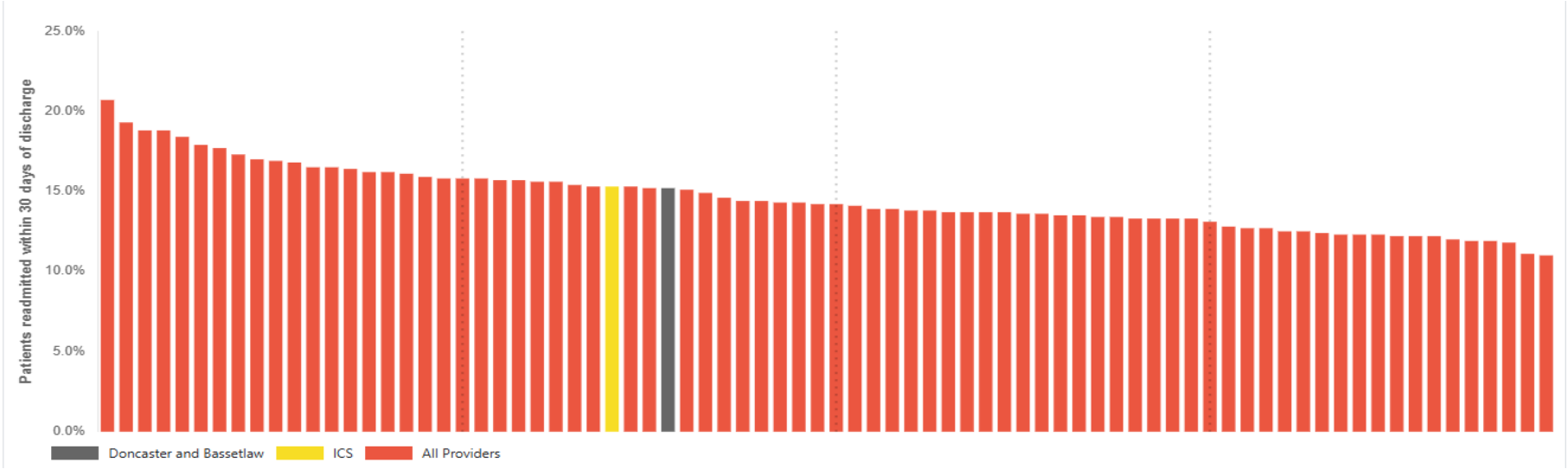
- **Pathway delays**: Review Pathways 1–3 delays with community, social care and intermediate care partners.
- **System escalation**: Strengthen joint escalation to resolve delays in onward care.
- **Performance review**: Monitor delayed discharges, actions and impact through regular system meetings

Risks

- **System capacity**: Limited community, social care and intermediate care capacity may delay external discharges, particularly at Bassetlaw.
- **Partner engagement**: Delays in joint decision-making and escalation may hinder resolution of discharge barriers.
- **Data and oversight**: Inconsistent recording of delays may limit identification of improvement opportunities and measurement of impact.

Assurance report

30 day readmission rate band



Understanding the performance

The percentage of patients readmitted to inpatient capacity within 30 days of being discharged is shown as a comparative banding compared with the national average.

For the most recent reporting period 24/25, the Trust scored significantly higher than the national average at the 99.8% level, indicating a significant opportunity to improve discharge planning, admission avoidance and post-discharge support. The rate was 15.2%.

A deep dive has been undertaken to understand the cause of this variance and identify opportunities for improvement.

Actions (SMART)

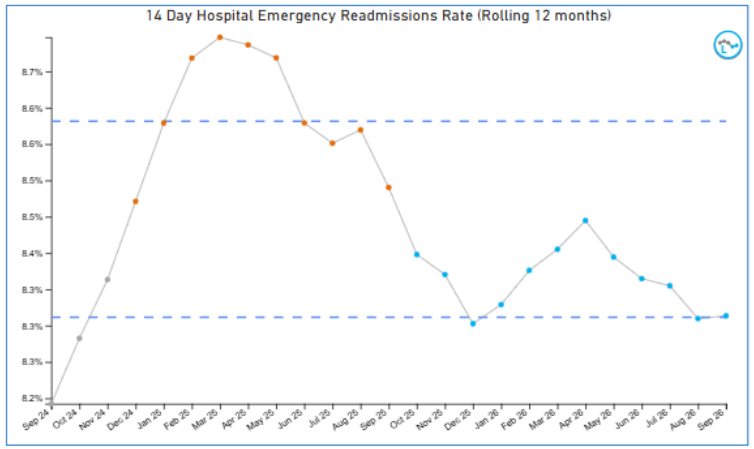
- **Readmission review:** a deep dive into all readmissions. This has shown that a significant proportion of readmissions take place 0 – 3 days and 4 – 7 days. Further analysis into these readmissions is being undertaken. 0 – 3 days will be complete in November and 4 – 7 days will be completed in December 2026.
- **Discharge pathway:** Identify the discharge pathway (P0–P3), destination and any gaps in discharge planning, clinical decision-making or post-discharge support.
- **Identify opportunities:** By January 2027, analyse findings by specialty, ward and readmission timeframe to identify avoidable returns and recurring themes.
- **Implement improvements:** By March 2027, implement targeted actions with priority specialties and monitor monthly readmission rates and action delivery.

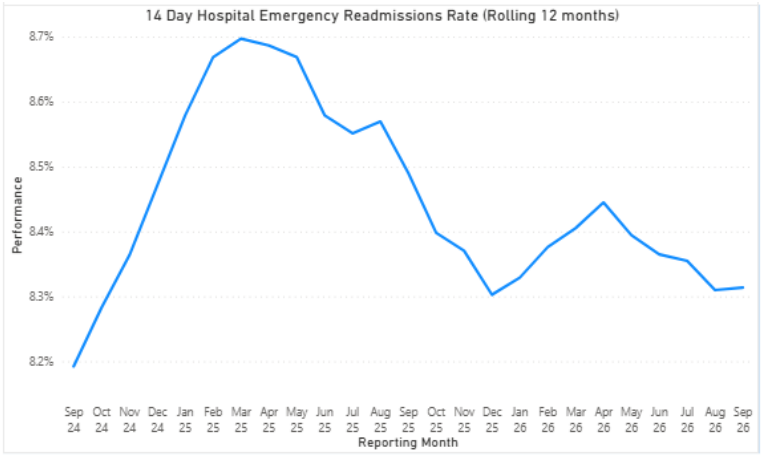
Risks

- **Capacity**: Clinical and operational pressures may delay case reviews and delivery of improvement actions.
- **Attribution**: Complex patient needs and multiple contributing factors may make it difficult to determine whether readmissions were avoidable.
- **Sustainability**: Agreed actions may not translate into sustained reductions in readmission rates.

Assurance report

14 day readmission rate





Understanding the performance

The 14-day readmission rate was **8.3%**. Initial audit findings show that over 50% of readmissions occurred within 72 hours and 77% within seven days of discharge.

General Surgery, A&E, Paediatrics and Acute Medicine account for 54% of readmissions, providing the greatest opportunity for high-volume review. General Medicine recorded the highest 8–30-day readmissions (19 spells), primarily driven by Respiratory Medicine.

Most patients were readmitted from their usual place of residence; however, readmission rates were higher among patients returning from alternative destinations, warranting further investigation.

Actions (SMART)

- **Readmission review:** By December 2026, review readmissions in sequence: within 72 hours, 4–7 days and 8–14 days, prioritising short initial admissions.
- **Discharge pathway:** Identify the discharge pathway (P0–P3), destination and any gaps in discharge planning, clinical decision-making or post-discharge support.
- **Identify opportunities:** By January 2027, analyse findings by specialty, ward and readmission timeframe to identify avoidable returns and recurring themes.
- **Implement improvements:** By March 2027, implement targeted actions with priority specialties and monitor monthly readmission rates and action delivery.

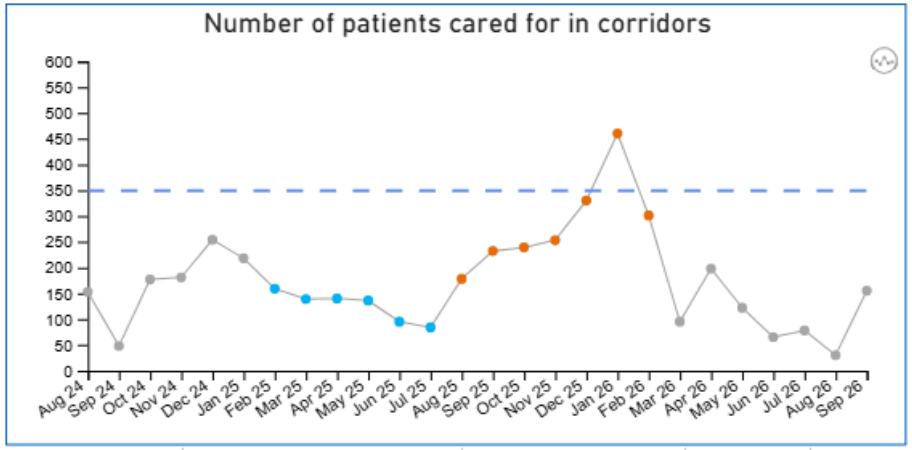
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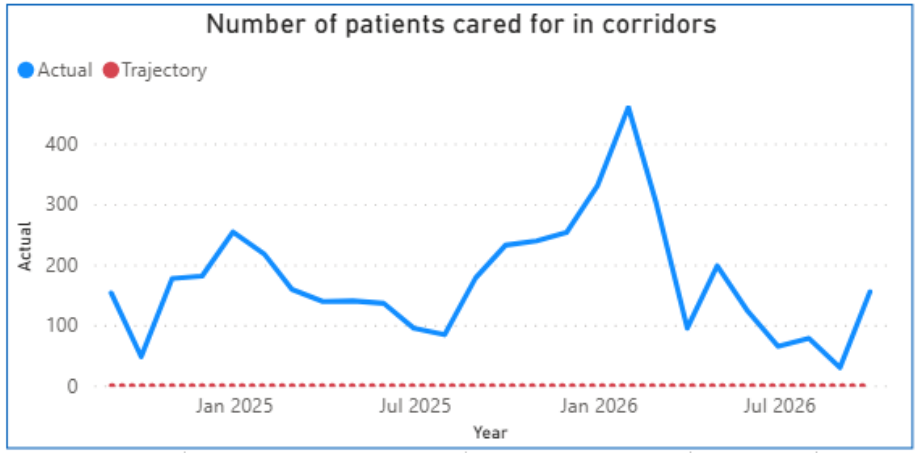
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- **Sustainability**: Agreed actions may not translate into sustained reductions in readmission rates.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Number of patients cared for in corridors





Understanding the performance

In September 2026, 155 patients received corridor care.

'Corridor care' in the Emergency Department is care delivered in a non- designated clinical space for >45 minutes.

Corridor care pressure points correlate closely with ambulance arrivals to maintain the 45 minutes standard at times of high occupancy.

Actions (SMART)

- **EEMAC implementation**: Implement EEMAC at Bassetlaw by the end of Q2 – an average of 8 patients per day are flowing through EEMAC.
- **Admitted pathway**: Increase SDEC / admission avoidance to reduce admissions by 5 patients – September achieved +2 additional patients per day.
- **GIRFT Improvement guide:** both Emergency Departments have undertaken a self assessment against the corridor care improvement guide and gaps identified have been incorporated into the improvement programme.

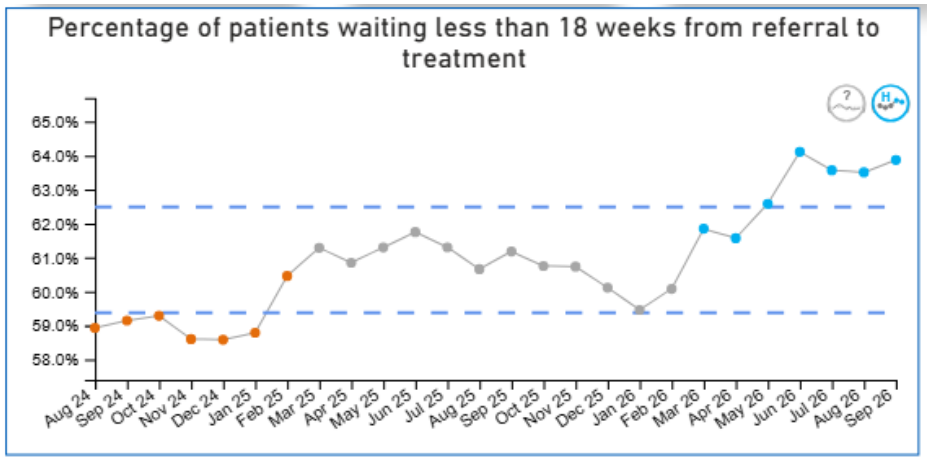
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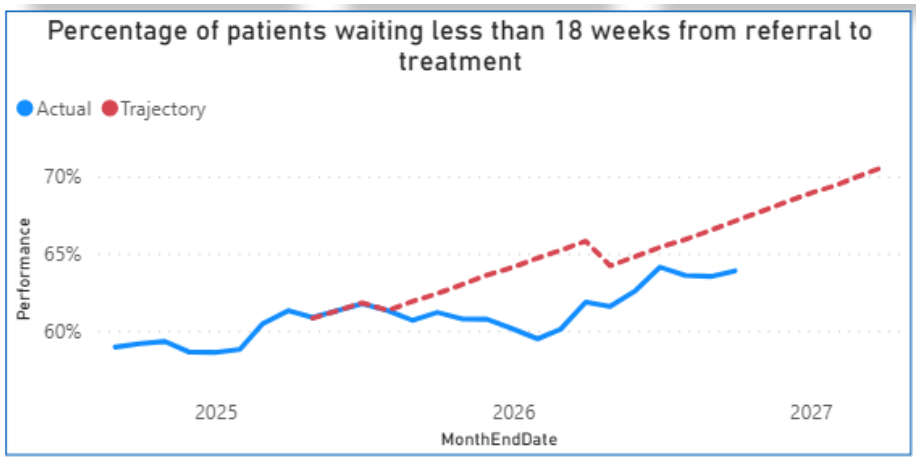
- **ED occupancy:** Continued high demand and limited flow out of ED may have an adverse impact on corridor care.
- **Bed capacity and specialty flow:** Reduction in timely bed availability over the winter period.
- **Specialty and ED review and discharge delays:** may have a detrimental impact on ambulance handover capacity.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patients waiting up to 18 weeks for care





Understanding the performance

- Unvalidated September RTT performance is 64.1%, up 0.6% from August but 3% below the 67.1% trajectory.
- Trauma and Orthopaedics (50.1%) and ENT (49.0%) remain the main drivers of underperformance.
- Missing clinic outcomes reduced by 1,800, including 568 in Trauma and Orthopaedics and 270 in ENT.
- Theatre utilisation increased from 64.0% to 73.1%.
- Gastroenterology delivered the largest reduction in patients waiting over 18 weeks, supported by additional capacity identified through job-plan review.

Actions (SMART)

- **Establish control of the waiting list**: PTL management and validation, prioritising clinically urgent patients and long wait patients.
- **Maximise elective capacity:** Through the theatre, outpatient and diagnostic improvement programme
- **Improve outpatient productivity:** Reduce avoidable follow-ups through PIFU, advice and guidance and clinically agreed pathway protocols.
- **Optimise booking and scheduling:** Through 6-4-2 process in Outpatients and Theatres.
- **Accelerate long-wait recovery**: Specialty-level recovery plans for the longest-waiting patients, monitored through weekly Corporate PTL meetings
- **Improve patient readiness:** Strengthen the text messaging provision across all specialties.
- **Recovery:** Establish specialty-level RTT recovery trajectories

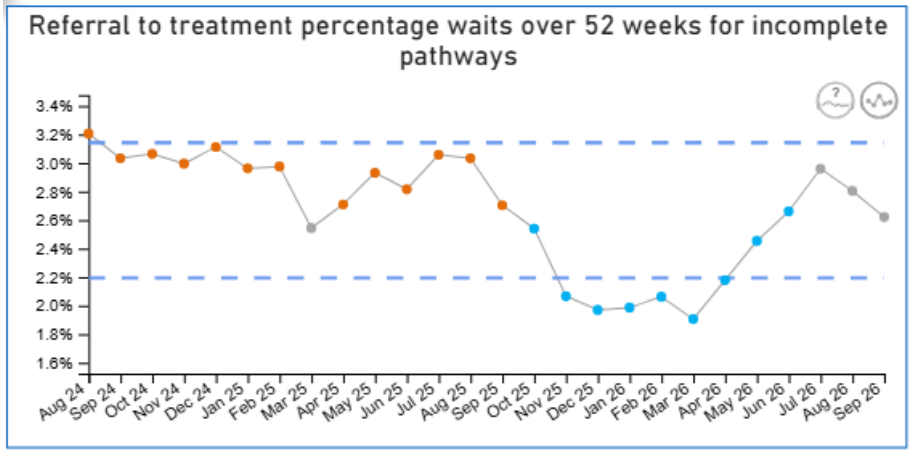
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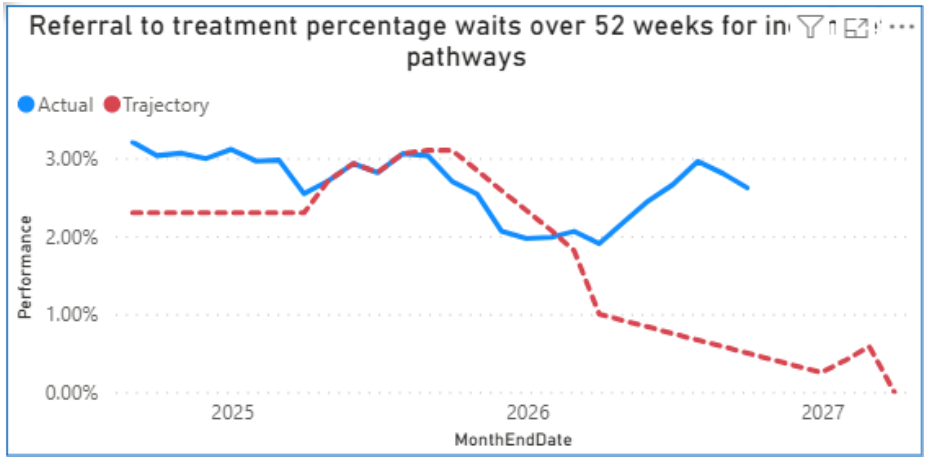
- Risk that outpatient and theatre productivity improvements are not delivered, resulting in under utilisation of available capacity
- Risk of insufficient validation capacity to maintain an up to date and accurate PTL, resulting in missed opportunities to improve RTT performance

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patients waiting over 52 weeks for care





Understanding the performance

- In September 2026, 2.6% were waiting > 52 weeks, against the trajectory of 0.5%. (unvalidated).
- Trauma and Orthopaedics and ENT remain the principal drivers of long waits, with 1,121 and 207 patients waiting over 52 weeks respectively. Together, these specialties account for 95% of the Trust's 52-week cohort.
- Weekly Corporate PTL reviews continue to provide focused oversight against specialty recovery trajectories. During September, the number of patients waiting over 52 weeks reduced by 77, comprising:
  - 27 in ENT, 26 in Pain Services, 19 in Trauma and Orthopaedics, 5 in General Surgery. Gastroenterology eliminated all remaining 52-week waits.

Actions (SMART)

Eliminate long waits through targeted speciality recovery

- Additional operational capacity in place for ENT and Trauma & Orthopaedics, providing dedicated senior operational oversight of the recovery plans and ensuring all available clinical capacity is fully utilised.
- By November 2026, ensure all patients waiting over 52 weeks who require diagnostic investigation have a prioritised diagnostic request and a planned follow-up review date, monitored weekly through the specialty PTL process.

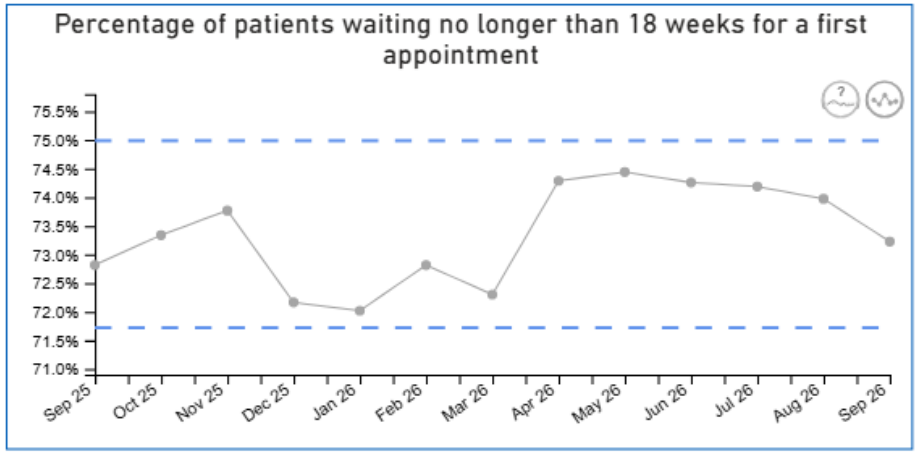
Risks

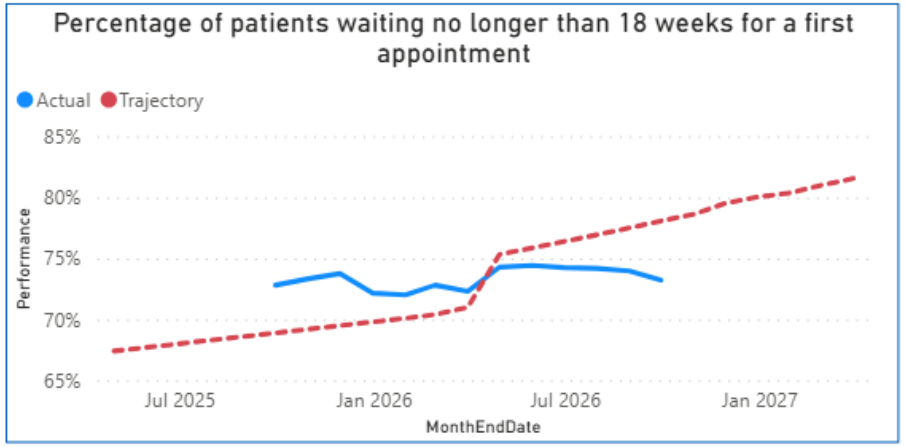
- Risk that outpatient and theatre productivity improvements are not delivered, resulting in under utilisation of available capacity
- Risk of insufficient validation capacity to maintain an up to date and accurate PTL, resulting in missed opportunities to improve RTT performance

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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





Understanding the performance

- In September 2026, 73.2% of patients were waiting < 18 weeks for first outpatient appointment, against the trajectory of 78.1%.
- The three largest specialty cohorts driving the underperformance are ENT (2,800 patients), Respiratory Medicine (1,070) and Ophthalmology (880). Collectively, these specialties account for 4,750 patients, representing 54.8% of the Trust's total backlog
- Clinic booked utilisation increased from 88.5% to 91.7% and DNA rate reduced from 9.4% to 8.6% in September compared to previous month.

Actions (SMART)

- Optimise clinic utilisation by reviewing capacity, templates and slot allocation to maximise new-patient appointments.
- Reduce DNAs through proactive patient reminders, appointment confirmation and targeted follow-up of high-DNA cohorts.
- Minimise cancellations by monitoring clinic changes and rebooking affected patients at the earliest available opportunity.
- Prioritise patients approaching 18 weeks through regular waiting-list reviews and targeted booking into available capacity.
- Strengthen performance oversight through weekly monitoring of waits for a first appointment, clinic utilisation and DNA/cancellation rates, with recovery actions agreed for underperforming specialties.

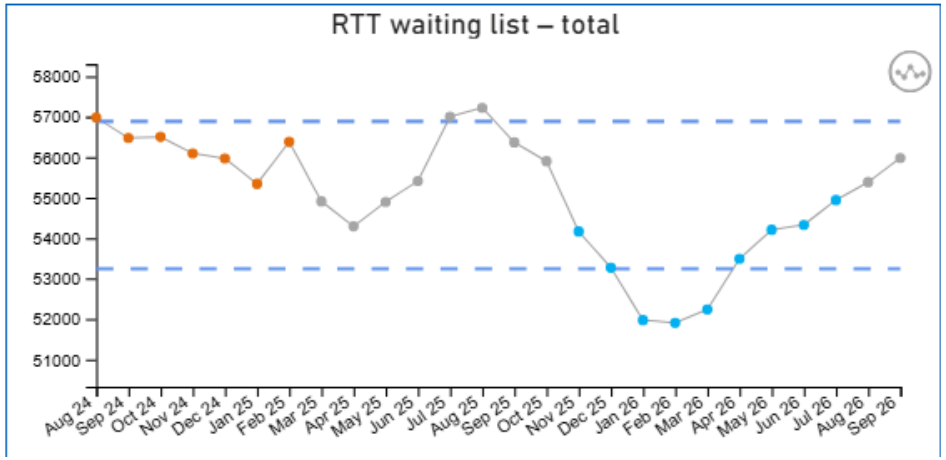
Risks

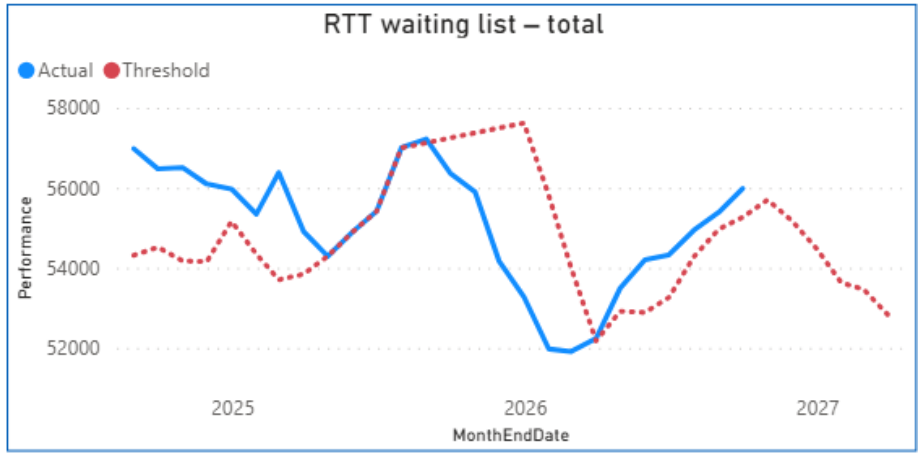
Risk of patients experiencing long waiting times for treatment where waits for first outpatient appointment are over 18 weeks.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

RTT waiting list – total





Understanding the performance

- In September 2026, the total waiting list size was 55,981 against the plan of 55,267
- Trauma & Orthopaedics remains the largest specialty waiting list with c. 13,000 pathways representing 23.3% of the Trust total.
- ENT has the second largest waiting list at 6,748 pathways, representing 12% of the Trust total.
- Unvalidated pathways over 18 weeks reduced by 1,081, including 768 in ENT and 313 in Trauma and Orthopaedics.
- Trust-wide 12-week validation improved by 4% to 50.1%, with ENT increasing to 66% and Trauma and Orthopaedics to 51%.

Actions (SMART)

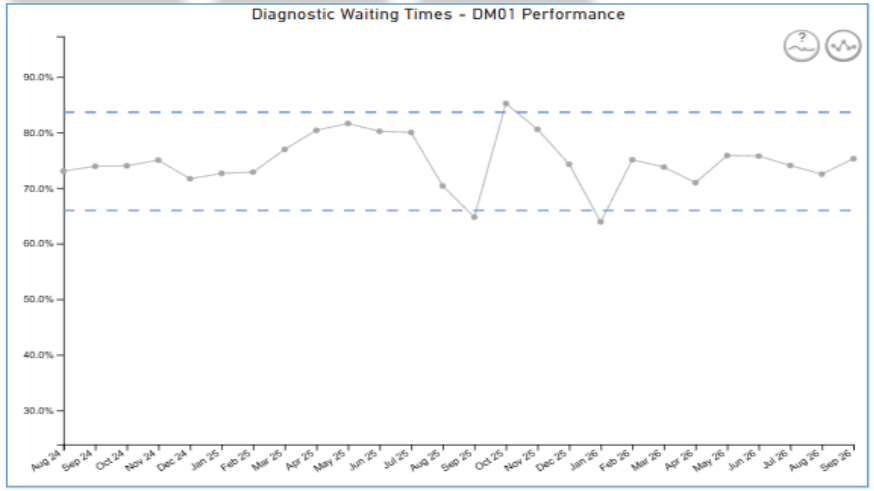
- Complete targeted reviews of Ophthalmology and General Surgery, identifying the causes of waiting-list growth with recovery actions in place by November 2026
- Increasing Trust-wide 12-week validation performance through routinely including admitted patients in specialities which have long admitted waiting times, supported by monthly review in Trust Access Group by November 2026.
- Continuing validating all pathways over 18 weeks, with additional validation resources deployed in ENT and Trauma and Orthopaedics, with progress monitored monthly Trust Access Group for Elective Care.

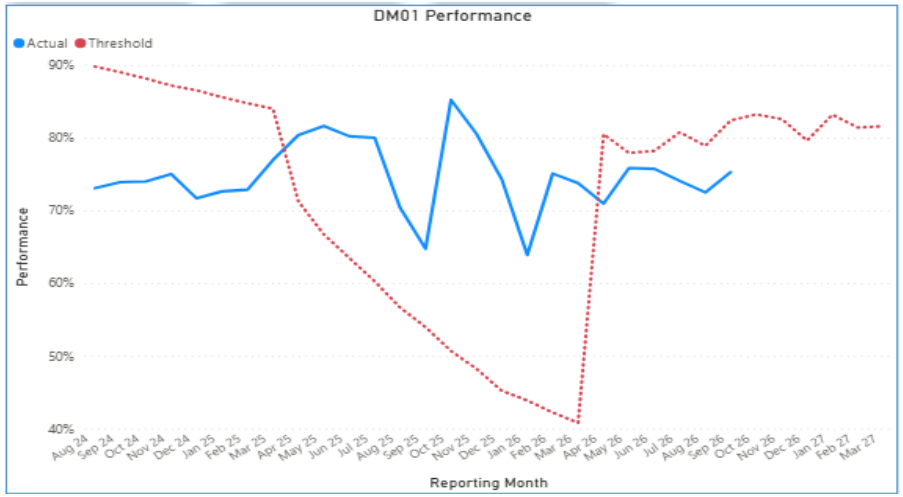
Risks

- Limited validation capacity, with resources prioritised for Trauma and Orthopaedics and ENT, constraining progress in other specialties
- Workforce and process constraints, including reliance on manual processing of patient responses, limiting further improvement in 12-week validation performance.

Assurance report

Diagnostic referrals waiting over 6 weeks





Understanding the performance

- In September 2026, 75.3% of patients had a diagnostic test within 6 weeks of referral, against the trajectory of 82.4%, with 3,031 patients waiting over six weeks
- The waiting list reduced by 489 patients to 12,260, while 6-week breaches reduced by 477 to 3,031.Improvements were noted in MRI, Audiology, Neurophysiology and DEXA.
- The under performance is driven by MRI and Audiology, which account for 87.6% of all patients waiting over 6 weeks.

Actions (SMART)

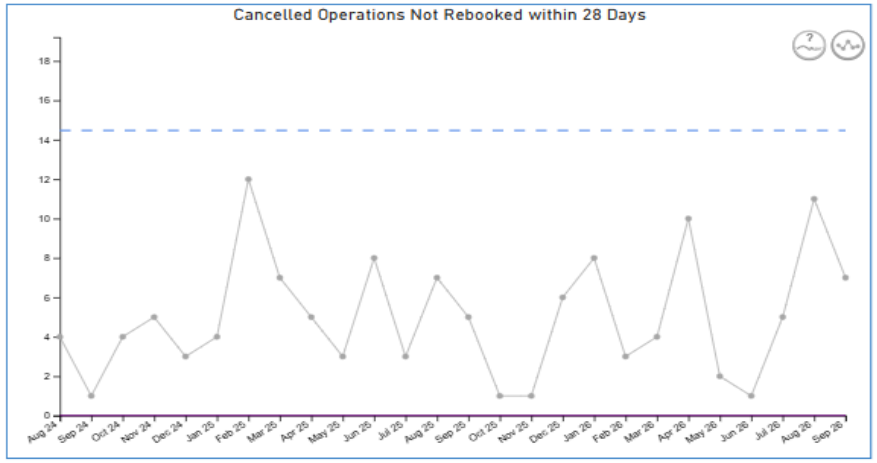
- Continued additional capacity to Paediatric Audiology, via an insourcing arrangement. This has supported an improvement of approximately 4% during September and reduced the number of patients waiting over six weeks by 119 since August.
- Continued additional capacity to MRI, delivered through 7-day working. To date this has delivered 399 additional scans, reducing the waiting list by 140 and six-week breaches by 281.
- A 3-month pilot for Consultant-only MRI requesting from November to reduce inappropriate referrals and improvement demand management.

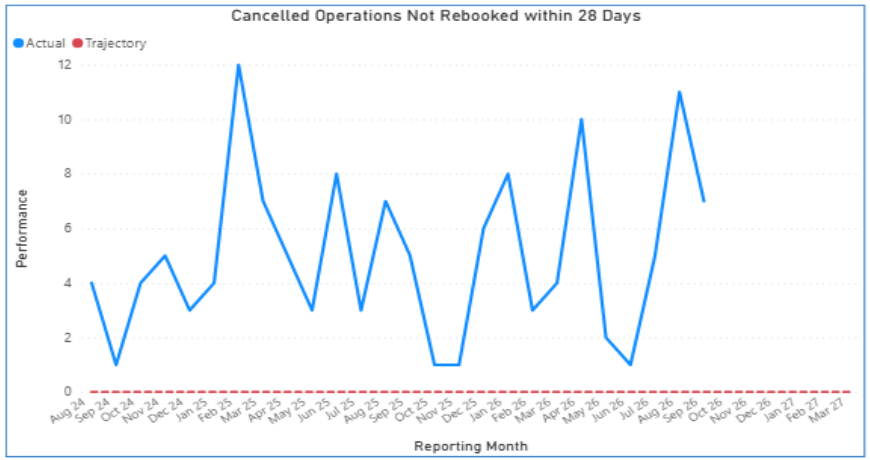
Risks

- Risk of MRI and Paediatric Audiology demand exceeding available capacity which would have a detrimental impact on delivery of the improvement trajectory.
- MRI capacity remains constrained by competing emergency, cancer and elective demand and continues to be the principal driver of the Trust's DM01 position.
- Risk of delays in the ENT pathway which increase the pressure on Paediatric Audiology capacity.

Assurance report

28 day theatre cancellations





Understanding the performance

In September 2026, there were 7 cancelled operations not rebooked within 28 days. These were 3 x Ophthalmology, 1x general surgery, 1 x cardiology, 2 x T&O

- 3 x Ophthalmology: caused theatre staff availability and delays in theatre. 2 patients were rebooked for 27 October and 25 November 2026 and 1 patient date to be confirmed.
- 2 x Trauma & Orthopaedics: Insufficient theatre capacity due to list overrunning, with one patient also requiring further clinical review. 1 patient was rebooked for 7 October 2026 and 1 patient date to be confirmed.
- 1 x General Surgery: caused by bed unavailability and consultant availability. Rebooked for 9 September 2026.
- 1 x Cardiology: caused by insufficient theatre time and rebooked for 18 September 2026

Actions (SMART)

- **Strengthen the 28-day rebooking process** requiring all patients cancelled on the day of surgery to be rebooked within 28 days, with a confirmed date or documented escalation
- **Introduce a central cancellation tracker** to record affected patients, cancellation reasons, rebooking status and deadlines, with weekly review of outstanding cases by November 2026.
- **Assign clear accountability** by allocating each cancelled patient to a named specialty lead responsible for ensuring timely rebooking and escalating capacity constraints.

Risks

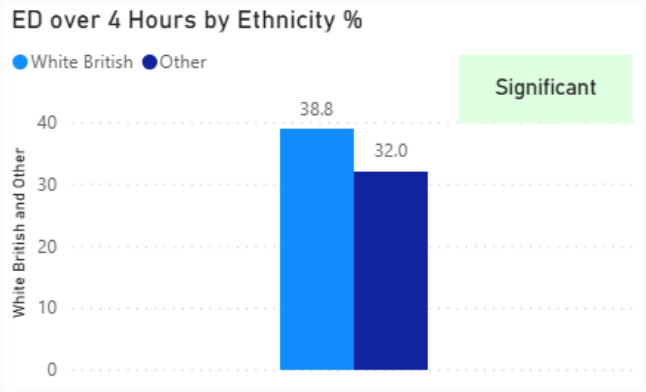
- Risks of insufficient theatre or clinician capacity to rebook patients within 28 days of cancellation

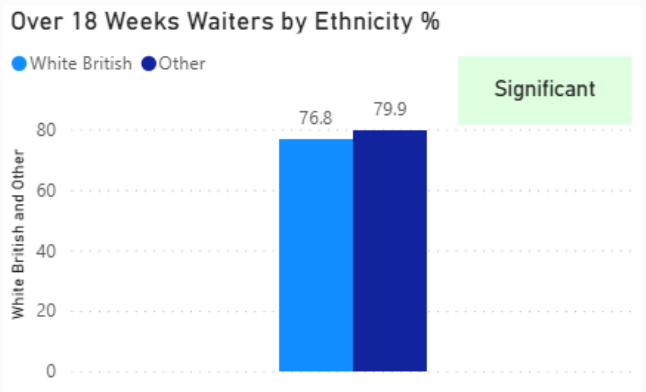
Health Inequalities

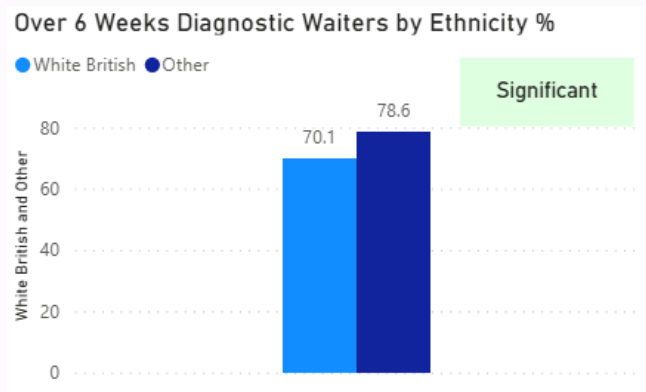
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

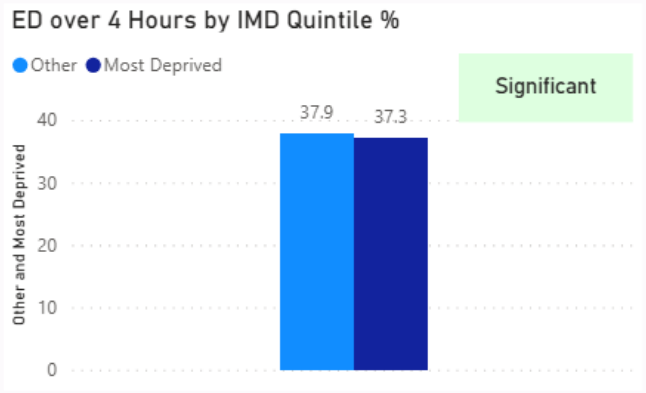
Combined commentary

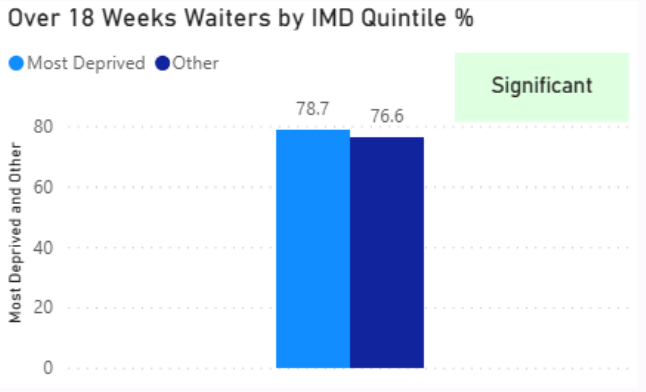
For ED waits greater than 4 hours, marked statistically significant favourable variation toward ethnic minority groups, minimal statistically significant favourable variation toward the most deprived population. For waiters greater than 18 weeks, moderate statistically significant unfavourable variation toward ethnic minority groups, slight statistically significant unfavourable variation toward the most deprived population. For diagnostic waiters greater than 6 weeks, marked statistically significant unfavourable variation toward ethnic minority groups, minimal unfavourable variation toward the most deprived population; however the difference was not statistically significant.

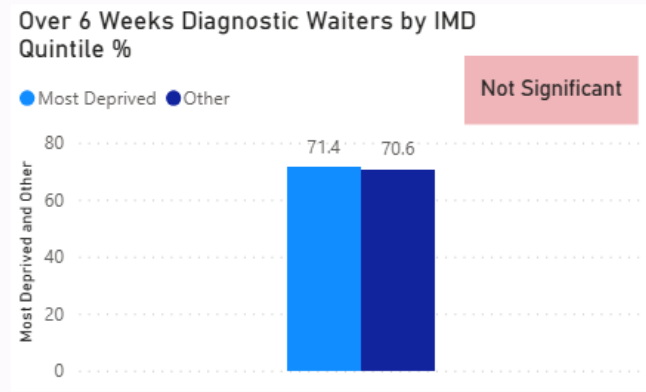












NHS Oversight Framework 2026/27 KPIs - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Experience of Care

2 Scoring KPIs Mean Score: 2.25

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC inpatient survey satisfaction rate	2026	-	4.0			2.00
Staff Survey - Advocacy sub-score	2025	-	6.46			2.91

2 NOF Metrics

Effectiveness of Care

3 Scoring KPIs Mean Score: 2.51

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Delayed inductions rate	Q1 26/27	-	12.8			1.53
Patients readmitted within 30 days of discharge	2025	-	15.2%		Non-Linear Spread	4.00
Summary Hospital Mortality Indicator	May 26	-	1.16		Non-Linear Spread	2.00

3 NOF Metrics

Patient Safety

5 Scoring KPIs Mean Score: 2.44

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Clinical audit outlier score	Q1 26/27	-	1			1.00
Number of MRSA bacteraemia cases	Jul 26	0	5			3.08
Rate of C-Difficile	Jul 26	-	1.36		Non-Linear Spread	3.00
Rate of E-Coli bacteraemia	Jul 26	-	0.00		Non-Linear Spread	3.00
Staff Survey - Raising Concerns sub-score	2025	-	6.33			2.45

Key performance indicators - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling	26/27 NOF	Jun-26	100	115.61	115.61	115.61	15.61	100	115.61	115.61	115.61	15.61
Summary Hospital - Level Mortality Indicator (SHMI) - Monthly	26/27 NOF	Jun-26	100	118.85	118.85	118.85	18.85	100	118.85	118.85	118.85	18.85
Rate of pregnant women with a delayed planned induction per 1,000 deliveries	26/27 NOF	Q1 2026/27				12.8					12.8	
Inpatients who suffer a new hip fracture while an inpatient	26/27 NOF	Jul-26				2.50%					2.50%	
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month	26/27 NOF 26/27 Standard contract	Sep-26	0	0	0	0	0	0	1	1	1	1
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month	26/27 NOF 26/27 Standard contract	Sep-26	1	5	5	5	4	6	12	12	12	6
Escherichia coli	26/27 NOF	Sep-26	7	7	7	7	0	47	71	71	71	24
Number of Hospital and Community Onset Healthcare associated (HOHA) Clostridioides difficile cases in month	26/27 NOF 26/27 Standard contract	Sep-26	5	4	4	4	-1	29	41	41	41	12
Klebsiella	26/27 Standard contract	Sep-26	3	8	8	8	5	15	27	27	27	12
Pseudomonas	26/27 Standard contract	Sep-26	1	1	1	1	0	8	14	14	14	6
Venous Thromboembolism - percentage of patients having a Risk Assessment	26/27 Standard contract	Sep-26	95.0%	8931	9782	91.3%	-3.7%	95.0%	52700	57537	91.6%	-3.4%
Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	26/27 Standard contract	Sep-26	90.0%	98	169	58.0%	-32.0%	90.0%	686	1310	52.4%	-37.6%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	26/27 Standard contract	Sep-26	90.0%	19	36	52.8%	-37.2%	90.0%	106	177	59.9%	-30.1%

Key performance indicators - Quality

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

			Current month					Year to date				
Metric	**Source & Description**	**Latest month reported**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**	**Local trajectory**	**Numerator**	**Denominator**	**Actual**	**Variance**
CQC inpatient survey satisfaction rate	26/27 NOF	Qtr 4 25/26				8.4/10					8.4/10	
Breadth and depth of clinical audit outliers	26/27 NOF	Qtr 1 26/27				NOF Band 1					NOF Band 1	
Duty of candour (Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations)	26/27 Standard contract			3	3	100.0%			25	30	83.3%	
Complaints Signed Off In Agreed Timeframe (40 day)	Local	Sep-26	-	19	54	35.2%	-	-	99	280	35.4%	-
Complaints Signed Off In Agreed Timeframe (60 day)	Local	Sep-26	-	11	23	47.8%	-	-	33	88	37.5%	-
Planned Vs Actual Care hours per patient day (CHPPD) - Registered midwife	Local	Sep-26	90.0%	15587	18823.3	82.8%	-7.2%	90.0%	118589.16	116093.55	102.1%	12.1%
Planned Vs Actual Care hours per patient day (CHPPD) - Registered nurse	Local	Sep-26	90.0%	170335.4	174594.5	97.6%	7.6%	90.0%	1047629.6	1071341.25	97.8%	7.8%
Planned Vs Actual Care hours per patient day (CHPPD) - Total	Local	Sep-26	90.0%	185922.4	193417.8	96.1%	6.1%	90.0%	1166218.76	1187434.8	98.2%	8.2%
Patient Safety Incident Investigation (Psii) reported in month	Local	Sep-26	0	3	3	3	3	0	10	10	10	10

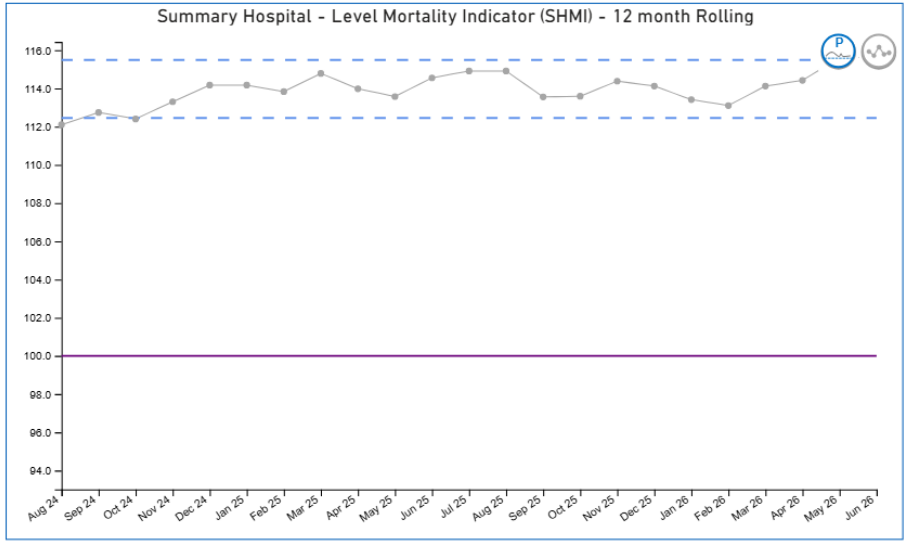
Our Quality domain matrix

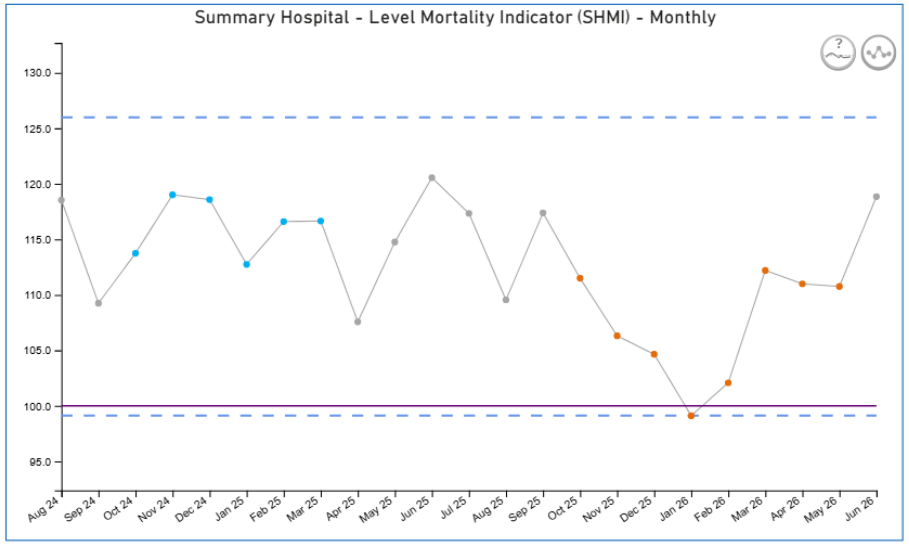
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

		Assurance		
	Icon	P	?	F
Variation	H			
	L			
		Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling Planned Vs Actual Care hours per patient day (CHPPD) - Registered nurse Planned Vs Actual Care hours per patient day (CHPPD) - Total	Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month Escherichia coli Number of Hospital and Community Onset Healthcare associated Clostridioides difficile cases in month Klebsiella Summary Hospital - Level Mortality Indicator (SHMI) - Monthly Planned Vs Actual Care hours per patient day (CHPPD) - Registered midwife Pseudomonas PSiis	Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis
	H			
	L	Venous Thromboembolism - percentage of patients having a Risk Assessment	Venous Thromboembolism - percentage of patients having a Risk Assessment	

Assurance report

Summary Hospital Mortality Indicator





Understanding the performance

- In June 2026 the SHMI was 118.85. the 12 month rolling position was 115.61.

Actions (SMART)

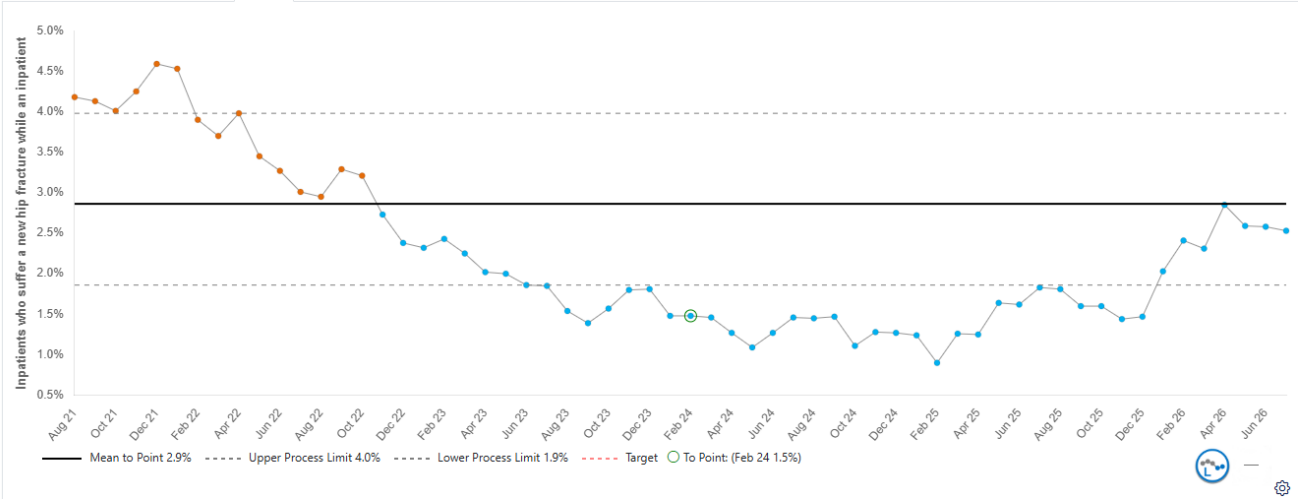
Renewed focus on deteriorating patient through Sepsis Action Group
Sepsis workshops throughout the Trust
Increase Mortality Assurance Group meeting frequency
Maxwell Stanley reviewing non elective coding, in addition to elective coding
Review order in which diagnoses are coded and effect on SHMI
Investigate highest SHMI conditions – breast cancer at DRI and bruising and contusion at BDGH

Risks

Continued deterioration in SHMI performance will result in the Trust becoming a negative outlier nationally
SDEC coding at Bassetlaw continues in a non-admitted data set which drives a higher mortality rate at that site

Assurance report

Inpatients who suffer a new hip fracture while an inpatient



Understanding the performance

The number of inpatients who suffer a hip fracture where admitted from a healthcare provider in the same or in a different trust in the rolling 12 month period was 2.5% for July 2026.

Actions (SMART)

- Falls Prevention improvement plan in place, which has oversight from the fall's improvement group.

Key actions include:

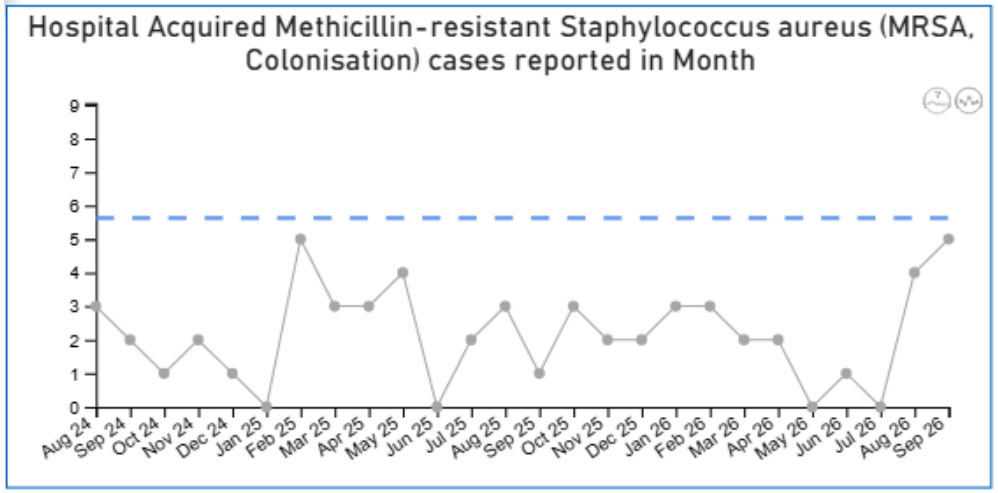
- Safer Mobility
- Achieve ≥80% compliance with mobility plans, early supported mobilisation and timely therapy referrals; ≥85% staff competency by March 2027.
- Decaffeinated Drinks
- Achieve ≥90% ward availability of decaffeinated drinks as standard and ≥80% staff awareness training completion.
- Safer Mobility Champions
- Establish champions in ≥90% of wards within 6 months, with ≥90% implementing a mobility QI project within 12 months.

Risks

- Despite established prevention measures, there remains a risk that inpatient falls will result in patient harm. Mitigation and ongoing oversight processes are in place.

Assurance report

Number of cases of MRSA in the last 12 months



Understanding the performance

- There were 5 MRSA colonisation cases identified against a trajectory of 4.

Actions (SMART)

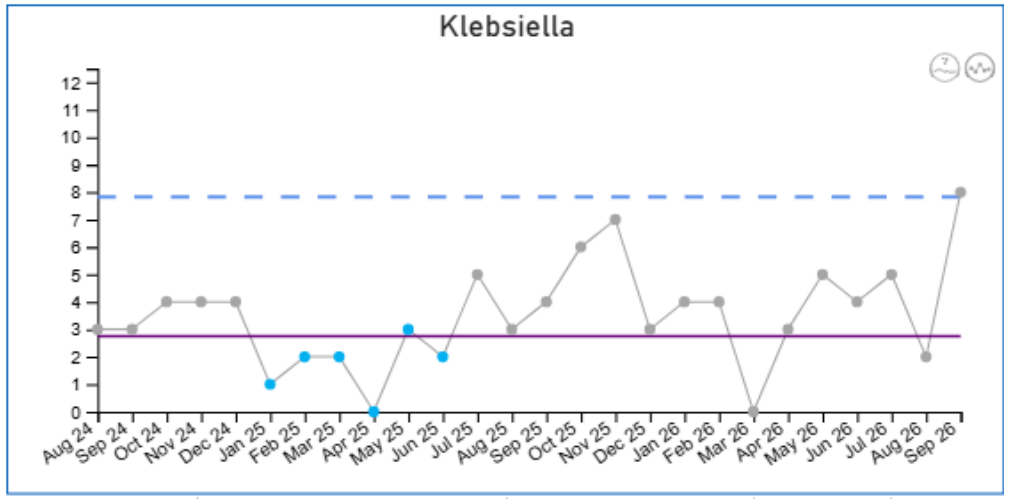
- Continue surveillance of MRSA colonisation cases and review for ward-based or epidemiological links.
- Undertake targeted invasive-device audits, focusing on device necessity, documentation, dressing integrity and timely removal.
- Address identified gaps through local action plans and follow-up assurance via ICOG.
- Investigate all MRSA colonisation cases, with learning and actions shared through DSERP and established governance processes

Risks

- Increasing MRSA colonisation raises the risk of healthcare-associated transmission, infection and bacteraemia. Variability in invasive device management and delayed identification of IPC concerns may hinder timely intervention and increase patient safety risk.

Assurance report

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



Understanding the performance

- Eight Klebsiella bloodstream infections were reported in September 2026 against a monthly trajectory of 3, representing an increase above the expected position.

Actions (SMART)

- Maintain surveillance of *S. aureus* bacteraemia by acquisition category and source, with focused review of hepatobiliary, urinary and respiratory infections.
- Maintain environmental IPC assurance.
- Monitor compliance with catheter insertion, clinical indication and timely removal through quarterly audits, with improvement actions and feedback provided where required.
- Continue delivery of the Hot Gall Bladder Service to reduce recurrent admissions, complications and infection risk through early definitive treatment.

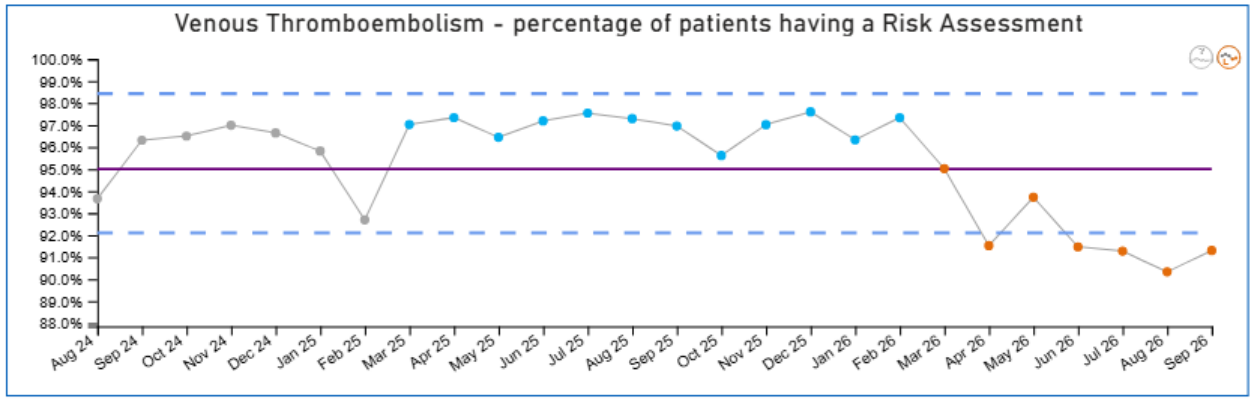
Risks

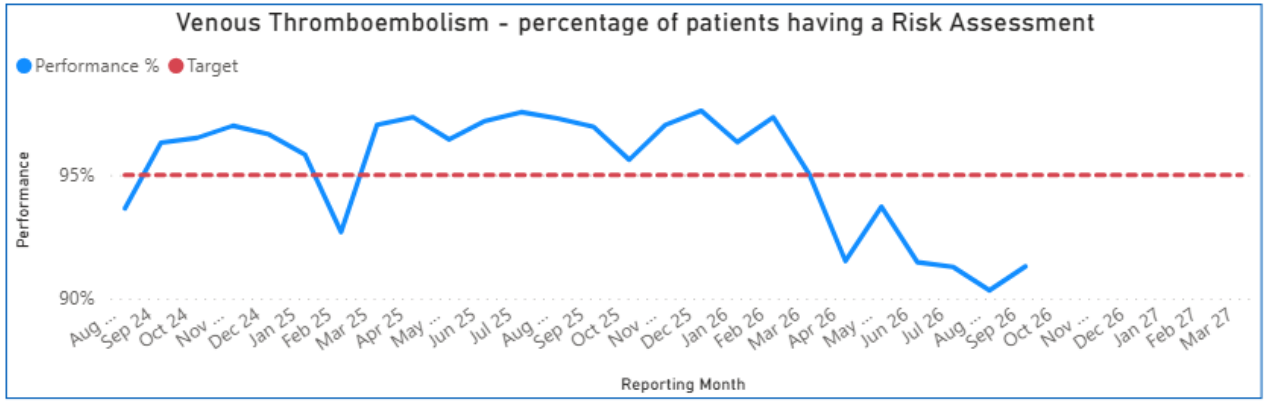
- Klebsiella bloodstream infections remain above the desired trajectory; however, mitigating actions are in place and subject to ongoing monitoring and review.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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





Understanding the performance

- In September 2026, 91.3% of patients had a VTE risk assessment against a target of 95%.

Actions (SMART)

Appoint Clinical Lead for VTE

Targeted audit of A2 and Maternity to understand deterioration in performance

Risks

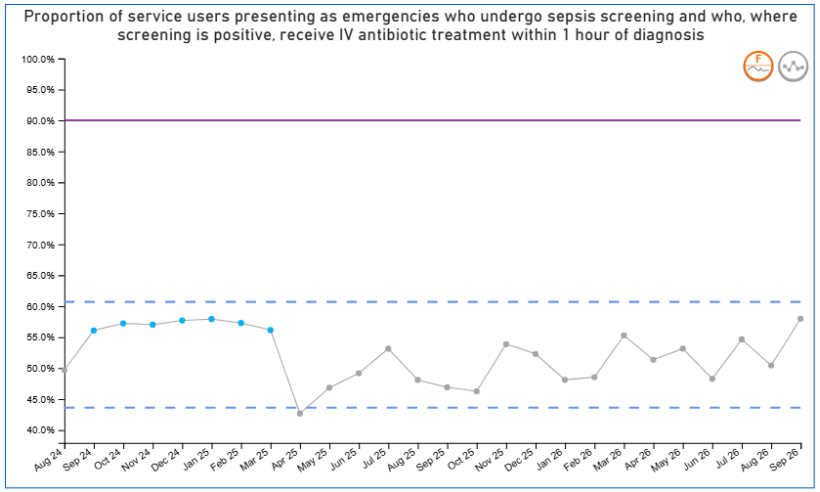
Underperformance may lead to hospital acquired DVT and PE

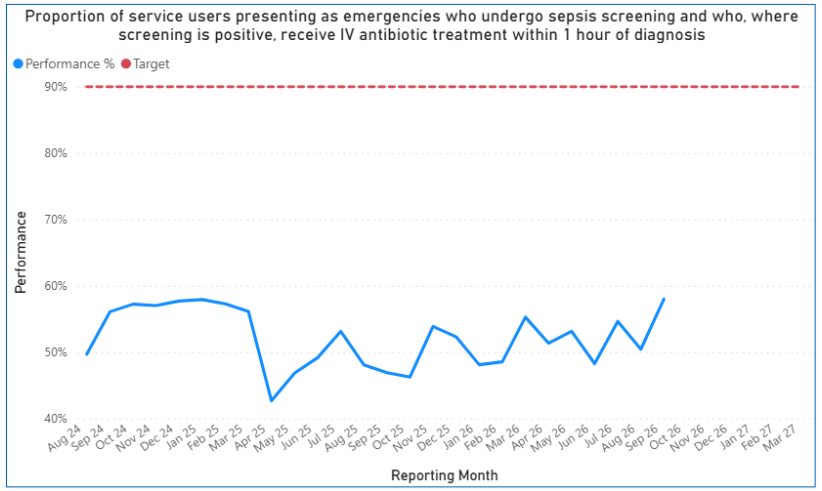
Unable to meet national target

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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





Understanding the performance

- In September 2026, the proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 58.0% against a trajectory of 90%.

Actions (SMART)

Dedicated clinical audit to understand the rates – mismatch between clinical audit rates and Trust reported rates through the electronic system

Sepsis team to meet with Barnsley and STH to understand their methods of sepsis report and improvement in time to antibiotics

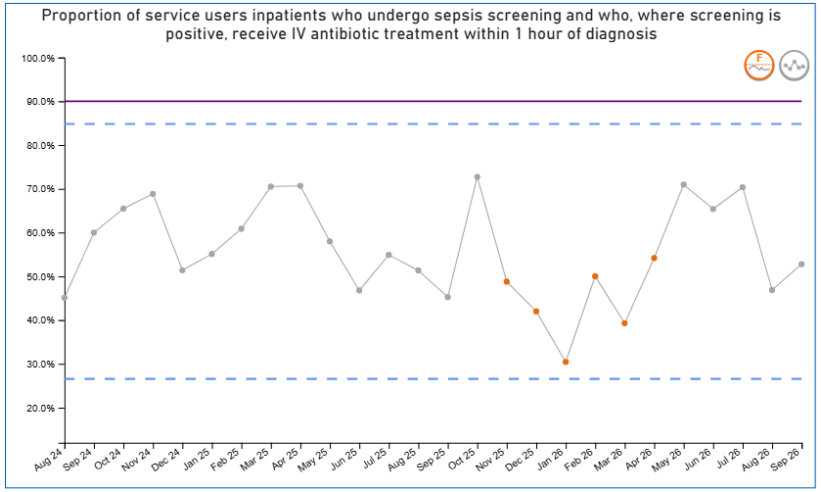
Risks

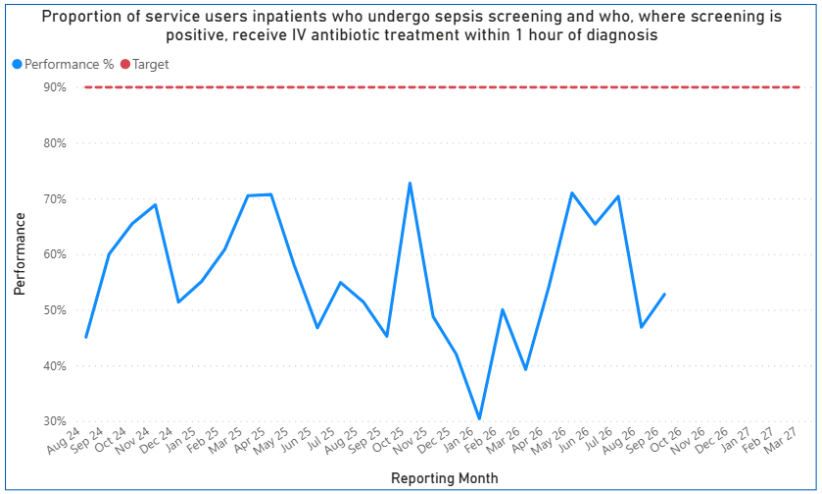
Delay in time to antibiotics can lead to deteriorating patient and avoidable harm to patient

Assurance report

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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





Understanding the performance

- In September 2026, the proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 52.8% against a trajectory of 90%.

Actions (SMART)

Dedicated clinical audit to understand the rates – mismatch between clinical audit rates and Trust reported rates through the electronic system

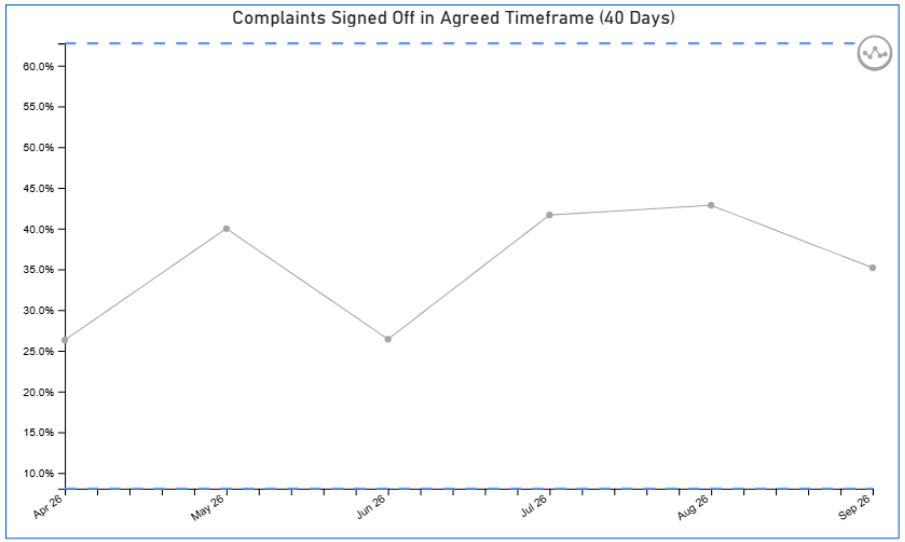
Sepsis team to meet with Barnsley and STH to understand their methods of sepsis report and improvement in time to antibiotics

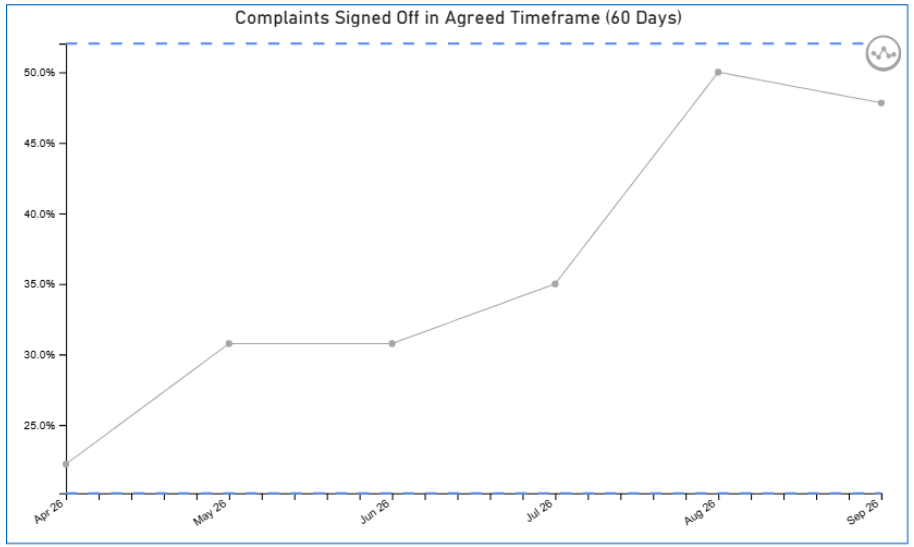
Risks

Delay in time to antibiotics can lead to deteriorating patient and avoidable harm to patient

Assurance report

Complaints Not Signed Off In Agreed Timeframe





Understanding the performance

- In September 2026 35.2% of complaints were signed off in the timeframe of 40 days and 47.8% within 60 days.
- The previous target aligned with PHSO expectation that no complaint should remain open for longer than six month. Following a review by the CEO, revised targets of 95% compliance within 40 and 60 days has been agreed.
- No complaints have exceeded six months.

Actions (SMART)

- Trust-wide dashboard developed that provides timely oversight of complaints performance and clearly flag cases approaching or exceeding KPI deadlines, to be rolled out at Divisional level.
- Weekly reporting to the Chief Nurse and Divisional Leadership Teams in place identifying complaints closure compliance, number of complaints exceeding the time frame that remain open and number of complaints that will move into being overdue within 10 days of the data pull.
- Review underway of the structure and agenda of monthly complaints performance meetings with Divisional Lead Nurses and Complaints Managers to strengthen challenge, accountability, escalation and monitoring of agreed actions

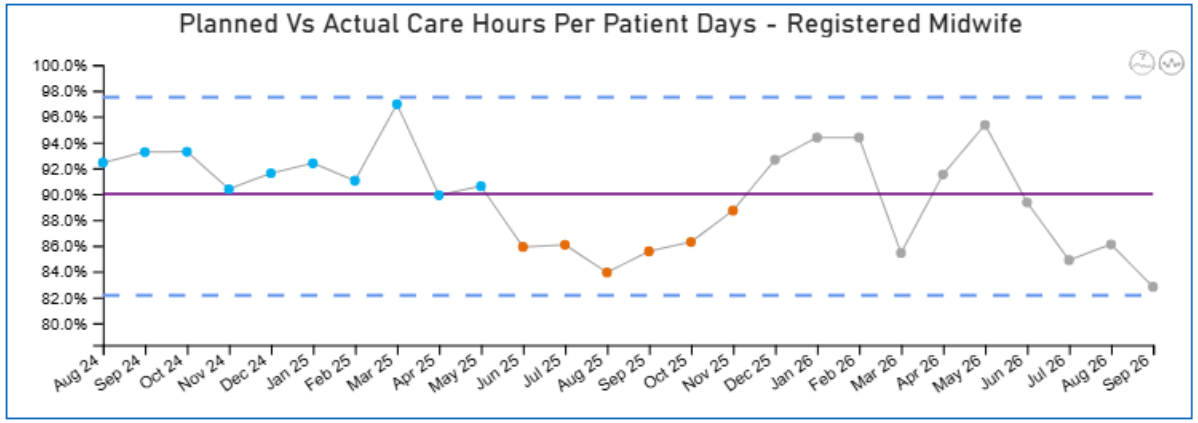
Risks

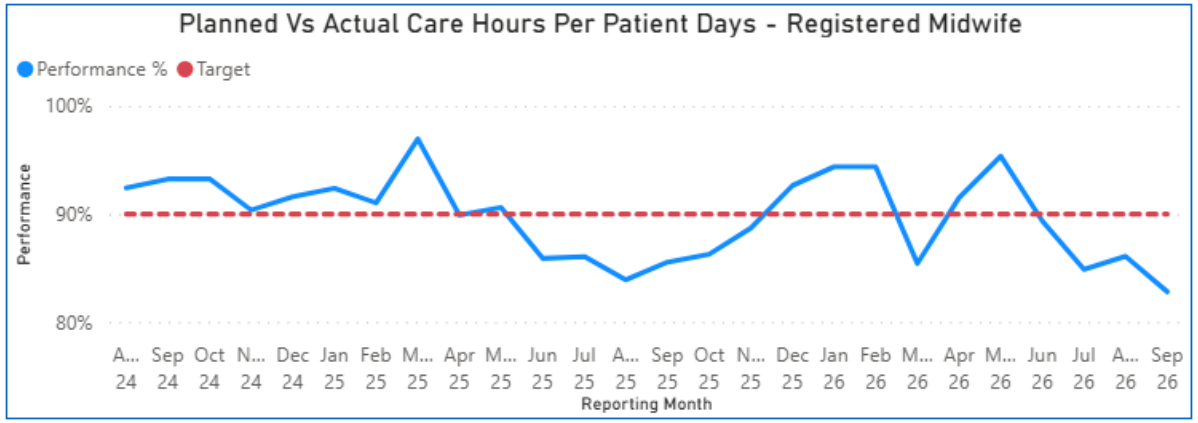
- Backlog Recovery Risk: Current complaint backlogs in some Divisions may continue to adversely affect performance against complaint response timescales, resulting in delays to investigations and case closure, however there is an improving position.
- Resource Capacity Risk: Delivery of the backlog reduction programme will require significant input from Matrons and Business Managers acting as Investigating Officers, which may temporarily reduce capacity available for other divisional priorities and operational duties.

Assurance report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Care hours per patient day (CHPPD) - Midwife





Understanding the performance

- In September 2026 Care hours per patient day for **ward-based** midwives was 82.8% against the standard of 90%.

Actions (SMART)

- Weekly prospective management of the roster
- Daily oversight by Manager of the Day (MOD) & Senior Manager to manage staffing / workload & mitigate risks, including appropriate redeployment to support high risk areas.
- NHSP shifts offered a week in advance on Monday & ad hoc to cover short term sickness
- Specialist midwives on call to support clinically
- Matrons & ward managers work clinically
- Community midwives utilised to support service if required
- Senior midwifery manager on call 24/7 to support

Risks

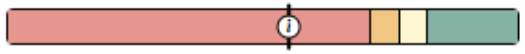
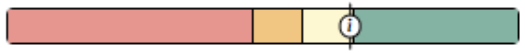
- NHSP filled leaving shifts vacant
- High levels of sickness leads to shifts not being staffed to the optimum but remain safe
- Greater chances of diversion or suspension of services
- Homebirth service suspended if community midwives used in the unit
- Increased stress for staff working in the service

NHS Oversight Framework 2026/27 KPIs - Finance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Finance, Productivity and Innovation

6 Scoring KPIs Mean Score: 3.42

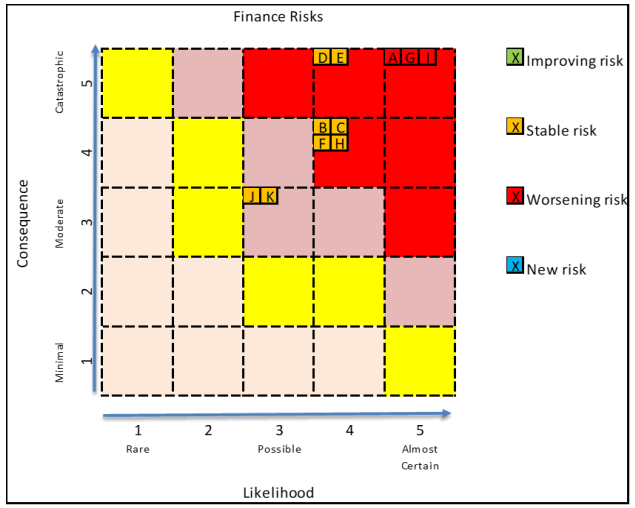
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Clinical trials set up within 90 days	Q1 26/27	95.00%	**50.00%**		Non-Linear Spread	4.00
Data Quality Maturity Index (DQMI)	Jun 26	-	90.3			3.30
Finance - Combined finance score	Q1 26/27	-	4			4.00
Finance - Planned surplus/deficit	Q1 26/27	0.00%	**-2.51%**			4.00
Finance - Variance year-to-date to financial plan	Q1 26/27	0.00%	**-2.51%**			4.00
Productivity - Relative difference in costs	Q4 24/25	-	94.9%			1.83

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

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust M06 September 2026 Income and Expenditure vs. Budget									
Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		YTD Budget	YTD Actual	Variance to budget	
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Income	(647,639)	(54,753)	(53,043)	1,709	A	(323,753)	(317,784)	5,970	A
Pay	434,859	36,855	37,356	502	A	219,830	219,688	(142)	F
Non Pay	204,112	16,959	18,570	1,611	A	102,094	105,485	3,391	A
Financing Costs	9,455	788	794	6	A	4,727	4,555	(173)	F
(Profit)/Loss on Asset Disposals	0	0	6	6	A	0	6	6	A
(Surplus)/Deficit for the period	**787**	**(151)**	**3,683**	**3,834**	**A**	**2,898**	**11,950**	**9,052**	**A**
Donated Asset Adjustment	(787)	(66)	(66)	(1)	F	(393)	(406)	(12)	F
Impairment Adjustment	0	0	0	0	F	0	(0)	(0)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**0**	**(217)**	**3,616**	**3,833**	**A**	**2,505**	**11,544**	**9,040**	**A**
Remove Deficit Support Funding	***15,700***	***1,308***	***0***	*(1,308)*	***F***	***7,850***	***3,924***	*(3,926)*	***F***
Adjusted Financial Performance Excluding Deficit Support Funding	***15,700***	***1,092***	***3,616***	***2,525***	***A***	***10,355***	***15,468***	***5,114***	***A***

Income: Over-achieved F | Under-achieved A
Expenditure: Underspent F | Overspent A
Key: F = Favourable A = Adverse



Key Risks	26/27 Plan	M4	M5	M6
	£'000	£'000	£'000	£'000
Efficiency risk	(32,659)	(18,640)	(17,579)	(15,657)
Commissioner Growth and clawback	(8,700)	(6,485)	(6,485)	(6,485)
Delays to acceleration of structural changes	(3,700)	0	0	0
Incremental drift	(500)	0	0	0
Potential error in estimation of revenue to capital transfer	(100)	0	0	0
Total	**(45,659)**	**(25,125)**	**(24,064)**	**(22,142)**

Understanding the performance

Excluding deficit support funding, the Trust is reporting an £15.5m year to date deficit, £5.1m adverse to plan. The adverse variance is driven by a £6.9m shortfall in efficiency delivery offset being partially offset by non recurrent technical benefits £1.4m.

Income

- Income is adverse to plan YTD mainly due to Clinical Income £4.3m; Deficit support funding of £3.9m, CDC activity £0.2m and ERF activity of £0.4m. Operating income is adverse to plan £1.6m mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges

Pay

- Pay is £0.5m adverse in month and £0.1m favourable YTD mainly due efficiency not being delivered offset by delays in spend for transformation funding/investments.
- YTD spend bank £9.1m. Agency £5.4m – adverse to plan due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

- Non-pay is in £1.6m adverse in month and £3.4m adverse YTD mainly due to clinical supplies additional activity, equipment hire and repairs and unachieved CIP.

Actions (SMART)

- **Accelerate cash releasing savings – Ongoing**

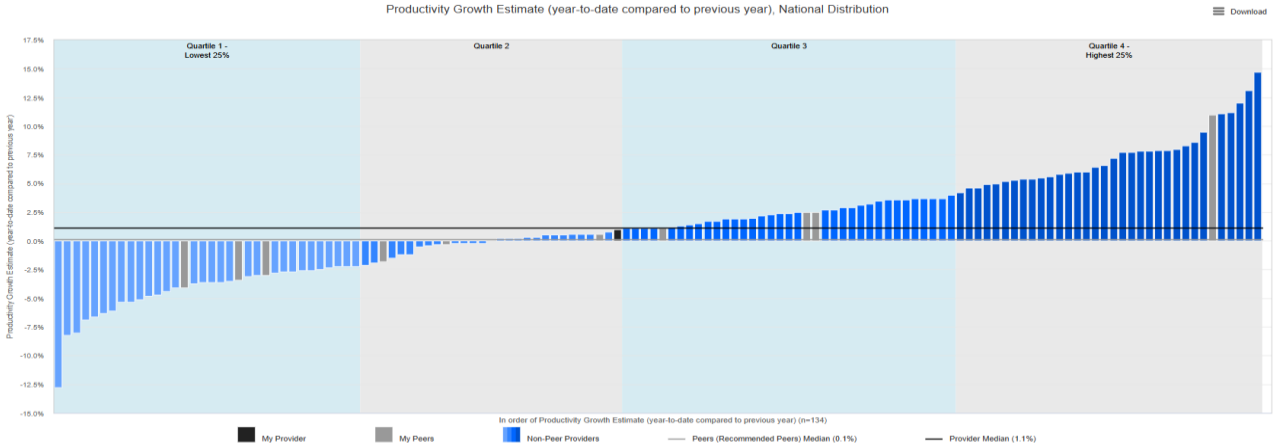
Reset/Local Savings need to take place at pace to ensure the financial plan is to be delivered.

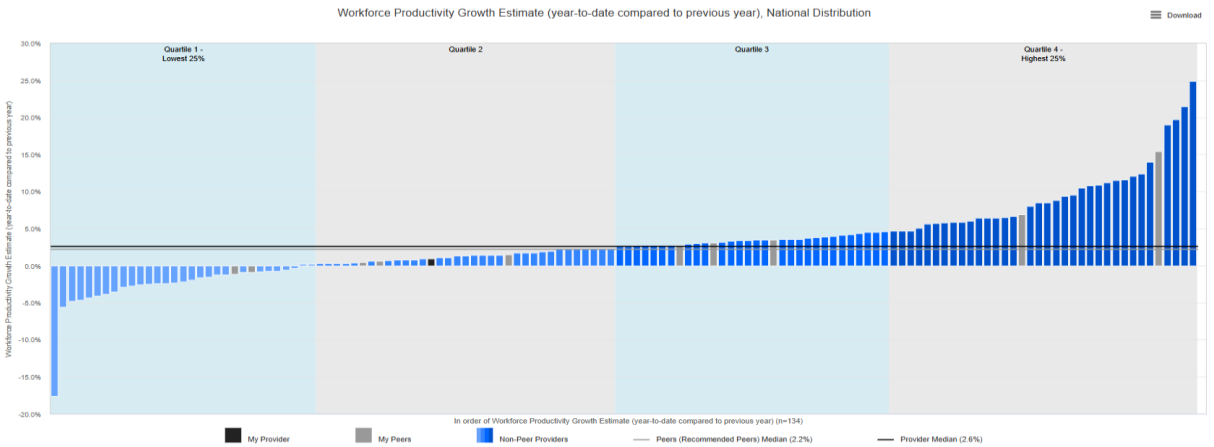
- Turnaround - Weekly meeting (fortnightly rotation of different areas) to update on development progression and delivery against plans, key part of the meetings is to allow for actions and intervention, for any blockages to be removed, to align required resources, to ensure progress is being made.
- Projects fully in delivery with assurance on value will not need to attend. Core focus on financial improvement plans but can also cover other delivery improvement areas as appropriate.

Risks

- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.
- There has been a £23.5m improvement in the gross risk profile (see above) since the plan was set.
- The key remaining risks are around efficiency delivery (£15.7M gross risk) and commissioner growth funding/clawback (£6.5M gross)

Implied productivity growth





Understanding the performance

The most recently published data (year to June 26) shows an 1.0% improvement in implied productivity for DBTH in comparison to the same period in the previous year (prior month: +11.3%). This places the Trust in the 3rd best quartile of performers nationally and is slightly behind the national median (1.1% improvement) but ahead of the median of the group of peer Trusts selected by NHS England (0.1% improvement).

The most recently published data (year to June 26) shows a 0.9% improvement in implied workforce productivity for DBTH in comparison to the same period in the previous year (prior month: +8.7%). This places the Trust in the 2nd quartile of performers nationally and is behind against both the national median (2.2%) and the median of the group of peer Trusts selected by NHS England (2.6%).

Actions (SMART)

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

Since April planning submission negotiations have continued with SYICB to agree the Income Gap of £6.485m. Side letter to contract approved, including various CFO meetings to agree growth with SYICB. Meetings taking place at Chief Executive level.

- **Agree payment of MEOC risk share income – End of November 2026**

MEOC Partnership agreement pending sign off. Local Trusts owe DBTH £1.3m - Invoices for risk share not paid since April 2024. CFO agreeing income with counterparts.

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

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

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

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

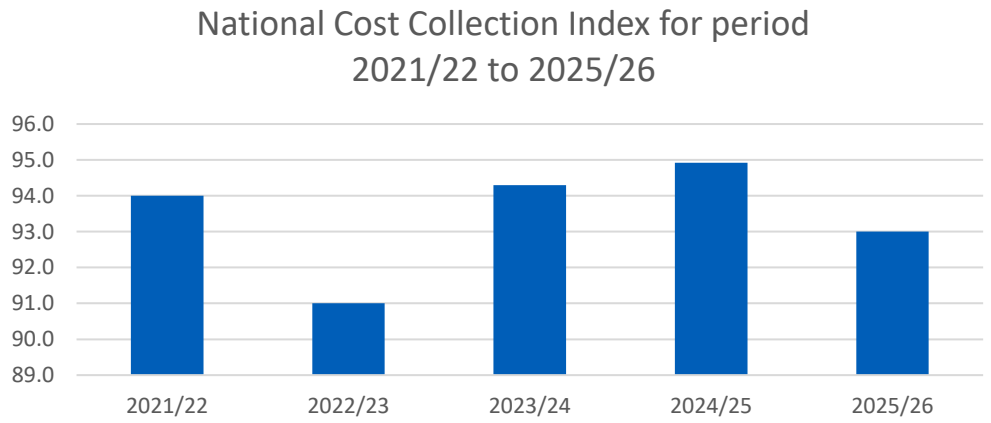
- **Develop revenue loan cash request – End of October 2026**

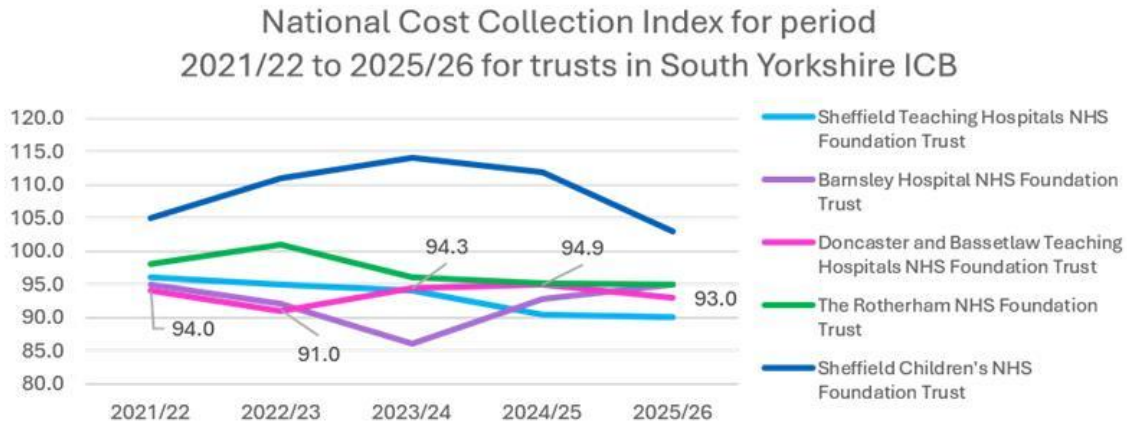
Loan request completed submission to NHSE – awaiting approval.

Risks

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

Relative cost difference (National Cost Collection Index) - Annual





Understanding the performance

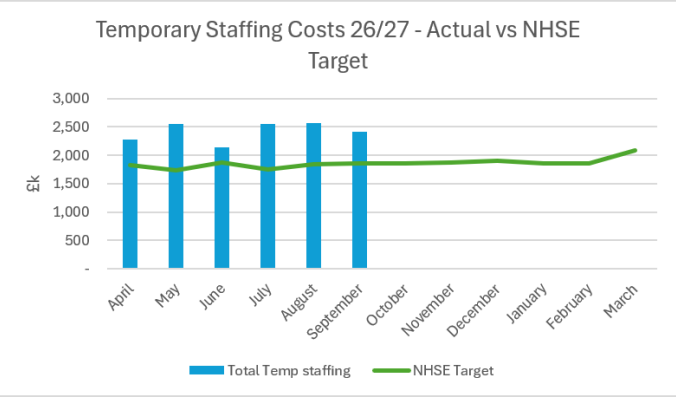
- The data shown in the tables relates to the 25/26 National Cost Collection Index (NCCI), published by NHS England on their website. This index shows the comparison of the Trust's costs to the national average and tells us that where the national average cost of services is £100, we spend £92.77.
- The second graph shows the NCCI of the other trusts in our ICB for comparison. DBTH's index has improved between 24/25 and 25/26 comparatively to the national position.

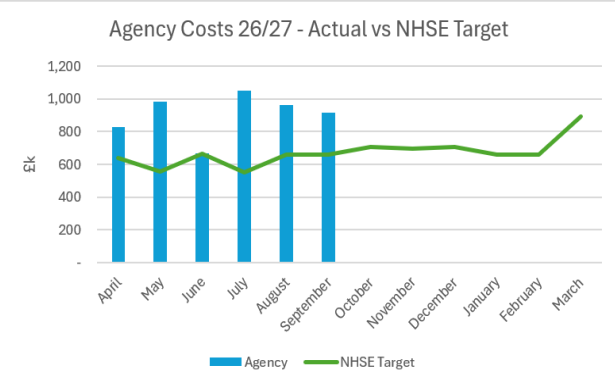
Actions (SMART)

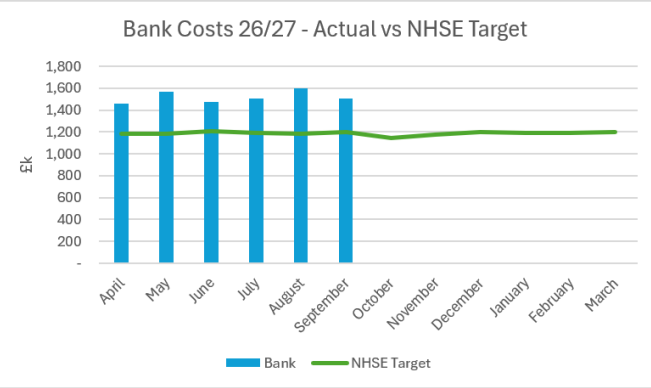
- National cost collection for 25/26 submitted on 26th June 2026.
- Review Model Hospital data for 25/26 when published.
- Costing Arrangements Audit is on the schedule for Internal Audit this year, with a report due in Q3.

Risks

Temporary staffing cost







Understanding the performance

- The NHSE target is based on the plan submission to NHSE and meets the cap limit. Annual target for Agency is £8.0m Bank is £14.2m.
- Agency costs in month are £0.9m, adverse to plan by £0.3m.
- Bank costs in month are £1.5m, adverse to plan by £0.3m
- The majority of agency spend is within the Medical staff group covering premium costs for vacant posts, sickness and industrial action costs.
- Operational pressures – additional beds due to increased activity.

NHS Oversight Framework (NOF) temporary staffing	Actual	Cap Level Plan	FOT	Variance	Compliance
Total employee benefits excluding capitalised costs	219,688				
Total agency costs excluding outsourced bank and capitalised agency costs	5,402	8,162	8,050	-112	Yes
Total bank staff costs excluding capitalised bank staff costs	9,099	16,597	14,246	-2,351	Yes
Trust YTD spend on agency as proportion of Trust YTD total paybill	2.5%				
Trust YTD spend on bank as proportion of Trust YTD total paybill	4.1%				

Actions (SMART)

Completed Actions

- Approved the Supporting Attendance at Work policy and launched training and support.
- Implemented two-tier staffing approval across all divisions.
- Completed NHSP controls strengthening and the review of agency controls in Theatres.

Ongoing actions

- Maintain weekly Executive vacancy approval and review hard-to-fill medical vacancies with Holt.
- Complete the resident doctors' sickness absence process by **30 October 2026** and agree a revised completion date for the overdue medical sickness absence process.
- Review HCA bank requests, roster finalisation controls and roster/NHSP interface use against the **October 2026** roadmap.
- Continue monitoring bank and agency requests against vacancies, sickness absence and roster efficiency.
- Secure final SOP sign-off and audit temporary medical staffing approval processes.
- Review ED budgets and roster templates following CQC recommendations.

Future Actions

- Complete reviews of medical sickness reporting, return-to-work responsibilities and long-term sickness management by **30 November 2026**.
- Agree the scope and date for the follow-up review of internal locum rates.

Risks

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

NHS Oversight Framework 2026/27 KPIs - People

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

People

6 Scoring KPIs Mean Score: 2.87

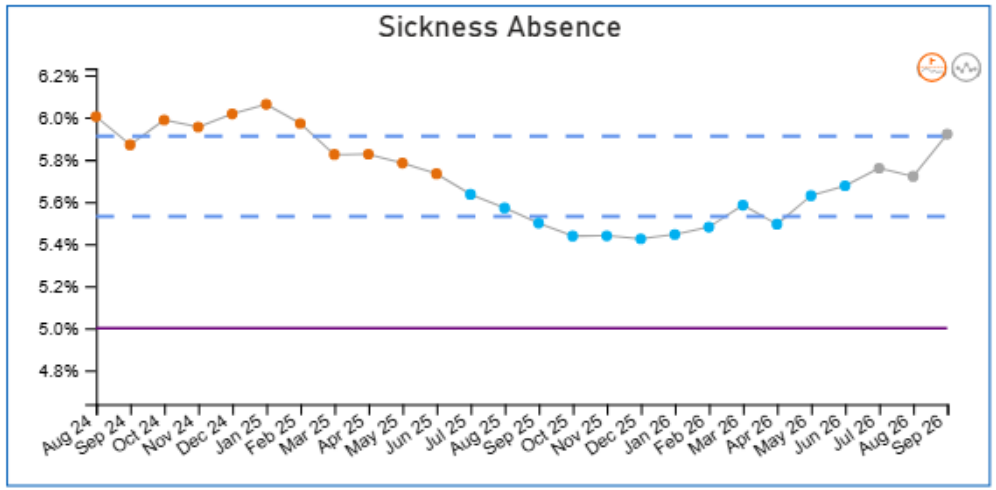
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Frontline healthcare workers to receive a flu vaccination	Q4 25/26	-	45.6%			3.12
NETS - Overall Experience subscore	2025	-	71.60			3.55
NHS staff standards sub-score	2026	-	7.52			2.44
Sickness Absence Rate QTD	Q1 26/27	-	5.74%			3.59
Staff Survey - Engagement Theme Score	2025	-	6.68			2.84
Temporary staffing cost relative band	Q1 26/27	-	1			1.00

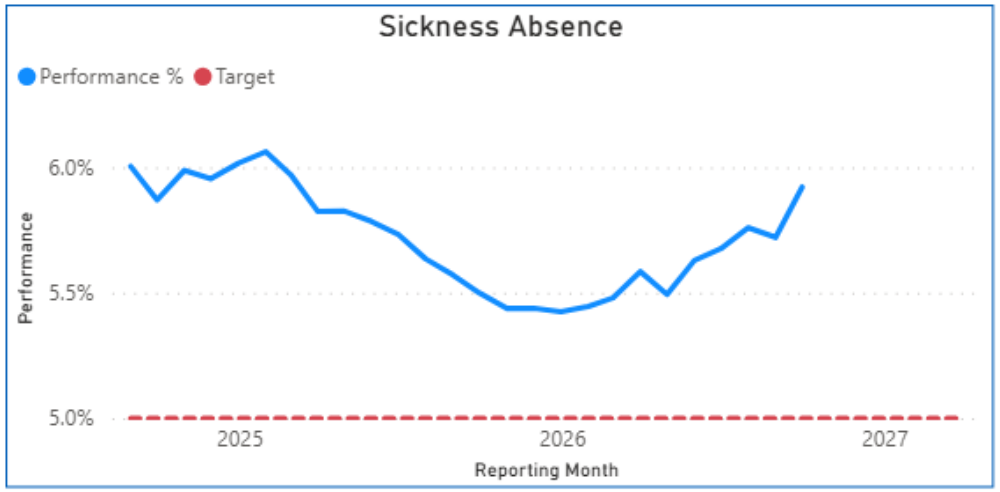
Key performance indicators - People

Metric	Source & Description	Latest month reported	Local trajectory	Actual	Variance
Overall Sickness Absence	26/27 Standard contract	Sep-26	5.0%	6.0%	1.0%
Healthcare worker flu vaccination rate	26/27 Standard contract	2025	60% (end of campaign)	45.60%	-2.4%
National education and training survey satisfaction rate	26/27 Standard contract	2025	-	71.6%	
NHS staff survey advocacy rate	26/27 Standard contract	2025	-	6.46	
NHS staff survey engagement theme score	26/27 Standard contract	Qtr 4 25/26	-	6.68	
NHS staff survey raising concerns sub-score	26/27 Standard contract	Qtr 4 25/26	-	6.33	
NHS staff standards score	26/27 Standard contract	2025	-	7.5%	

Assurance report

Sickness absence rate





Understanding the performance

- In September 2026, the sickness rate was 6% compared to a target of 5%.

Actions (SMART)

- New Supporting Attendance at Work policy launched, supported by refreshed training and guidance.
- Continuation of KPI clinics/workshops for managers with People & OD (monthly).
- Executive oversight of divisional sickness absence rates at Performance Review Meetings (PRMs).
- Improvement work ongoing supporting absence management for medical colleagues (throughout 26/27)
- Deep dives on sickness absence in targeted areas (Q3/4)
- Deep dive on increased sickness absence in summer holiday period concluded and actions identified for next year, e.g. use of flexible working and oversight of leave requests.
- Increased central scrutiny of long-term sickness cases (Q3/4)

Risks

- Impact of wider pressures, external context and organisational change on colleague wellbeing and attendance.
- Increased sickness absence in specific areas, consistent with operational pressures and other factors.

Assurance report

Healthcare worker flu vaccination rate



Understanding the performance

- The percentage of individuals who are frontline healthcare workers and had an NHS administered flu vaccination is 45.6%

Actions (SMART)

- Flu planning group and fortnightly meetings remain in place with Trust-wide representatives (ongoing during Q2/3).
- Flu campaign commenced 30 September 2026.
- New delivery model for colleague vaccination introduced for this year's campaign, including increased Occupational Health (OH) roving vaccinators, regular presence in key areas such as outside the canteen and reducing OH clinics to focus on vaccinations (Q3)
- Weekly data reports received at Executive Team meetings.
- Active communications campaign including clinical and Executive leadership messages.
- 26.1% of healthcare workers vaccinated as at 15 October.

Risks

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

Assurance report

National education and training survey satisfaction rate



Understanding the performance

- The National Education and Training survey (NETS) satisfaction rate is 71.6.
- This is an annual survey - the 2025 survey ran from 7 October to 2 December 2025, and the results were released March 2026.

Actions (SMART)

- 2026 survey opened on 6 October and closes on 1 December.
- Comms/engagement plan in place across all learner groups, including national materials and local information/cascade to encourage participation.
- Triangulation of NETS findings 2025 undertaken with other learner survey data and local intelligence to validate themes/identify gaps. Action plans developed to target speciality improvement, with involvement of College Tutors.
- Delivery and impact of actions are monitored through education governance with escalation processes in place.
- Sharing good practice and learning through education governance routes. Workforce & Education Group oversight.

Risks

- Data assurance – variations in the different national learner surveys' methodologies may slow validation and targeted action. Uneven survey completion rates may not provide a true reflection of overall learner experience.
- Impact of wider pressures and external context on learner wellbeing and satisfaction.

Assurance report

NHS staff survey advocacy rate



Understanding the performance

- The 2025 NHS staff survey advocacy sub score was 6.46 for 2025.

Actions (SMART)

- Advocacy score includes recommendation as a place to work and place to receive care elements in the staff survey.
- 2026 staff survey launched 18 September 2026, with communications and engagement plan ongoing, survey closes 27 November. Response rate 27.77% as at 19 October.
- Culture and Leadership pillar of Reset programme has wide programme of activities (throughout 2026/27). Regular reports to every Reset Board and People Committee.
- Mapping of NHS Staff Standards including Leadership and Management Framework shows strategic alignment with DBTH Way, People Plan and Culture & Leadership pillar.
- Quality and access measures and actions also relevant.

Risks

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

Assurance report

NHS staff survey engagement theme score



Understanding the performance

- The 2025 staff survey engagement theme score was 6.68.

Actions (SMART)

- Culture and Leadership pillar of Reset programme has wide programme of activities to support colleague engagement (throughout 2026/27). Regular reports to every Reset Board and People Committee.
- New colleague engagement forum launched - DBTH Assembly – first meeting held 23 September 2026. Positive feedback from attendees and further dates scheduled.
- 2026 survey launched 18 September, with communications including examples of improvements made based on previous feedback. Survey closes 27 November. Response rate 27.77% as at 19 October.
- Mapping of NHS Staff Standards including Leadership and Management Framework shows strategic alignment with DBTH Way, People Plan and Culture & Leadership pillar.

Risks

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

Assurance report

NHS staff survey raising concerns sub-score



Understanding the performance

- The 2025 staff survey raising concerns sub score was 6.33.

Actions (SMART)

- Alignment of Speaking Up activity with Culture & Leadership programme, e.g. Speaking Up for Patient Safety is one of the three focus behaviours for 2026/27 (through 26/27).
- Ongoing engagement following communication of FTSU peer review key themes and feedback (Q3).
- FTSU month activities ongoing during October 2026, which is traditionally FTSU month.
- Launch of national staff survey on 18 September 2026 until 27 November, with communications and engagement plan during survey period (Q2/Q3).
- FTSU Guardian involved in cultural workstreams, e.g. Just Culture, data triangulation group.

Risks

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

Assurance report

NHS staff standards score



Understanding the performance

A composite sub score made up of NHS staff survey measures associated with the NHS Staff Standards. The 2025 score was 7.52.

Actions (SMART)

- The NHS Staff Standards were published in July 2026, and cover the following areas: Line Management, Health & Wellbeing, Violence Reduction & Prevention, Championing Sexual Safety, Tackling Racism, Promoting Flexible Working.
- People Committee has oversight of all these areas.
- An initial mapping against the Staff Standards has been undertaken and shows a strategic alignment with the DBTH People Plan, DBTH Way and Culture & Leadership pillar.
- The comprehensive implementation tool is being completed.
- Papers/presentations on the NHS Staff Standards and Leadership & Management Framework have been presented at the Executive team, Hospital Leadership Team and People Committee in September/October 2026. Further presentations planned at Partnership Forum, Trust Leadership Team and Board development session in Q3.

Risks

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

Metrics still to be included within the IPR

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

- % of patients waiting less than 18 weeks for community care – it has been identified that specific cohorts of pathways are not being included in the Community Sit Rep return. These patients have been identified, and work is ongoing to validate the pathway prior to adding to the submission.

- No urgent operation should be cancelled for a second time – metric critical data is not captured within the Bluespier theatre system.

- Inpatients making a supported quit attempt with an in-house tobacco dependence treatment service – identified and escalated issue with data not pulling through to national upload. System supplier reviewing.

- % of clinical trials set up within 90 days – under review

- New to NOF for 26/27, technical specification available expected to be in IPR next month.
  - % of safety incidents causing harm
  - % of inpatients to acquire a new grade 3 or 4 pressure ulcer

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust



Finance And Activity Report

September 2026

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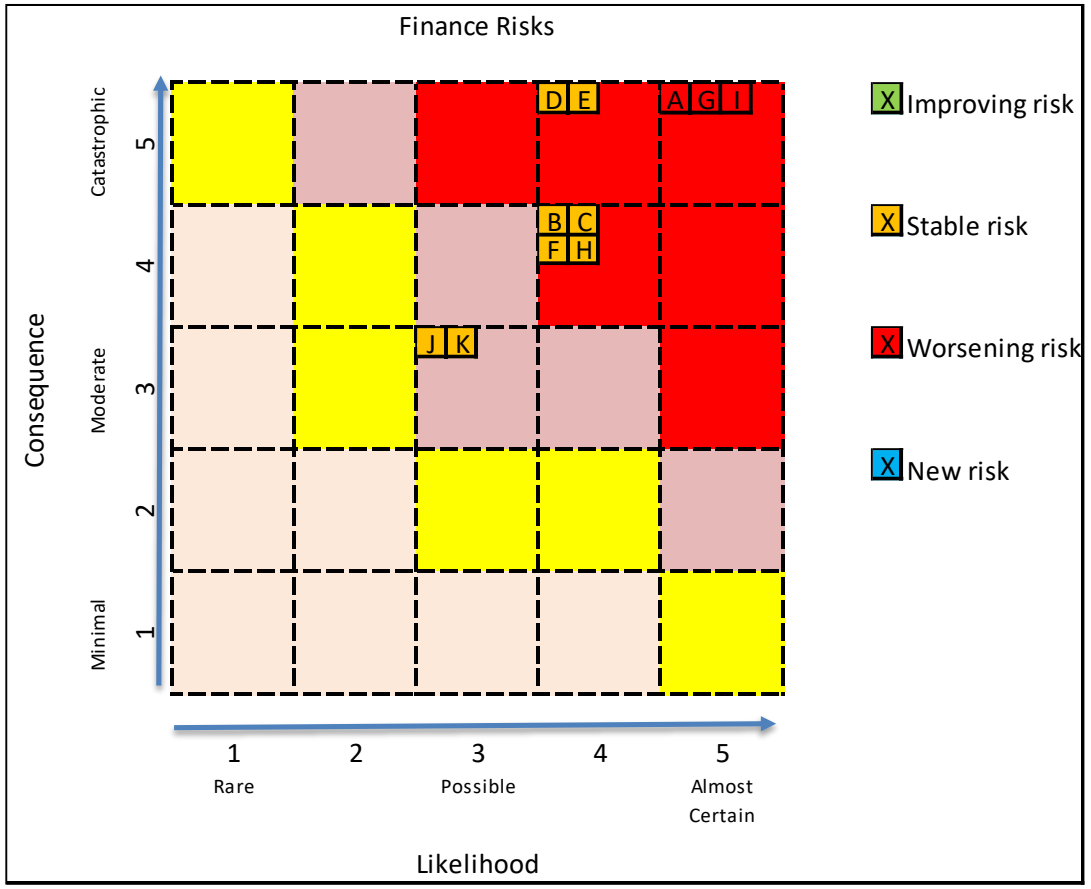
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SECTION 1
Financial Risks

Financial Risks



Ref	Risk ID	Title
A	3895	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate
B	3896	Failure to redesign services leads to failure to improve implied productivity at the required rate
C	3897	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate
D	3898	Failure to secure income, deliver funded activity and demand schemes
E	3899	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels
F	3900	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan
G	3901	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings
H	3902	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme
I	3903	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow
J	3880	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust
K	3826	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm

Updates

Risks A, G and I have had their risks reassessed to 25 (5 x 5)

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

Underlying Deficit

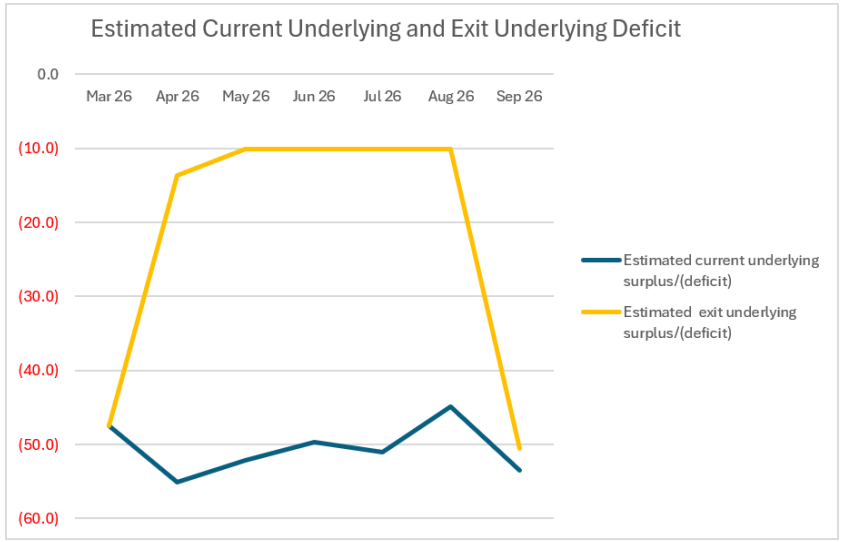
The analysis shows the current estimated underlying deficit as well as the estimated exit rate for each financial year.

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At month 6, the current underlying deficit is estimated at £53.5m and the 26/27 exit rate is estimated at £50.5m.

There has been a deterioration of both the estimated current underlying deficit and the estimated exit underlying deficit as a result of the forecasted full year effect of the recurrent CIPs being reduced significantly to reflect the mid-case scenario in the PAM submission, as well as the financial cost of investments being included.

As the efficiency schemes are becoming more mature and being implemented, the level of underlying deficit reduces.

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



Estimated Underlying surplus/(deficit)	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
YTD reported adjusted surplus/(deficit)	0.0	(1.2)	(4.3)	(6.4)	(5.1)	(7.9)	(11.5)
Less YTD DSF (£17M - 25/26, £15.7m, 26/27)	(17.0)	(1.3)	0.0	0.0	(3.9)	(3.9)	(3.9)
Less YTD NHSE 24/25 brokered support (£10m 25/26, £0m 26/27)	(10.0)	0.0	0.0	0.0	0.0	0.0	0.0
Less YTD CIP	(31.4)	(2.7)	(5.5)	(8.2)	(9.7)	(11.4)	(10.6)
Other Non-Recurrent Support/Pressures	(11.4)	0.0	(0.1)	(0.3)	(2.0)	(2.6)	(6.3)
Subtotal	**(69.8)**	**(5.2)**	**(9.8)**	**(14.9)**	**(20.7)**	**(25.8)**	**(32.3)**
Extrapolated to full year	(69.8)	(62.5)	(58.9)	(59.5)	(62.0)	(62.0)	(64.6)
Add Recurrent CIP FYE (implemented already)	22.3	7.4	6.8	12.3	11.0	17.1	17.8
Investments							(6.7)
Estimated current underlying surplus/(deficit)	**(47.5)**	**(55.1)**	**(52.1)**	**(49.7)**	**(51.0)**	**(44.9)**	**(53.5)**
Remove Recurrent CIP FYE (implemented alread	(22.3)	(7.4)	(6.8)	(12.3)	(11.0)	(17.1)	(17.8)
FYE Investments							(5.1)
Add Recurrent CIP FYE (full year forecast)	22.3	48.8	48.8	51.9	51.9	51.9	25.9
Estimated exit underlying surplus/(deficit)	**(47.5)**	**(13.7)**	**(10.1)**	**(10.1)**	**(10.1)**	**(10.1)**	**(50.5)**

Underlying Deficit – PAM version

As a result of the development of the Provider Assurance Model (PAM), the Trust has also developed the estimated underlying deficit from the mid-case forecast deficit of £38.8m assuming CIP delivery at the risk-adjusted forecast level (In-year £30.6M vs £46.3M plan, recurrent FYE £25.1M vs £48.8M plan),

At month 6, the current underlying deficit is estimated at £50.5M similar to the previous slide. However there is a difference between the extrapolated normalised run rate included in the PAM (£49.9M) and the estimated current underlying deficit in the previous slide (£53.5M) due to different methodologies. It is proposed to use the PAM model going forward.

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

Estimated Underlying surplus/(deficit) - PAM (£m)	Income	Pay	Non Pay	Financing Costs	Total
YTD reported adjusted surplus/(deficit)	**317.8**	**(219.7)**	**(105.1)**	**(4.6)**	**(11.5)**
Less: Year to Date Deficit Support Funding	(3.9)				(3.9)
Less: Non recurrent CIP	(0.1)	(2.5)	(0.3)		(2.9)
Less: Non recurrent transformation funding/costs	(1.5)	0.1	0.4	(0.2)	(1.2)
Less: Non recurrent technical adjustments		(0.7)	(4.4)		(5.1)
Normalised Run Rate	**312.2**	**(222.7)**	**(109.5)**	**(4.8)**	**(24.7)**
Clinical income - working days	(0.5)				
Extrapolated normalised run rate	**624.0**	**(445.4)**	**(218.9)**	**(9.6)**	**(49.9)**
Add:					
YTD Normalisation adjustments from above	1.6	3.0	4.4	0.2	9.2
In year additional recurrent CIP	0.1	6.2	1.0		7.4
CIP - non recurrent	-	2.4	0.7		3.1
Non recurrent - operational	5.4	(6.7)	(0.8)		(2.1)
Seasonal impacts	-	(1.3)	(0.9)	-	(2.2)
Investments	-	(1.9)	(2.4)	-	(4.3)
26/27 midrange forecast deficit	**631.1**	**(443.7)**	**(216.9)**	**(9.3)**	**(38.8)**
Non recurrent CIP	(0.1)	(4.9)	(1.0)	-	(6.0)
Full Year Effect CIP	0.1	3.2	0.3		3.6
Non recurrent - technical	-	(0.7)	(4.4)	-	(5.1)
Non recurrent - operational	(6.9)	6.9	1.1	(0.2)	0.9
Pending Investment Cases		(1.5)	-	-	(1.5)
Full Year Effect Approved Investments		(1.0)	(1.9)	(0.7)	(3.6)
Estimated underlying deficit exit	**624.2**	**(441.6)**	**(222.8)**	**(10.3)**	**(50.5)**

IDP Programme NB Includes both the Reset Programme and Local Schemes

In terms of recurrent full year effect:

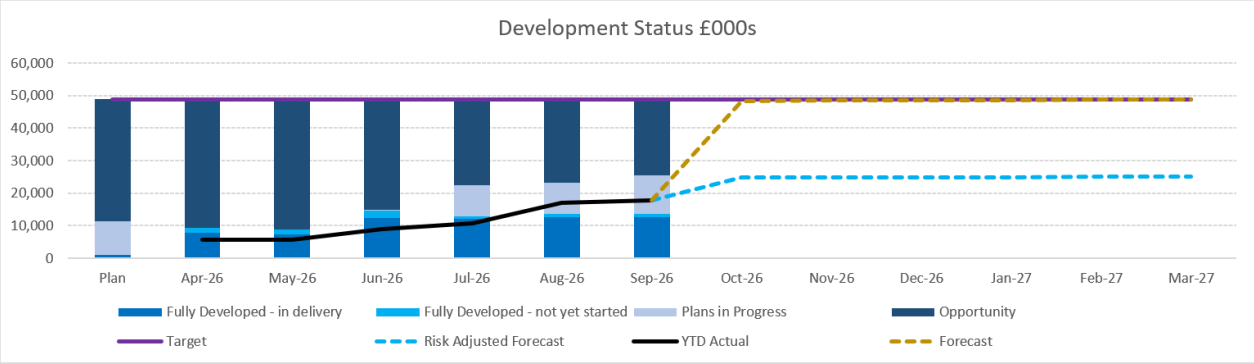
- Schemes implemented in the year to date will yield a recurrent full year effect of £17.8m.
- Forecast delivery by the end of the year is in line with plan of £48.8m.
- The risk adjusted forecast stands at £25.1m, as at month 6 many schemes have a status of 'opportunity', so this is expected to grow as schemes mature.
- The committed plan is to reduce recurrent establishment by 507.4 WTE recurrently. At the end of month 6 we have delivered a recurrent reduction of 72.08 WTE, this is forecast to rise to 502.0 WTE by the end of the year.

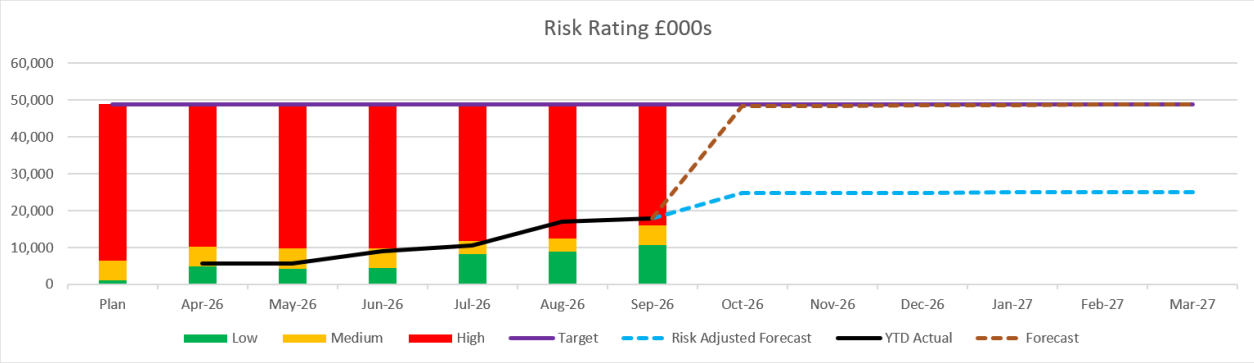
IDP Programme – Recurrent FYE (£)

Recurrent FYE £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
Fully Developed - in delivery	1,000	12,605	12,521	(84)
Fully Developed - not yet started	0	907	1,103	196
Plans in Progress	10,311	9,713	11,799	2,086
Opportunity	37,518	25,604	23,407	(2,198)
Unidentified	0	0	0	0
Total	**48,829**	**48,829**	**48,829**	**(0)**

Recurrent FYE £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
High	42,329	36,387	32,898	(3,490)
Medium	5,500	3,468	5,160	1,692
Low	1,000	8,974	10,771	1,798
Total	**48,829**	**48,829**	**48,829**	**(0)**

At the end of month 6 we have delivered a recurrent FYE of £17.8m and are forecasting delivery of £48.8m in line with plan by the end of the year in the best case. The risk adjusted forecast is £25.1m.





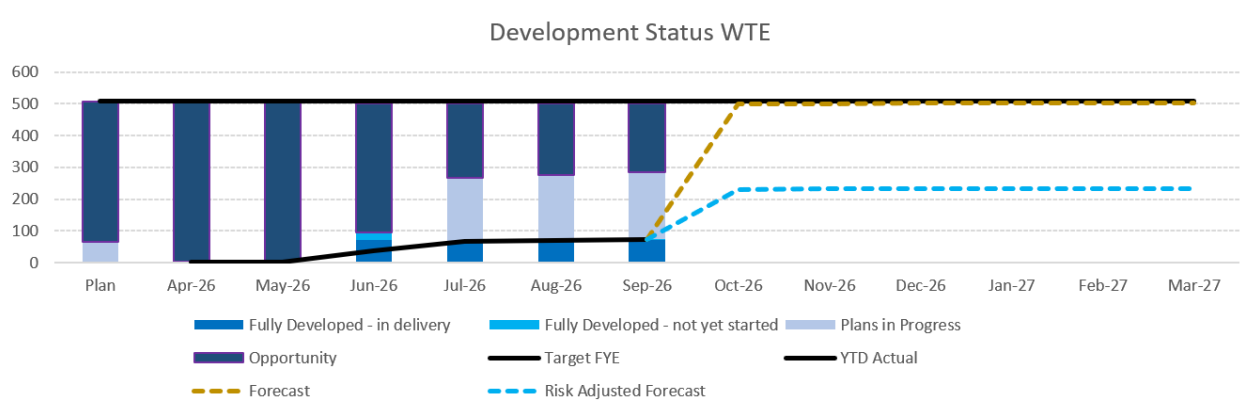
Workstream / Scheme	Movement from prior month FYE	Value £000's	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Local - All	Divisional forecasts aligned to their PRM summaries	4,048	High	Medium	Opportunity	Plans in Progress
Reset - Ward Consolidation	MMH Rehab assumed to no longer deliver in 26/27	(1,360)	High	n/a	Plans in Progress	n/a

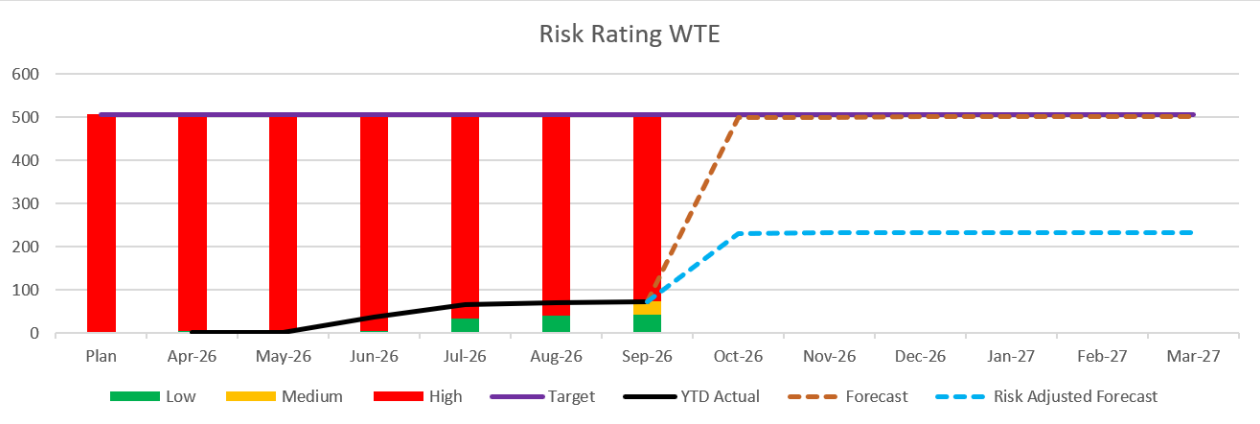
IDP Programme – Recurrent FYE (WTE reduction)

WTE - FYE	April Plan Submission	Month 5	Month 6	Increase (Decrease)
Fully Developed - in delivery	0.0	71.8	72.1	0.3
Fully Developed - not yet started	0.0	3.5	3.9	0.4
Plans in Progress	66.5	200.8	207.7	6.9
Opportunity	440.9	225.9	218.3	(7.6)
Unidentified	0.0	0.0	0.0	0.0
Total	**507.4**	**502.0**	**502.0**	**(0.0)**

WTE - FYE	April Plan Submission	Month 5	Month 6	Increase (Decrease)
High	507.4	460.0	427.2	(32.8)
Medium	0.0	0.0	32.0	32.0
Low	0.0	42.0	42.8	0.8
Total	**507.4**	**502.0**	**502.0**	**(0.0)**

Our committed plan is to reduce by 507.4 WTE recurrently in the year. At the end of month 6 we have delivered a recurrent FYE WTE reduction of 72.08 and are forecasting delivery of 502.0 WTE by the end of the year.





Workstream / Scheme	Movement	WTE	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Local - All	Increase in Forecast based on PRM discussions	6.90	High	Medium	Opportunity	Plan in Progress

SECTION 3
Delivering the 2026/27 committed plan

Executive Summary

Income and Expenditure surplus/deficit

Excluding deficit support funding, the Trust is reporting a £15.5M year to date deficit, £5.1m adverse to plan. The adverse variance is driven by a £6.9M shortfall in efficiency delivery offset partially by non-recurrent technical benefits.

Activity

Outpatient New, Outpatient Follow up, and daycase were below plan in September. Elective was above plan in month, however ERF activity is below plan. Year to date, outpatient new and outpatient follow up are behind plan and daycase and elective are above plan, ERF activity is below plan.

Efficiencies

Schemes implemented in the year will yield recurrent full year savings of £17.8M. Year to date in-year savings (which also include non-recurrent) are £12.7M (adverse to plan by £6.9M). The full year forecast for in-year savings remains in line with plan at £46.3M in the best case.

Implied Productivity

The most recently published data (full year 25/26) shows DBTH implied productivity is 0.2% **above** pre-covid (2019/20) levels. This places the Trust in the top quartile of performers nationally and is better than both the national median (-5.2%) and the median of the group of peer Trusts selected by NHS England (-4.3%). There has not been a data refresh since the previous report.

Cash

The cash balance is £7.1M and has reduced by £3.2M in month as a result of cash outflows of PDC Dividend (£5.4M) and Capital payments (£4.2M), partially offset by cash inflow for PDC Capital monies of £2.4M. An application for revenue cash support has been submitted through region to the national NHSE Finance team.

Capital

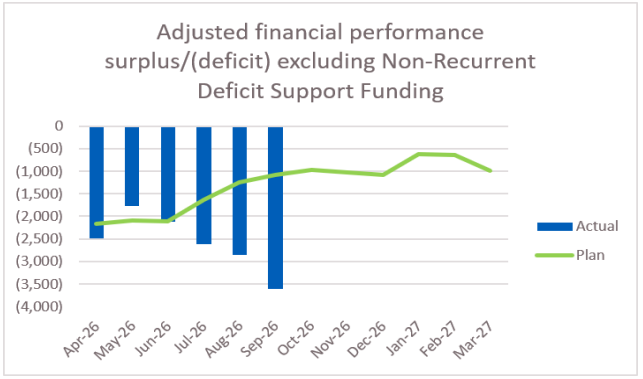
Capital expenditure (excluding charitable funds) is £1.6M in month against a plan of £2.8M and year to date is £3.1M against a plan of £12.8M.

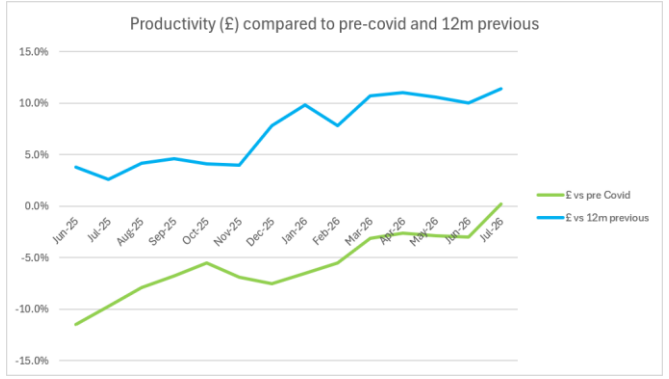
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
M06 September 2026
Income and Expenditure vs. Budget

Performance Indicator	Annual budget £'000	Monthly Performance Budget £'000	Monthly Performance Actual £'000	Monthly Performance Variance to budget £'000		YTD Performance YTD Budget £'000	YTD Performance YTD Actual £'000	YTD Performance Variance to budget £'000	
Income	(647,639)	(54,753)	(53,043)	1,709	A	(323,753)	(317,784)	5,970	A
Pay	434,859	36,855	37,356	502	A	219,830	219,688	(142)	F
Non Pay	204,112	16,959	18,570	1,611	A	102,094	105,485	3,391	A
Financing Costs	9,455	788	794	6	A	4,727	4,555	(173)	F
(Profit)/Loss on Asset Disposals	0	0	6	6	A	0	6	6	A
(Surplus)/Deficit for the period	**787**	**(151)**	**3,683**	**3,834**	**A**	**2,898**	**11,950**	**9,052**	**A**
Donated Asset Adjustment	(787)	(66)	(66)	(1)	F	(393)	(406)	(12)	F
Impairment Adjustment	0	0	0	0	F	0	(0)	(0)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**0**	**(217)**	**3,616**	**3,833**	**A**	**2,505**	**11,544**	**9,040**	**A**
Remove Deficit Support Funding	***15,700***	***1,308***	***0***	*(1,308)*	***F***	***7,850***	***3,924***	*(3,926)*	***F***
Adjusted Financial Performance Excluding Deficit Support Funding	***15,700***	***1,092***	***3,616***	***2,525***	***A***	***10,355***	***15,468***	***5,114***	***A***

Income: Over-achieved F | Under-achieved A
Expenditure: Underspent F | Overspent A

Key
F = Favourable **A** = Adverse





Deficit Support Funding

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

Eligibility for Q2 DSF, along with any decision to award Q3 DSF, will be re-assessed later by NHSE using month 5 results and will be determined in October. At the time of writing the decision on Q2 DSF award has yet to be formally confirmed.

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

At the month 6 reporting point £23.1M (49.9%) of the £46.3M in-year CIP programme is categorised within the fully-developed categories.

Key Risks and Mitigations to Delivery of In-Year Plan

Key Risks	Risks (R)				
	26/27 Plan	M4	M5	M6	(Increase) Decrease
	£'000	£'000	£'000	£'000	£'000
Efficiency risk	(32,659)	(18,640)	(17,579)	(15,657)	1,922
Commissioner Growth and clawback	(8,700)	(6,485)	(6,485)	(6,485)	0
Delays to acceleration of structural changes	(3,700)	0	0	0	0
Incremental drift	(500)	0	0	0	0
Potential error in estimation of revenue to capital transfer	(100)	0	0	0	0
Total	**(45,659)**	**(25,125)**	**(24,064)**	**(22,142)**	**1,922**

Key Mitigations	Mitigations (M)				
	26/27 Plan	M4	M5	M6	Increase (Decrease)
	£'000	£'000	£'000	£'000	£'000
Reset programme	6,786	6,786	6,786	4,864	(1,922)
Negotiation with SY ICB	0	6,485	6,130	6,130	0
Reset Programme	0	0	0	0	0
Non Recurrent technical	0	0	0	0	0
Non Recurrent technical	0	0	0	0	0
Total	**6,786**	**13,271**	**12,916**	**10,994**	**(1,922)**

26/27 Plan Net Risk	M6 Net Risk	(Increase) Decrease in month
£'000	£'000	£'000
(25,873)	(10,793)	0
(8,700)	(355)	0
(3,700)	0	0
(500)	0	0
(100)	0	0
(38,873)	**(11,148)**	**0**

- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.
- There has been a £23.5m improvement in the gross risk profile since the plan was set (£45.7M to £22.1M).
- Mitigations have improved by £4.2M (£6.8M to £11.0M) since the plan submission.
- The net risk has reduced by £27.7M since plan submission to £11.1M.

Surplus/Deficit – Graphs M06

In month/Year to Date

- In month £3.6m deficit, a £3.8m adverse to plan mainly due to Deficit Support Funding (DSF) not being received for M6 £1.3m and unachieved efficiencies.
- Year to date (YTD) £11.5m deficit, £9.0m adverse to plan mainly due to the DSF not being achieved for Q2, (£3.9m) unachieved efficiencies (£6.9m), offset by non recurrent technical benefits.
- As per NHSE guidance, the Trust is only able to recognise Deficit Support Funding when paid.

Income

- Income is adverse to plan YTD mainly due to Clinical Income £4.4m; Deficit support funding of £3.9m, CDC/ERF activity below plan, NR transformation funding offset by favourable variable income for UEC and other clinical income. Operating income is adverse to plan £1.6m mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges.

Pay

- Pay is £0.5m adverse in month and £0.1m favourable YTD mainly due efficiency not being delivered offset by delays in spend for transformation funding/investments.
- Bank/agency and additional medical sessions spend in month is £4.0m (previous month: £4.2m) due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

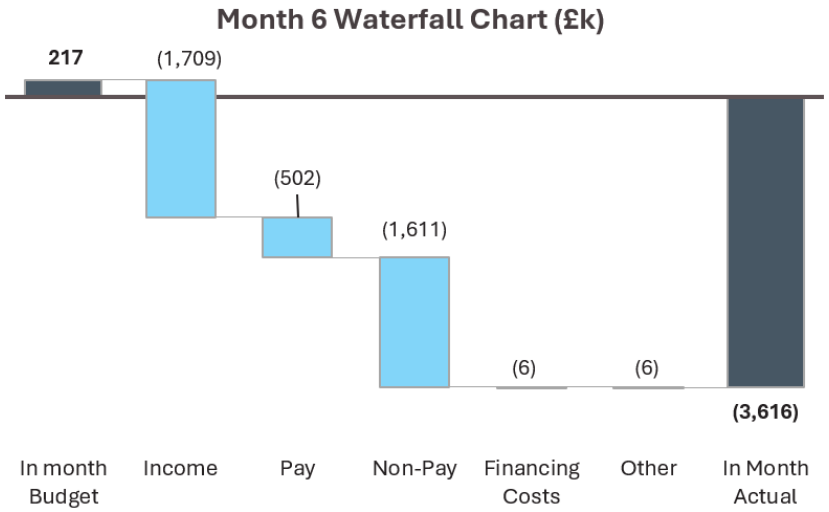
- Non-pay is £1.6m adverse in month and £3.4m adverse YTD mainly due to clinical supplies additional activity, equipment hire and repairs and unachieved CIP, partially offset by the release of reserves.

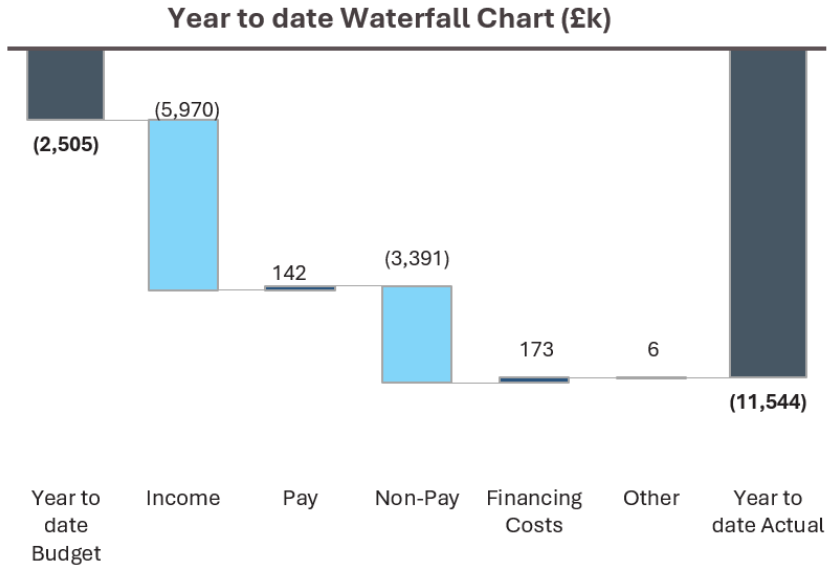
Other

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

Financing Costs

- Financing costs are broadly in line with plan in month.





Financial Performance – Income

Clinical Income Position Month 6

	Annual Plan	Plan - M6 YTD	Actuals - M6 YTD	Variance
	£'000	£'000	£'000	£'000
ICB				
NHS South Yorkshire ICB	(398,856)	(199,597)	(198,023)	1,574
NHS Nottingham and Nottinghamshire ICB	(120,913)	(60,457)	(60,769)	(313)
NHS Humber and North Yorkshire ICB	(9,051)	(4,525)	(4,467)	59
NHS Derby and Derbyshire ICB	(6,315)	(3,157)	(3,227)	(70)
NHS West Yorkshire ICB	(4,127)	(2,063)	(2,059)	4
NHS Lincolnshire ICB	(2,294)	(1,147)	(1,148)	(1)
LVA	(1,363)	(681)	(678)	3
ERF	0	0	363	363
CDC	0	0	209	209
UEC	0	0	(370)	(370)
Excluded drugs (ICB)	1,676	1,676	1,676	0
ICB sub total	**(541,241)**	**(269,951)**	**(268,494)**	**1,457**
NHS England				
NHSE Support Funding	(15,700)	(7,850)	(3,924)	3,926
Armed Forces / Retained Block	0	0	(63)	(63)
Drugs and Devices	(10,691)	(5,294)	(5,523)	(229)
Offender Health	(1,683)	(841)	(844)	(2)
Public Health	(4,728)	(2,364)	(2,380)	(16)
NHS England sub total	**(32,802)**	**(16,349)**	**(12,733)**	**3,616**
Other Clinical Income	(273)	(339)	(911)	(572)
Grand Total	**(574,316)**	**(286,640)**	**(282,138)**	**4,501**
other income - RTAs, PPs, OSV, CIP	(6,013)	(3,007)	(3,129)	(122)
	(580,329)	(289,646)	(285,267)	4,379

Month 6

The Clinical Income position is showing an adverse variance to plan of £4.4M due to Deficit Support Funding (£3.9M), CDC activity (£0.2M) ERF Activity (£0.4M) and non recurrent transformation income (£2.2M). This has been offset by UEC income (£0.4M), depreciation funding (£0.4M), API / Devices (£0.9M) and other clinical income (£0.7M). Operating income is adverse to plan (£1.6M) mainly due to HEE offset by a reduction in expenditure, MEOC and salary recharges. Deficit support funding has been assumed in the year-to-date position as per the NHSE guidance up to Month 3, as payment has been made.

ERF Performance

The activity has not yet been fully coded with estimated case mix applied. Below is a table showing the ERF position at Month 6 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying ERF performance.

ICB	ERF Annual Plan	Plan M6	Actual M6	Variance	Notes
South Yorkshire	(91,652)	(46,962)	(47,182)	(220)	No variance transacted
Associate ICB's					
Nottinghamshire	(31,100)	(15,935)	(15,451)	484	
Lincolnshire	(758)	(389)	(301)	87	
Derbyshire	(1,036)	(531)	(558)	(27)	
West Yorkshire	(749)	(384)	(475)	(91)	
Humber & North Yorkshire	(1,911)	(979)	(1,070)	(90)	
Sub Total	(35,554)	(18,218)	(17,855)	363	

Financial Performance – UEC Position

Urgent and Emergency Care Income Position Month 6

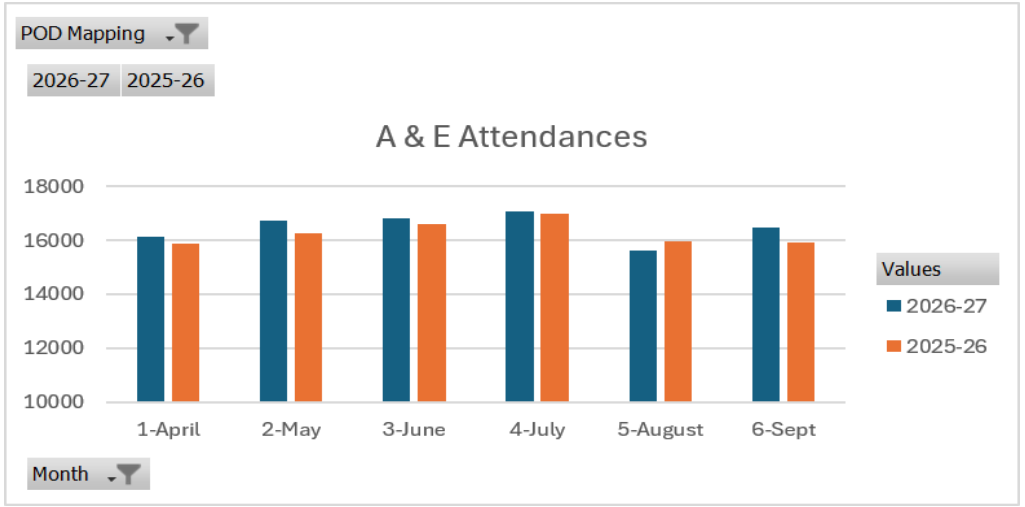
Change in Commissioning Approach 2026-27

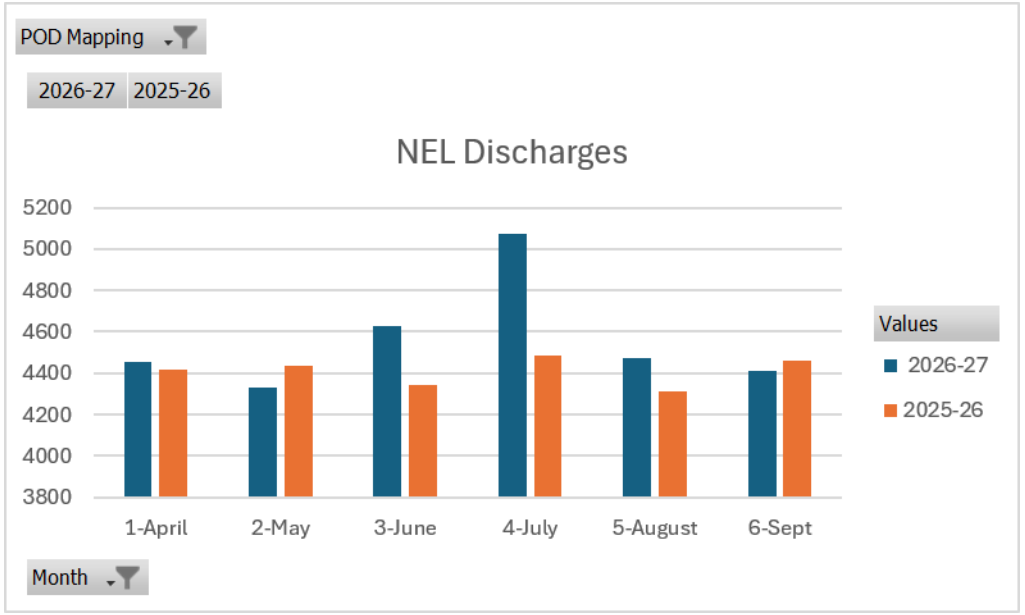
For 2026/27, urgent and emergency care (UEC) activity is commissioned and reimbursed through the NHS Payment Scheme using the Aligned Payment and Incentive (API) model. Under this approach, providers receive a fixed annual payment alongside an activity-based adjustment for emergency care services.

UEC Performance

The activity has not yet been fully coded with estimated case mix applied. Below is a table showing the UEC position at Month 6 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying UEC performance. For the associates, the YTD month 6 performance was £0.4m favourable after applying the marginal rate. SY ICB is monitoring in shadow form by agreement in a side letter to the contract, whereas the other commissioners are implementing the NHS payment guidance fully.

ICB	UEC Annual Plan	Plan M6	Actual M6	Variance	UEC Marginal Rate	Notes
South Yorkshire	(144,180)	(71,099)	(74,667)	(3,568)	(714)	No variance transacted
Associate ICB's						
Nottinghamshire	(54,295)	(26,831)	(28,518)	(1,687)	(337)	
Lincolnshire	(408)	(201)	(290)	(89)	(18)	
Derbyshire	(3,020)	(1,489)	(1,434)	56	11	
West Yorkshire	(1,589)	(784)	(782)	1	0	
Humber & North Yorkshire	(4,552)	(2,245)	(2,378)	(133)	(27)	
Sub Total	(63,864)	(31,550)	(33,402)	(1,852)	(370)	



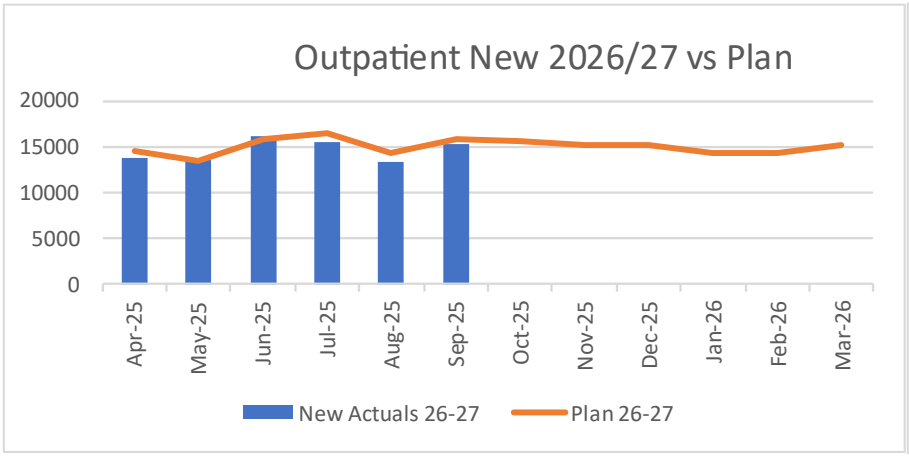


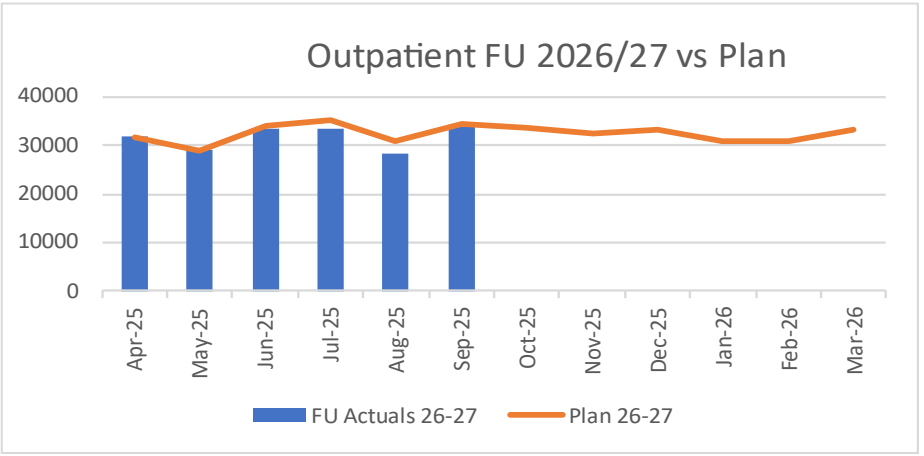
Activity Against Plan 2026/27

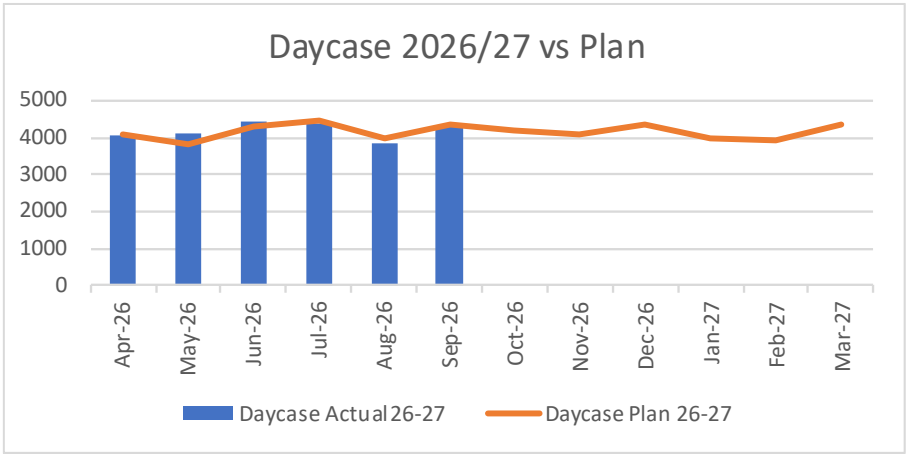
Data as at 06/10/2026

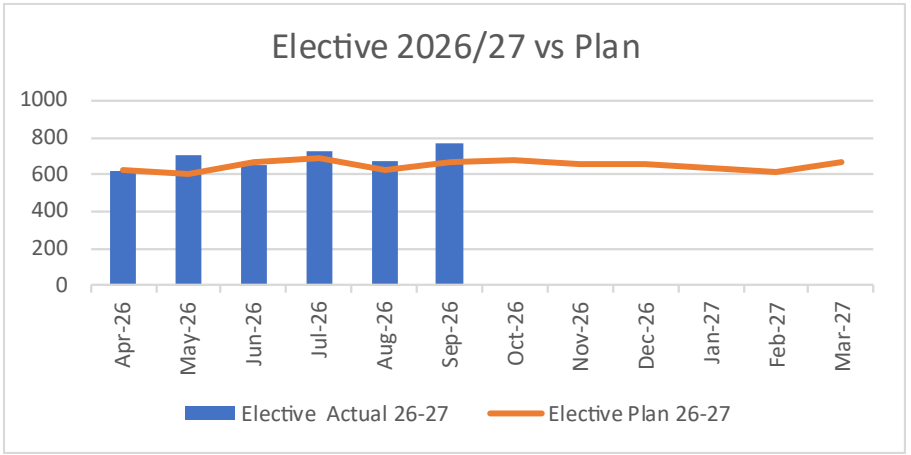
Point of Delivery	Activity vs Plan (September 2026)
Outpatients New	97.4%
Outpatient Follow up	98.2%
Daycase, excluding MEOC	99.2%
Elective, excluding MEOC	116.2%

- Outpatient New, Outpatient Follow up, and daycase were below plan in September. Elective was above plan.
- Outpatient New were -405 below plan in month and -2229 below plan YTD (97.5%).
- Outpatient Follow up were -614 below plan in month and -4920 below plan YTD (97.5%)
- Daycases were -35 below plan cases in month and 182 cases above plan YTD (100.7%)
- Electives were 108 cases above plan in month and above by 265 cases YTD (106.9%)







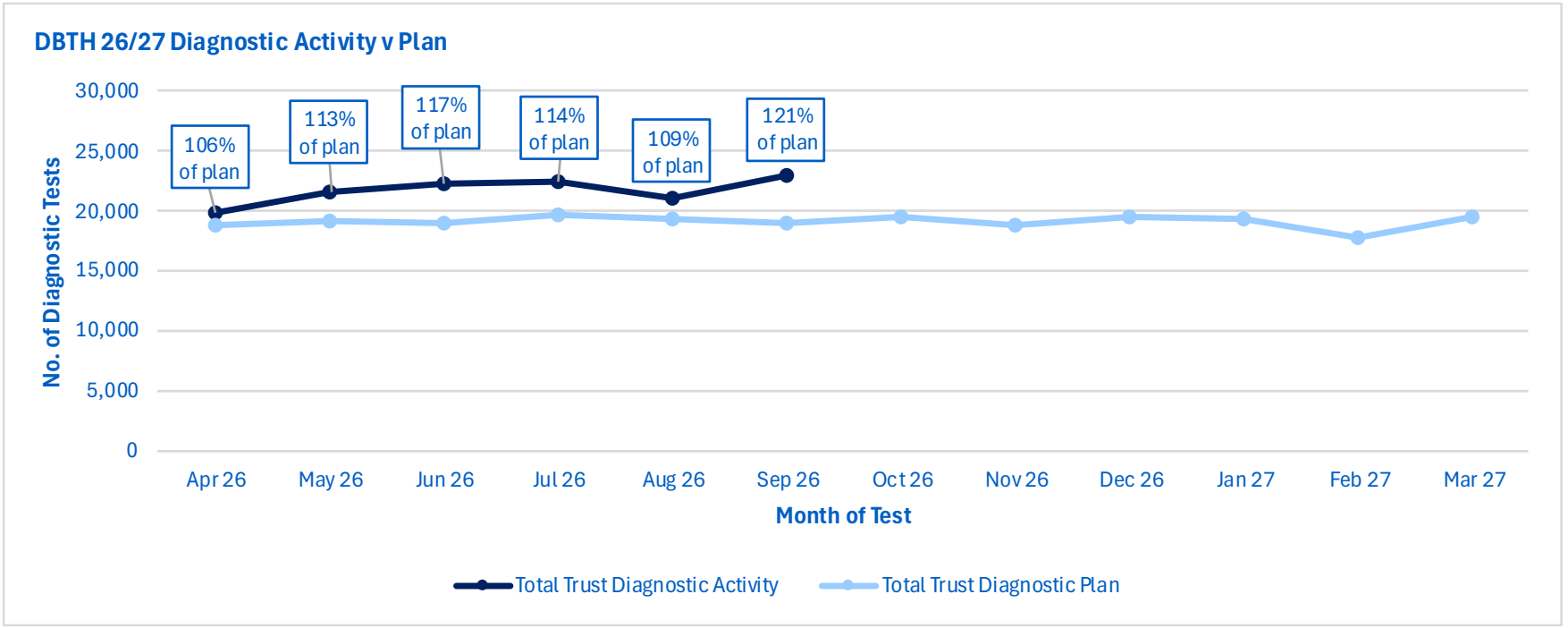


Please note that the performance is expected to improve as further clinics are reconciled after the data was extracted for this reporting period

Diagnostic Activity Against Plan 26/27

Data as at 06/10/2026

- Diagnostic activity in September (22,922) continues above Trust plan, delivering 3,914 over plan (121%), taking the YTD activity delivery (130,158) to 113% of plan (114,881).
- NOUS and CT continue to have the largest over delivery of plan in September in terms of activity numbers (1,777 and 989 exams above plan respectively). This month saw MRI and Dexa follow in a close 3rd & 4th place with 758 and 576 additional exams respectively.
- Dexa had the highest additional activity in terms of percentage of plan at 281%, followed by Nerve at 147% of plan.
- Audiology was behind plan in month by 366 and the lowest percentage of plan delivered (36% in September).



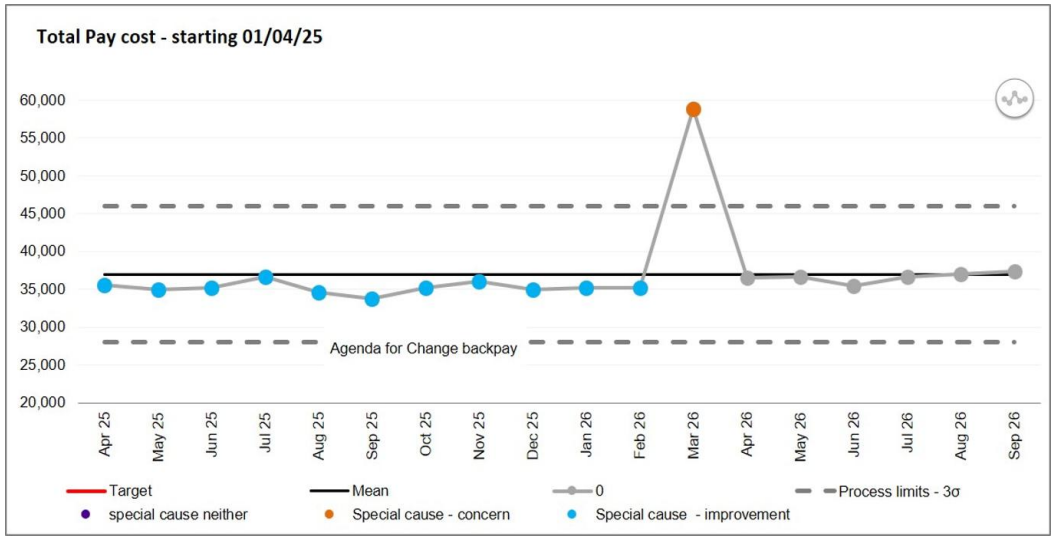
Please note: *the activity numbers above are taken from the DM01 Diagnostic Reconciliation file and the plan numbers are taken from the Trust's Plan Submission. The plan specified the 'number of diagnostic tests or procedures carried out' and so therefore the activity numbers do not include interventional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

Financial Performance - Pay

In Month – £0.5M adverse in month and £0.1M favourable YTD.

- Pay is £0.1M favourable YTD mainly due to efficiency not being delivered offset by delays in spend for transformation funding/investments.
- Bank/agency and additional medical sessions spend in month is £4.0M (previous month: £4.1M) due to operational pressures, cover for vacant posts and sickness cover.
- Additional sessions spend (£1.5M) remained in line with the previous month.
- Bank spend reduced by £0.1M, mainly due to the bank holiday in the previous month.
- Agency spend reduced by £0.1M, mainly in Medicine due to an increase in substantive staffing.

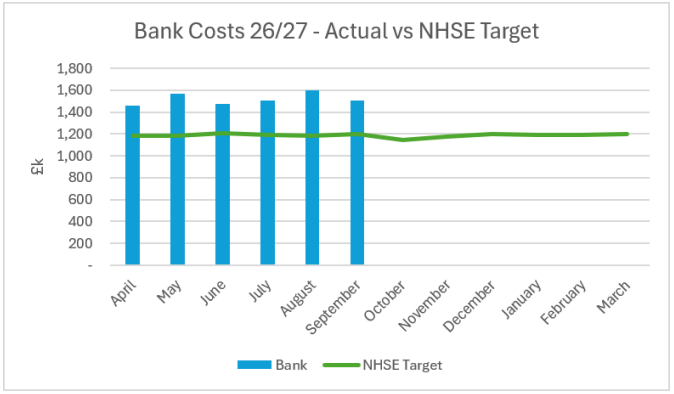
Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,748	6,187	-561	F	-2,849	F
Ambulance staff						
Apprenticeship Levy	135	132	-3	F	-20	F
Allied health professionals	3,115	3,102	-13	F	-176	F
Healthcare science staff	64	426	362	A	466	A
Medical and dental	11,690	12,760	1,071	A	5,680	A
Non Medical Non Clinical				A		A
Nursing & midwifery	13,924	13,792	-132	F	-275	F
Comprising:						
Registered nursing	*10,678*	*10,141*	*-537*	F	*-2,943*	F
Unregistered nursing	*3,245*	*3,640*	*395*	A	*2,632*	A
Scientific, therapeutic and tech	895	930	36	A	-34	F
Reserves & Technical Adjustments	285	27	-259	F	-2,935	F
Total Trust	**36,855**	**37,356**	**502**	A	**-142**	F

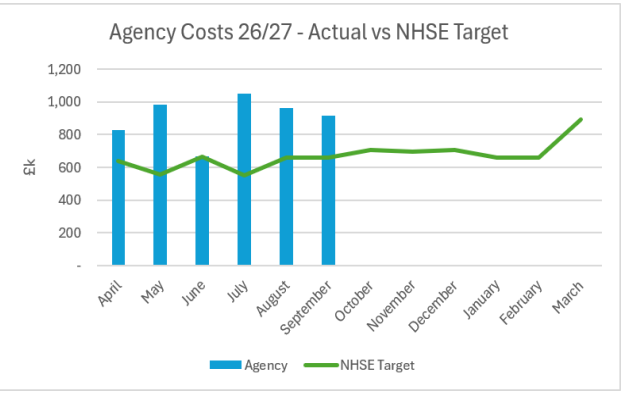


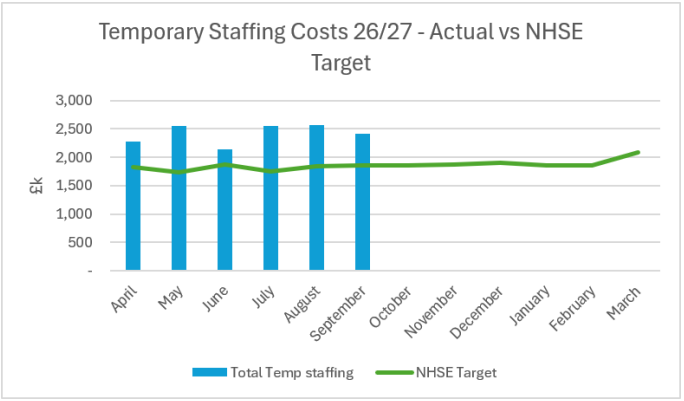
Financial Performance – Bank & Agency

In Month: Bank, £1.5M & Agency, £0.9M
Previous Month: Bank, £1.6M & Agency, £1.0M

- The NHSE target is based on the plan submission to NHSE and meets the cap limit.
- Agency costs in month are £0.9M, above plan by £0.3M and £0.1M less than the previous month mainly due to improved controls.
- Bank costs in month are £1.5M, above plan but are in line with average spend across months 1-5.
- The majority of agency spend is within the Medical staff group covering premium costs for vacant posts, sickness and industrial action costs.





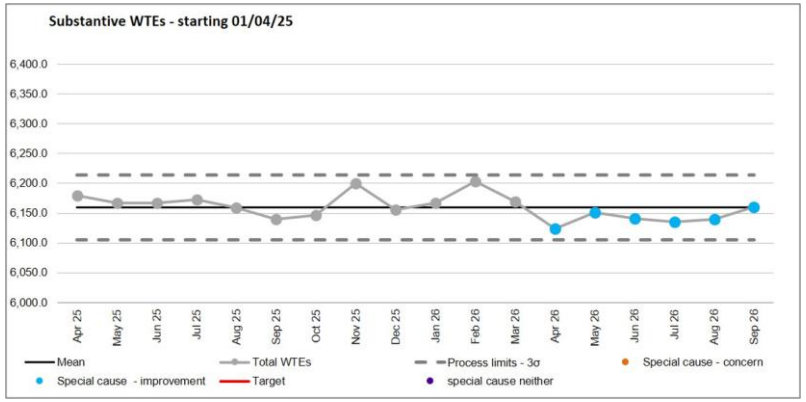


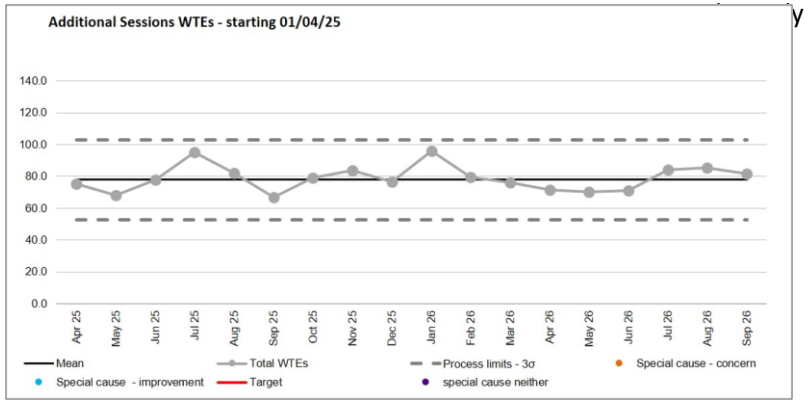
Temporary Staffing	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	YTD Spend	Annual target
Bank - Actual	1,458	1,566	1,471	1,504	1,596	1,504							9,099	
Bank - Target	1,183	1,181	1,204	1,194	1,181	1,198	1,148	1,172	1,200	1,193	1,193	1,199		14,246
Variance	**275**	**385**	**267**	**310**	**415**	**306**								
Agency - Actual	826	981	665	1,052	965	913							5,402	
Agency - Target	640	556	666	553	657	661	706	698	704	659	658	890		8,048
Variance	**186**	**425**	**- 1**	**499**	**308**	**252**							**14,501**	**22,294**

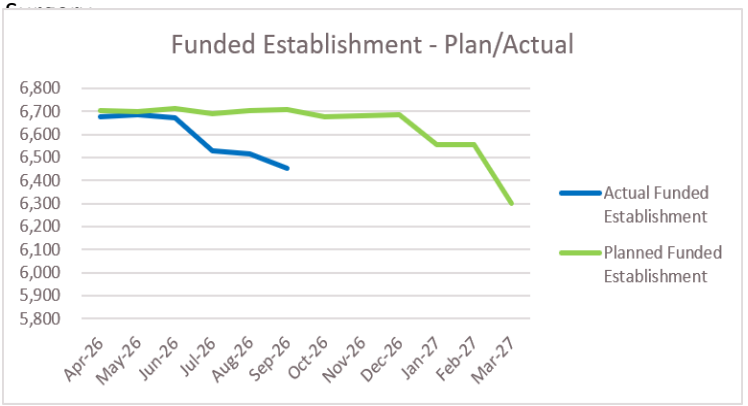
Financial Performance – Worked WTE

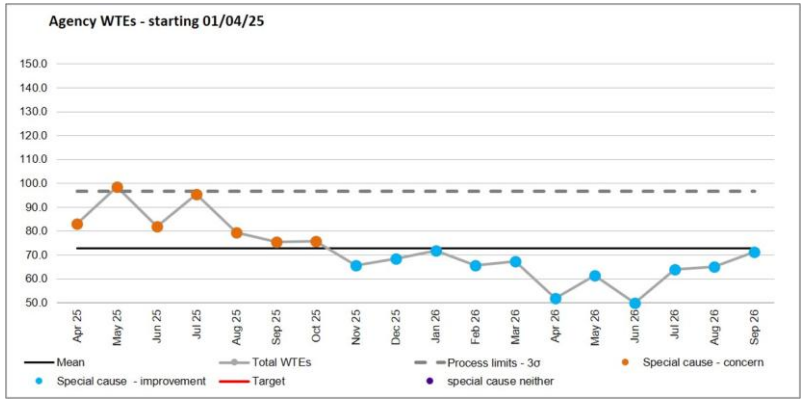
Workforce								
	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Additional Sessions	Total Temporary WTE	Total Worked WTE	Variance
Current Month	6,453.5	6,159.8	320.8	71.2	81.53	473.5	6,633.3	179.8
Previous Month	6,513.9	6,139.4	335.2	65.0	85.62	485.8	6,625.2	111.4
Movement	(60.4)	20.4	(14.5)	6.2	(4.1)	(12.4)	8.1	68.4

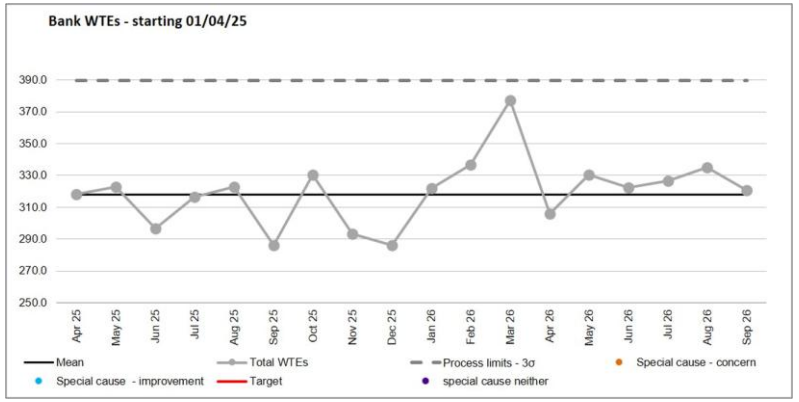
- The WTE's reported are worked WTE which are derived from the actual hours paid and worked.
- Funded Establishment – WTE Contracted and Plan Graph the WTEs for Additional Sessions, Bank and Agency are the worked WTE as the Trust does not have any contracted wte for temporary staffing.
- Funded WTE have reduced by 60.4 mainly due to the profile of CIP savings (54.3) and CDC workforce virement (5.2)
- Substantive staff have increased in month by 20.4 wte mainly in Medicine, UEC and Surgery due to recruitment .
- Bank WTE reduced mainly in Medicine due to a reduction in sickness and vacancy levels.
- Additional sessions wte have reduced mainly in CSS and W&C.

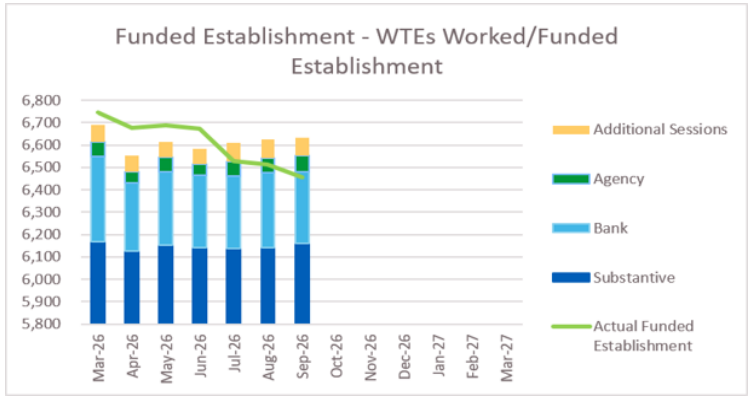










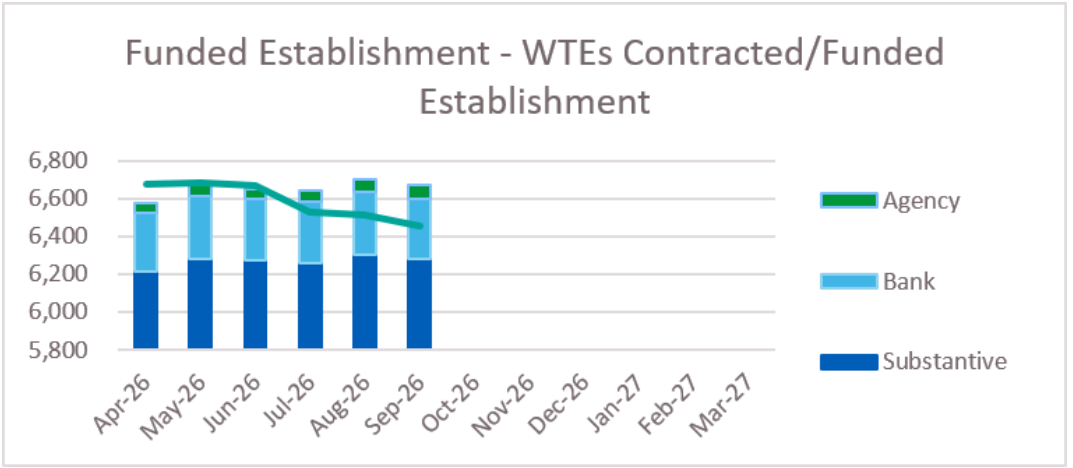


Financial Performance – Contracted WTE

Table 1 – Budget WTE

	2026/27 Budget WTE						
Total Pay WTE by Cost Type	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Movement
2a. Substantive	6,739.8	6,768.7	6,770.0	6,651.9	6,754.7	6,747.7	(7.1)
2b. Bank	1.4	1.3	1.3	1.3	1.3	1.3	0.0
2c. Agency	44.6	27.2	30.2	30.2	30.2	31.2	1.0
2d. Reserves - Pay	(108.3)	(111.0)	(129.7)	(156.8)	(272.4)	(326.7)	(54.3)
Total	**6,677.6**	**6,686.2**	**6,671.8**	**6,526.6**	**6,513.9**	**6,453.5**	**(60.4)**

Reserves – Relates to Reset Savings



	WTE Vacancies										
Table 2	Budget WTE	Substantive Contracted WTE	Gross Substantive Contracted Vacancies WTE	Gross Substantive Vacancies %	Bank Worked WTE	Agency Worked WTE	Additional Sessions	Total Temporary WTE	Contracted WTE & Worked Bank/Agency	Net of Temporary Staffing WTE	Net of Temporary Staffing %
Current Month	6,453.5	6,275.2	178.3	2.8%	320.8	71.2	0.0	391.9	6,667.2	(213.7)	(3.3%)
Previous Month	6,513.9	6,303.8	210.1	3.2%	335.2	65.0	0.0	400.2	6,704.0	(190.1)	(2.9%)
Movement	(60.4)	(28.5)	(31.8)	(0.5%)	(14.5)	6.2	0.0	(8.3)	(36.8)	(23.6)	(0.4%)

Table 2 - Vacancies are calculated as per national guidance on Contracted WTE and are submitted by Workforce to NHSE on a monthly basis. The funded establishment has reduced by 60.4 Whole Time Equivalents (WTE) in month 6, mainly due to CIP partially offset by CIG approved funded posts drawdowns. Based on the number of contracted staff, there is a 'vacancy' rate of 2.8% gross (3.2% last month) but overestablishment of 3.3% net of temporary staffing (3.0% last month).

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

Financial Performance – Non-Pay

In Month – £1.6M adverse to budget
YTD - £3.4M adverse to budget

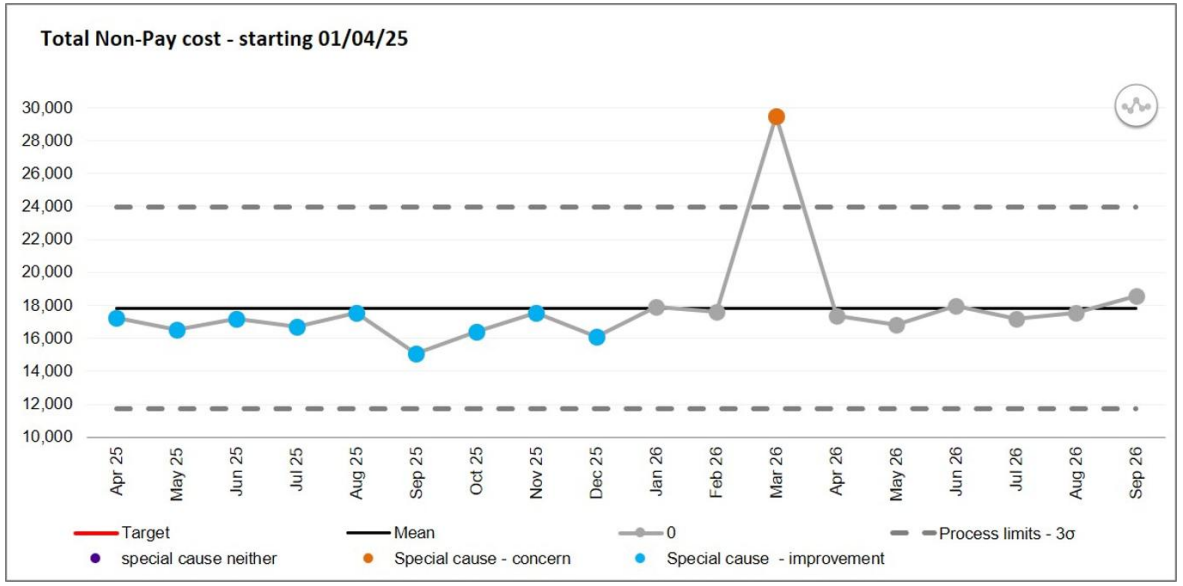
The main reasons for the adverse YTD variance is due to:

- £0.7M Drugs expenditure – additional activity
- £1.7M – Clinical supplies; £1.0M additional activity, £0.7M equipment contract hire and repairs
- £2.2M - Other costs - unachieved CIP
- £0.4M - Depreciation

Year to date Offset by:

- Non pay reserves of £1.6M have been released to support the position.

Non-pay trend by subjective	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Drugs (excluding non-PBR drugs)	1,651	1,935	284	A	873	A
Drugs (non PBR)	1,702	1,669	(33)	F	(140)	F
Clinical Supplies and Services	3,524	3,653	129	A	1,662	A
Other costs	6,943	8,035	1,092	A	2,261	A
Non-Executive Directors	16	14	(2)	F	(16)	F
Depreciation	1,658	1,769	111	A	407	A
Reserves & Technical Adjustments	(393)	(354)	39	A	(1,645)	F
Recharges	1,819	1,819	-	A	-	A
Parkhill	39	29	(10)	F	(11)	F
Total Trust	**16,959**	**18,570**	**1,611**	**A**	**3,391**	**A**



IDP Programme NB Includes both the Reset Programme and Local Schemes

In terms of 2026/27 in-year impact:

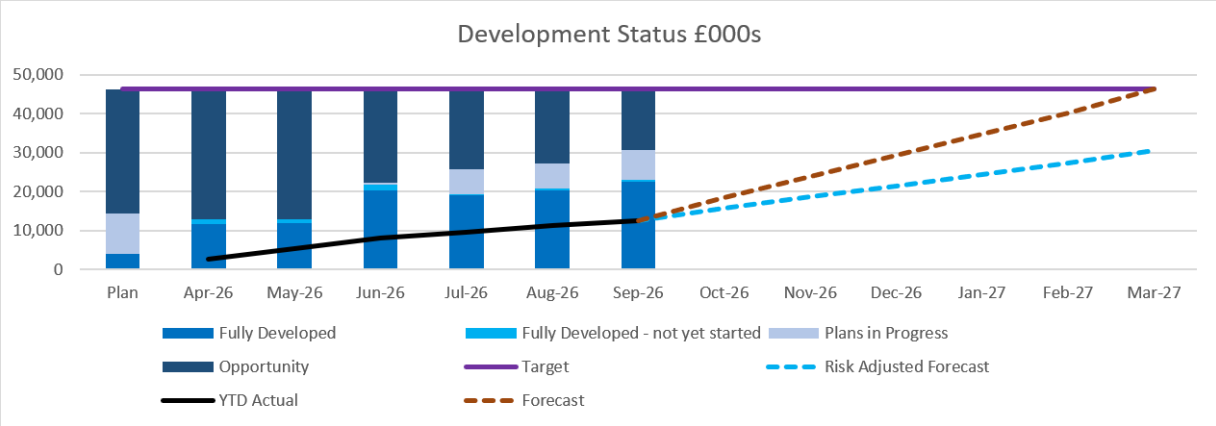
- In month 6 the Trust delivered £1.3M of savings vs a plan of £4.2M. This includes non-recurrent savings of £0.3M.
- Forecast in-year savings are £46.3M in line with plan, with a risk adjusted forecast of £30.6M.
- The committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction as at month 6 is 111.5 WTE, with an average of 70.3 WTE for pay underspends year to date. There is forecast to be an average reduction of 333.6 WTE across the full year.

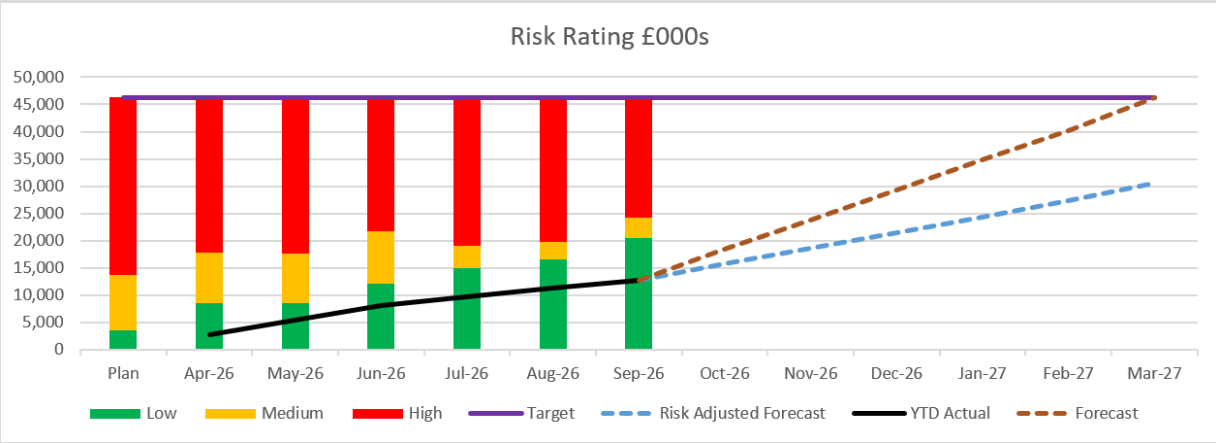
IDP Programme – 2026/27 In Year Savings (£)

Efficiency Plan Status £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
Fully Developed - in delivery	4,077	20,333	22,445	2,112
Fully Developed - not yet started	0	612	666	54
Plans in Progress	10,311	6,335	7,550	1,215
Opportunity	31,902	19,011	15,629	(3,382)
Unidentified	0	0	0	0
Total	**46,290**	**46,290**	**46,290**	**(0)**

Efficiency Plan Risk £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
High	32,657	26,539	22,072	(4,467)
Medium	10,072	3,253	3,771	518
Low	3,561	16,498	20,448	3,950
Total	**46,290**	**46,290**	**46,290**	**0**

The committed plan is to deliver £46.3M of in-year savings during 2026/27. As at month 6 we have delivered £12.7M of savings (27% of the full year plan). This is behind plan by £6.9M and includes non-recurrent savings. Forecast delivery for the full year is £46.3M and the risk adjusted forecast is £30.6M.





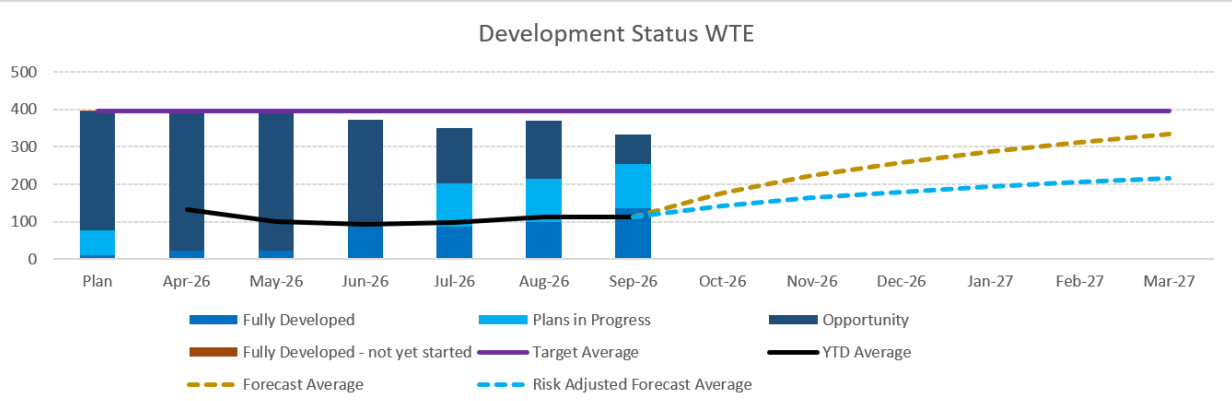
Workstream / Scheme	Movement	Value £000's	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Local - All	Divisional forecasts aligned to their PRM summaries	2,779	High	Medium	Opportunity	Plans in Progress
Local - All	Month End Underspends now forecast into future months	2,218	n/a	Low	n/a	Developed in Delivery
Reset - Ward Consolidation	MMH Rehab assumed to no longer deliver in 26/27	(683)	High	n/a	Plans in Progress	n/a
Reset - Medical Workforce	Validated schemes now live	350	High	Low	Opportunity	Developed in Delivery

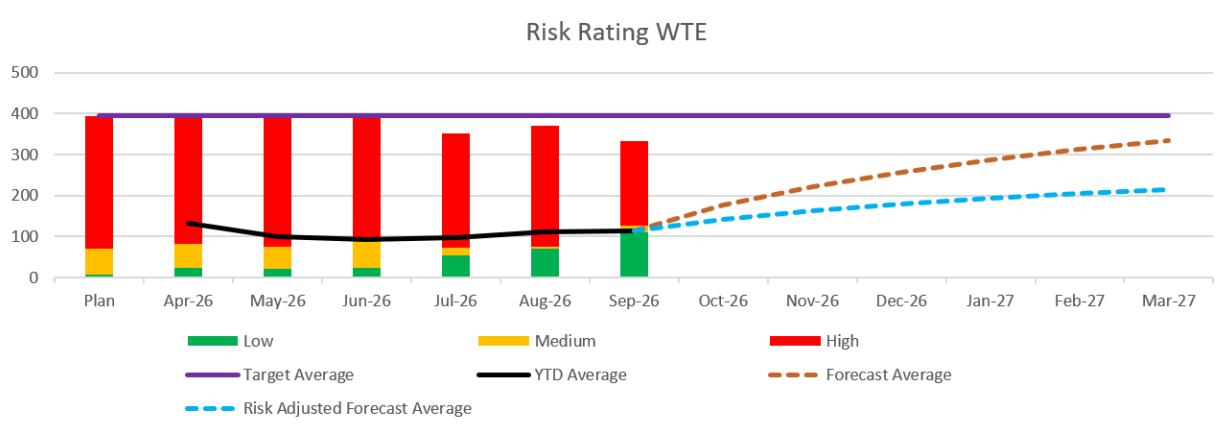
IDP Programme – 2026/27 In-Year (WTE reduction)

WTE - in year	April Plan Submission	Month 5	Month 6	Increase (Decrease)
Fully Developed - in delivery	9.3	98.5	135.9	37.4
Fully Developed - not yet started	0.0	0.6	0.5	(0.1)
Plans in Progress	66.5	117.0	118.7	1.7
Opportunity	319.4	155.2	78.5	(76.6)
Unidentified	0.0	-	-	0.0
Total	**395.1**	**371.2**	**333.6**	**(37.6)**

WTE - in year	April Plan Submission	Month 5	Month 6	Increase (Decrease)
High	323.9	295.5	205.7	(89.8)
Medium	64.9	6.1	17.4	11.3
Low	6.3	69.6	110.5	40.9
Total	**395.1**	**371.2**	**333.6**	**(37.6)**

Our committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction as at month 6 is 111.5 WTE and the forecast average reduction across the full year is currently 333.6 WTE.





Workstream / Scheme	Movement	WTE	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Local - All	Month End Underspends now forecast into future months	31.37	n/a	Low	n/a	Developed in Delivery
Local - All	Divisional forecasts aligned to their PRM summaries	(70.00)	High	n/a	Opportunity	n/a

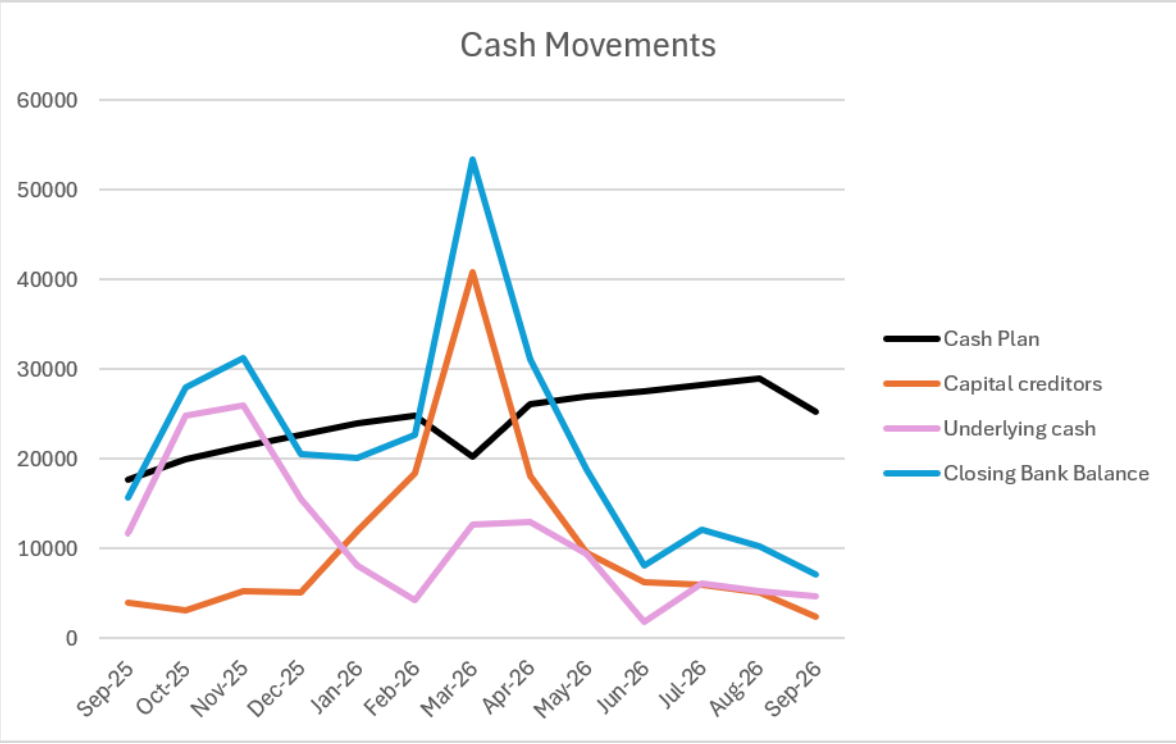
IDP Programme – Reset /Local

	In Year - Year to Date £000s			In Year - Full Year £000s			In Year - Year to Date WTE			In Year - Full Year WTE		
Pillar	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	750	35	(715)	3,416	1,500	(1,916)	0.00	0.00	0.00	31.96	0.00	(31.96)
Workforce & Organisational Design	4,722	592	(4,129)	11,980	6,380	(5,600)	163.12	5.88	(157.24)	252.98	133.59	(119.39)
Access & Flow	3,193	1,053	(2,139)	7,634	3,374	(4,260)	10.06	10.38	0.32	36.06	19.84	(16.22)
Productivity & Financial Reset	5,708	6,183	476	9,577	10,211	634	21.44	16.40	(5.04)	9.27	8.80	(0.46)
Total Reset	**14,372**	**7,864**	**(6,508)**	**32,607**	**21,465**	**(11,142)**	**194.62**	**32.66**	**(161.96)**	**330.27**	**162.23**	**(168.04)**
Local	5,175	3,314	(1,861)	13,683	9,628	(4,055)	64.86	78.88	14.02	64.86	98.09	33.23
Reserves Support	-	1,509	1,509	-	1,509	1,509	-	-	-	-	-	-
Total Local	**5,175**	**4,822**	**(352)**	**13,683**	**11,137**	**(2,546)**	**64.86**	**78.88**	**14.02**	**64.86**	**98.09**	**33.23**
Total Reset & Local	**19,547**	**12,687**	**(6,860)**	**46,290**	**32,602**	**(13,689)**	**259.48**	**111.54**	**(147.95)**	**395.13**	**260.32**	**(134.80)**
Local - GAP	-	-	-	-	13,689	13,689	-	-	-	-	73.30	73.30
Grand Total	**19,547**	**12,687**	**(6,860)**	**46,290**	**46,290**	**0**	**259.48**	**111.54**	**(147.95)**	**395.13**	**333.62**	**(61.50)**

	Recurrent FYE - Year to Date £000s			Recurrent FYE - Full Year £000s			Recurrent FYE - Year to Date WTE			Recurrent FYE - Full Year WTE		
Pillar	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	1,500	409	(1,091)	9,165	1,500	(7,665)	0.00	0.00	0.00	127.85	0.00	(127.85)
Workforce & Organisational Design	14,439	2,376	(12,063)	14,594	9,228	(5,366)	317.17	33.24	(283.93)	320.00	208.93	(111.07)
Access & Flow	7,120	3,627	(3,493)	8,763	4,686	(4,077)	25.15	26.60	1.45	59.54	26.60	(32.94)
Productivity & Financial Reset	6,500	3,594	(2,906)	6,500	5,000	(1,500)	0.00	2.68	2.68	0.00	2.68	2.68
Total Reset	**29,559**	**10,006**	**(19,553)**	**39,022**	**20,414**	**(18,608)**	**342.32**	**62.52**	**(279.80)**	**507.40**	**238.21**	**(269.19)**
Local	9,807	6,288	(3,518)	9,807	5,781	(4,025)	-	9.56	9.56	-	45.48	45.48
Reserves Support	-	1,509	1,509	-	1,509	1,509	-	-	-	-	-	0.00
Total Local	**9,807**	**7,797**	**(2,010)**	**9,807**	**7,290**	**(2,517)**	**0.00**	**9.56**	**9.56**	**0.00**	**45.48**	**45.48**
Total Reset & Local	**39,366**	**17,803**	**(21,563)**	**48,829**	**27,704**	**(21,124)**	**342.32**	**72.08**	**(270.24)**	**507.40**	**283.69**	**(223.71)**
Local - GAP	-	-	-	-	21,124	21,124	-	-	-	-	218.26	218.26
Grand Total	**39,366**	**17,803**	**(21,563)**	**48,829**	**48,829**	**(0)**	**342.32**	**72.08**	**(270.24)**	**507.40**	**501.94**	**(5.45)**

Cash, Receivables and Payables

Cash reduced by £3.2M in month as a result of as a result of cash outflows of PDC Dividend (£5.4M) and Capital payments (£4.2M), partially offset by cash inflow for PDC Capital monies of (£2.4M). The adverse variance to plan is as a result of non-cash-releasing benefits, planned Deficit Support Funding monies not yet received (£3.9M), shortfall in Efficiency delivery (£6.9M), MEOC invoices not being paid (£1.5M), SYICB growth funding remaining under discussion (£3.1M) and timing of capital creditors (£2.6M).



Invoice Turnaround

Average days	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	YTD
Between date of invoice and date available on system	16.7	12.5	11.8	17.3	13.7	18	15
Between being available on system and approval	8	8.1	6.4	6.7	8.5	9	7.8
Between approved date and payment date	24.1	21.1	22.1	22.1	22.7	23.1	22.5
Total	48.8	41.7	40.3	46.1	44.9	50.1	45.3
Total that the Trust has control over	**32.1**	**29.2**	**28.5**	**28.8**	**31.2**	**32.1**	**30.3**
Number of invoices	*8,981*	*7,645*	*9,663*	*7,939*	*7,915*	*9,224*	*8,561*

Better Payment Practice Code (In month)

Average days	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	YTD
NHS - %age based on invoice count	63.89%	86.96%	90.27%	80.11%	86.48%	80.26%	81.33%
NHS - %age based on invoice value	77.26%	84.89%	90.40%	87.78%	83.38%	72.32%	82.67%
Non NHS - %age based on invoice count	35.99%	31.80%	36.05%	31.34%	31.61%	28.42%	32.54%
Non NHS - %age based on invoice value	75.08%	69.76%	82.95%	68.92%	75.44%	61.05%	72.20%
Overall - %age based on invoice count	37.25%	32.87%	37.55%	32.26%	33.31%	29.27%	33.75%
Overall - %age based on invoice value	75.31%	70.69%	84.02%	71.01%	76.44%	61.73%	73.20%

Cash Projections

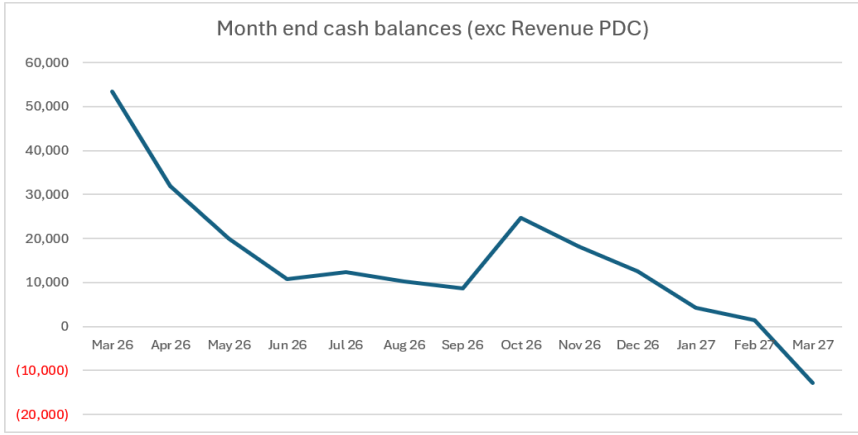
The charst shows a scenario analysis of cash movements for the rest of 2026/27 year. The cash position is supported by a significant level of capital creditors throughout the year and the revenue cash balance was planned to be between £5m-£10m throughout the year. Cash levels are projected to be less than plan at the end of the year in all scenarios except the best case scenario, which assumes full delivery of efficiencies.

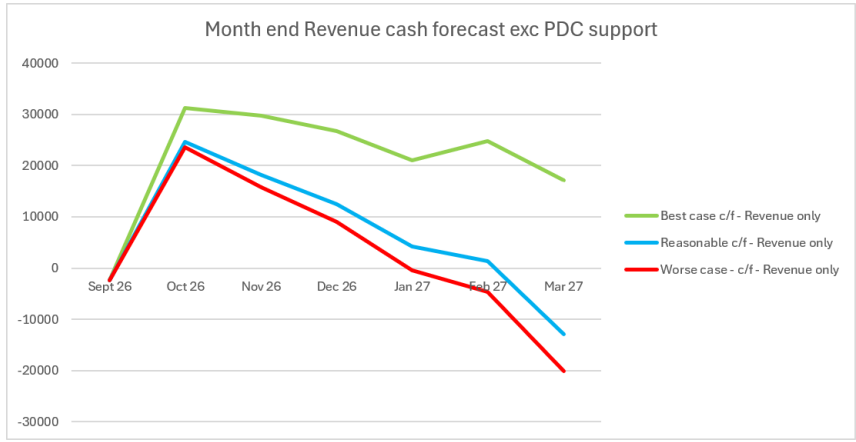
A key aspect underpinning the cash forecast is the achievement of efficiency schemes, particularly due to their size. It is important to note that such schemes will need to be cash releasing to ensure the achievement of the best and reasonable case scenarios.

Based on the worst case within the PAM, which assumes no further efficiency delivery and no cash management techniques, the Trust will require revenue cash support in October 2026, although this position will be supported by capital cash.

The increased overall cash balance is as a result of capital PDC monies which are drawn down as the capital activity takes place, but this means that there is a timing difference between receipt of monies and payment of invoices. In all scenarios, the revenue cash will need to be supported by revenue PDC cash throughout the rest of the year. There is also a timing difference in cash flows which often means that the month end cash balance is not the lowest cash balance in the month.

As such, an application for revenue cash support was submitted to NHSE in early October, for payment in mid November.





Key variations in models	Best	Reasonable	Worse
Provider Assurance Model adjustments	Total benefits of £15.6m (efficiency schemes back to plan)	Nil	Total costs of £7.2m (mirroring the worst case within PAM
Deficit Support Funding	Trust to receive all funding (in October, February and March)	Trust not to achieve Q3 and Q4 funding Total risk £7.8m	Trust not to achieve Q2, Q3 and Q4 funding Total risk £11.8m
Cash Management pressures	Extension of creditor payment terms by £2.5m	Nil	Nil

	Actual							Forecasted					
Month	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Month end cash balance	53,450	31,986	19,932	10,787	12,295	10,239	8,645	24,617	18,097	12,456	4,222	1,388	(12,855)
Lowest in-month cash balance	21,817	31,986	19,921	10,767	4,359	7,387	4,642	8,645	15,495	9,644	1,260	(1,954)	(14,006)
Lowest forecasted revenue in-month cash balance							(6,758)	(5,896)	(6,568)	(10,972)	(17,421)	(18,906)	(25,246)
Revenue cash balance at month end	12,642	12,602	8,079	621	1,091	(1,160)	(2,362)	134	(5,300)	(13,111)	(26,487)	(27,709)	(21,286)
Capital cash balance at month end	40,808	19,384	11,854	10,166	11,204	11,399	11,008	24,483	23,397	25,568	30,709	29,096	8,431
Made up of:													
- PDC capital	40,808	17,835	8,756	5,519	5,008	3,654	1,714	13,640	11,005	13,494	19,715	18,954	8,431
- Internally generated (depreciation)	0	1,549	3,098	4,647	6,196	7,745	9,294	10,843	12,392	12,074	10,994	10,143	0

Capital

Capital spend in month is £1.6M, £1.2M below plan, YTD £9.7M behind original plan.

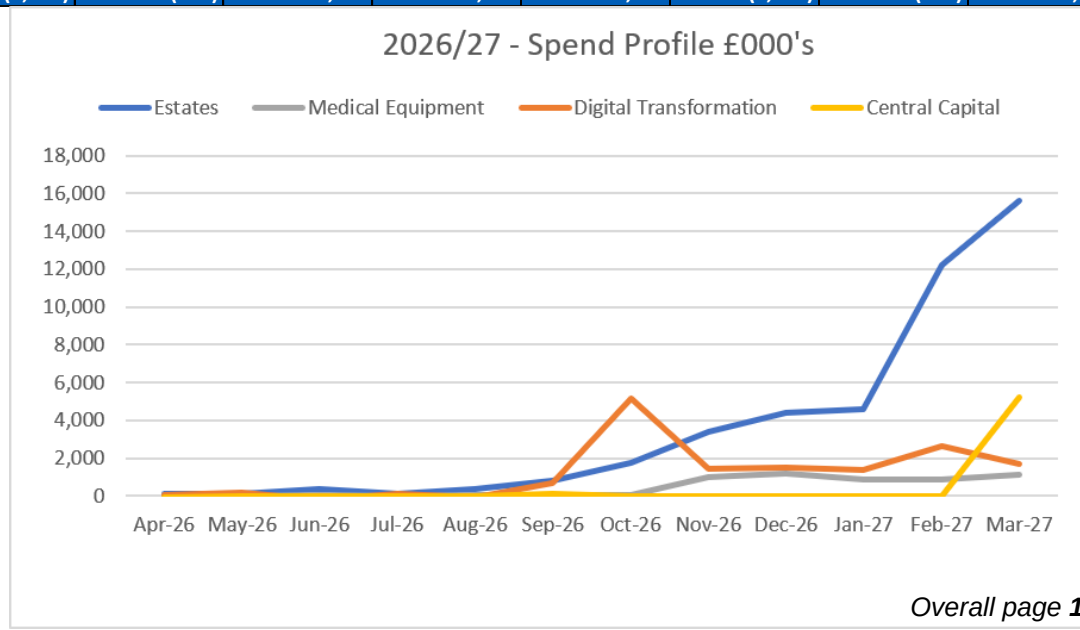
	In Month Plan (£'000)	In Month Forecast (£'000)	In Month Spend (£'000)	In Month Variance (£'000)	In Month Variance to Forecast (£'000)	YTD Plan (£'000)	YTD Forecast (£'000)	YTD Spend (£'000)	YTD Variance (£'000)	YTD Revised Variance to Forecast (£'000)	Annual Plan (£'000)
Estates Projects	1,946	689	791	(1,155)	103	6,280	1,758	1,860	(4,420)	103	45,359
Medical Equipment	0	181	33	33	(148)	0	372	223	223	(148)	5,951
Digital Transformation Projects	608	1,455	699	91	(757)	5,763	1,596	839	(4,923)	(757)	15,074
Central Capital	286	7	121	(165)	115	721	13	128	(593)	115	2,678
IFRS16 Leases	0	0	0	0	0	0	0	0	0	0	0
Total Capital Spend	**2,840**	**2,332**	**1,644**	**(1,196)**	**(688)**	**12,764**	**3,738**	**3,051**	**(9,713)**	**(688)**	**69,062**
Charitable Funds/Donated Assets	0	0	0	0	0	0	0	0	0	0	295
Total Capital Spend inc Charitable Funds/Donated Assets	**2,840**	**2,332**	**1,644**	**(1,196)**	**(688)**	**12,764**	**3,738**	**3,051**	**(9,713)**	**(688)**	**69,357**

The capital plan for 2026/27 includes the following

- £25.4M CDEL (Capital Departmental Expenditure Limit)
- £10.6M Frontline Productivity PDC for the EPR Project
- £9.0M RTCS PDC allocation for DRI UEC Reconfiguration
- £6.0M Estates Safety Fund
- £3.0M High Value Estates Fund – supporting the EWB programme
- £14.9M Emergency Estates Safety Funding

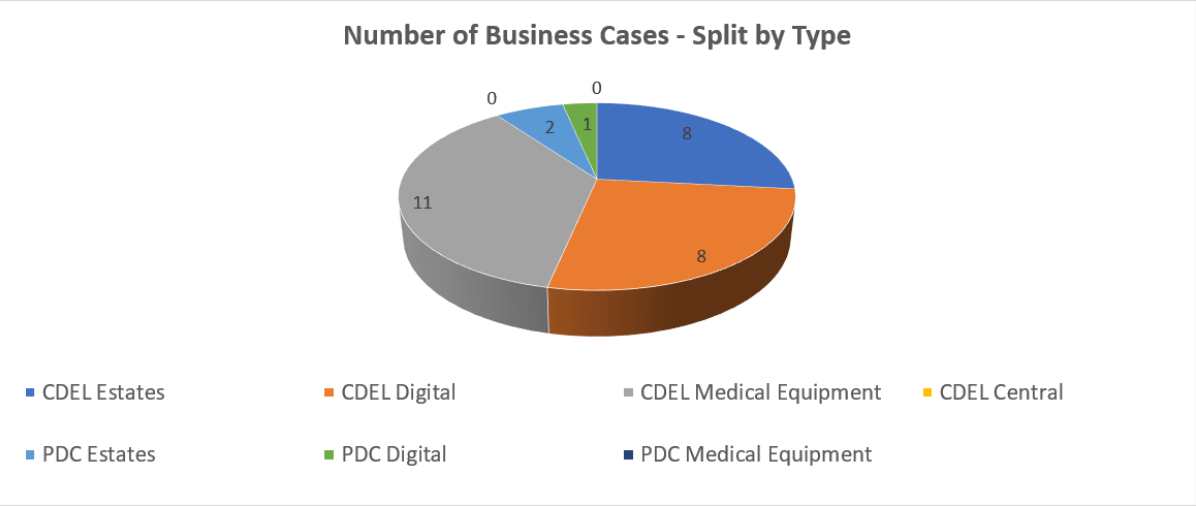
The recent approval of the £14.9m Emergency Estates Safety Funding has increased the Trusts overall capital programme for 26/27 to £69.4M.

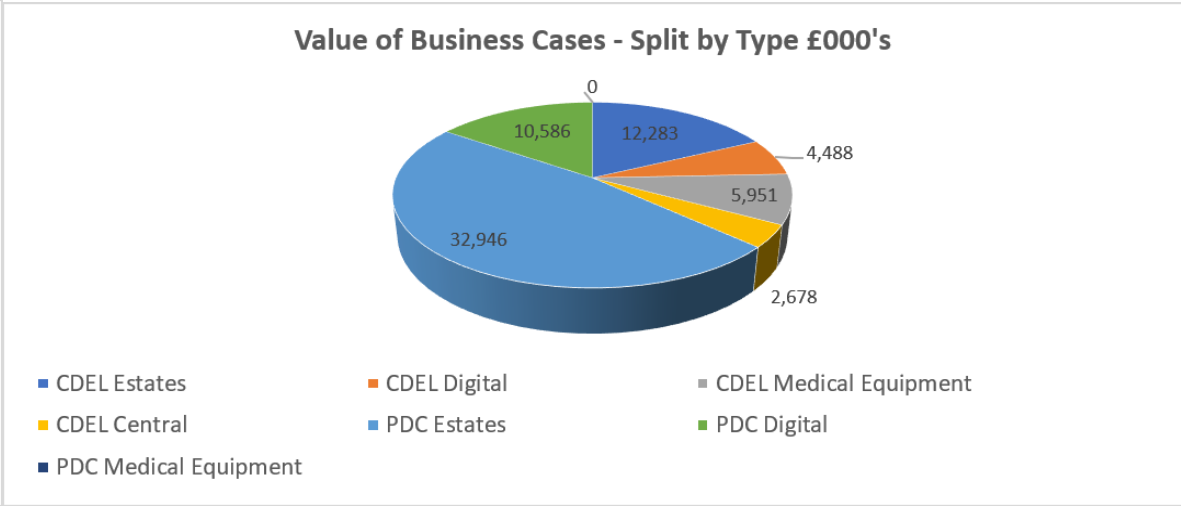
The variance to plan is predominantly driven by EPR and Estates delays which are expected to be recovered in the later months. Forecast reviews are taking place with capital sub-groups to monitor the delivery of the plan and expected cash outflow.



Capital

As at month 6, 30 capital business cases equating to £17.6m (£10.1M CDEL and £7,5m PDC) have been approved through Capital Investment Group (CIG), a further £12.2M CDEL and £10.1M EPR was approved as a pre-commitment in 25/26, giving total approval of £39.9M (57%) of the annual plan of £69.4M.





To support the delivery of the capital programme, all capital business cases were requested to be submitted by the September CIG meeting (at the latest), to ensure delivery before March. A review of the outstanding business cases and associated priorities is currently being undertaken, and a paper will be presented to the Executive for agreement on any re-allocation of capital funding. Of the £25.4M CDEL allocation for 26/27 £12.2M was approved through pre-commitments from 25/26, leaving £13.2M for approval, of which £10.1M has currently been approved through CIG.

Submission has been made to NHS England for Capital Cash support to enable the Trust to deliver the CDEL commitments, approval and MOU has been received and the first drawdown has been made in September. The Trust have received MOUs for the Estates Safety Fund and DRI UEC early drawdown funds (both schemes), and drawdowns have been requested and approved in October.

The table to the right shows the cumulative value of orders placed by week. 33% of the £69.4M annual capital programme has been ordered as at week commencing 12th October.

Week Commencing	28/09/2026	05/10/2026	12/10/2026
Estates	8,842,370	11,133,162	12,317,854
Digital Transformation	9,327,747	8,966,461	9,631,124
Medical Equipment	846,234	846,234	809,796
Central	8,047	8,047	127,885
TotalCapital excluding Charity	19,024,398	20,953,905	22,886,659
Charitable Funds/ Donations	201,172	201,172	201,172
Total Capital including Charity	201,172	201,172	201,172
Weekly Order Value	19,225,570	21,155,077	23,087,831
Movement		1,929,507	1,932,754

2611 - E PATIENTS

11:25

2611 - E1 PERINATAL SAFETY & QUALITY REPORT

Discussion Item | Karen Jessop, Chief Nurse & Nick Mallaband, Chief Medical Officer | 11:

Lois Mellor, Director of Midwifery & Tomas Barani, Clinical Director Obstetrics & Gynaecology
10 minutes

REFERENCES

Only PDFs are attached

- E1 - Perinatal Safety & Quality Interim Report.pdf
- E1 - Appendix 1 - Moss Critical Safety Check.pdf
- E1 - Appendix 2 - Perinatal Quality Oversight Measures & Maternity Metrics.pdf
- E1 - Appendix 3 - Equalities Dashboard.pdf
- E1 - Appendix 4 - QTR 1 Thematic Review.pdf
- E1 - Appendix 5 - Neonatal Nurse Staffing Action Plan.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

<table>
<tr><th colspan="6">Report Template</th></tr>
<tr><td>Meeting Title:</td><td colspan="3">Board of Directors</td><td>Meeting Date:</td><td>3 November 2026</td></tr>
<tr><td>Report Title/ Ref:</td><td colspan="5">Perinatal Safety & Quality (interim) Report - previously the Maternity and Neonatal update</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="5">Karen Jessop, Chief Nurse
Nick Mallaband, Chief Medical Officer</td></tr>
<tr><td>Authors:</td><td colspan="5">Lois Mellor - Director of Midwifery
Danielle Bhanvra - Deputy Director of Midwifery</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendix 1 - MOSS Critical Safety Check
Appendix 2 - PQOM Data Measures & Maternity Metrics
Appendix 3 - Equalities Dashboard
Appendix 4 - Thematic review
Appendix 5 - Neonatal Nursing Staffing Action Plan</td></tr>
<tr><td>Purpose of the report</td><td>Assurance</td><td><s>Approval / Decision</s></td><td colspan="2"><s>Information</s></td><td><s>Discussion</s></td></tr>
<tr><td>Proposed assurance Level (For assurance papers only)</td><td colspan="5">Significant Assurance</td></tr>
<tr><td>Assurance Rationale</td><td colspan="5">The Board is asked to take Significant Assurance that the maternity and neonatal service is progressing with the national requirements and that the metrics remain within expected ranges.

There are actions and / or business cases in place to address the outstanding requirements for BAPM medical and nursing standards for the single delivery plan that will be completed by the end of Q2.

Where training is below 90% it is proactively managed with allocated dates for all staff groups and oversight from the line managers.</td></tr>
<tr><td>Impacts on Strategic Risks (BAF 1-7)</td><td colspan="5">BAF1, BAF2, BAF6, BAF7</td></tr>
<tr><td>For decision papers only: Is this in line with Current risk appetite YES/NO</td><td colspan="5">Highlight only where this report is outside of the Board Risk Appetite and a decision is requested
<table>
<tr><th>Avoid</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Mature</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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Executive Summary – Key messages and Issues
This paper (previously called Maternity & Neonatal Safety & Quality Report) provides the Trust Board with a concise assurance update on Maternity and Neonatal safety for Aug & Sept 2026 drawing together the Perinatal Mortality Review Tool (PMRT) position and the maternity quality metrics/dashboards. It is intended to enable Board level scrutiny and confirm that appropriate governance and escalation arrangements are operating effectively. This report needs to be triangulated with any escalations and discussions from the Quality Committee held on 8 October 2026. **Board Assurance Summary Quarter Two** • Perinatal mortality performance: 3 term stillbirths within a 3-month period (July August and September) triggered a level 1 MOSS signal. A critical safety check has been completed (Appendix 1) • Reportable outcomes were: 2 stillbirths reportable to MBRRACE; and 0 neonatal deaths reportable to MBRRACE. • Learning from PMRT reviews 1 case was escalated for PSII • Quality metrics oversight is in place via the maternity dashboard (Appendix 2) and divisional governance, with defined escalation routes through the Quality Committee to the Trust Board. • PQOM data measures (Appendix 2). **Key areas requiring ongoing focus** The three-year single delivery plan concluded on 31 March 2026, however there are two outstanding actions to complete. These are to ensure that both the nursing and midwifery staffing are compliant with the British Association of Perinatal medicine (BAPM) recommendations. The business cases for these have been approved and recruitment is in progress. Compliance with training remains an issue, however, this is on an improving trajectory with oversight from the line managers and senior teams. The service has declared August as the midpoint reporting for the MIS Year 8 standards where all training should be and remain above 90%.
Recommendations
The Board is asked to receive and discuss this update, take significant assurance from the report in relation to maternity and neonatal safety performance and governance, and formally record in the Trust Board minutes (for Maternity Incentive Scheme evidence) that the Trust Quality Metrics, data measures, thematic review, 10 point plan progress update, Neonatal Nursing Staffing Action Plan and the MOSS update have been reviewed and approved /noted as appropriate.

Healthier together – delivering exceptional care for all	
Patients	We deliver safe, exceptional, person-centred care
People	We are supportive, positive, and welcoming.
Partnerships	We work together to enhance our services with clear goals for our communities.
Pounds	We are efficient and spend public money wisely
Health Inequalities	
Legal/ Regulation:	CQC regulation 12 safe care and treatment
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	• The Paediatric and Perinatal Safety Quality Group • Divisional Governance Meetings • Quality Committee

Any outcomes/next steps / time scales	Support to continue improvements in maternity & neonatal service, and achieve MIS year 8 standards

Perinatal Safety & Quality (Interim) Report

1. Report Overview

This interim report (previously called Maternity & Neonatal Safety & Quality Report), provides assurance to the Trust Board by confirming the items previously reviewed and approved by the Quality Committee on behalf of the Trust Board in October 2026, as documented in the Quality Committee Chair's Assurance Log

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

- Trust Quality metrics
- Perinatal Quality Oversight Data Measures
- MOSS Signal update
- 10 point plan progress update
- Thematic review
- Neonatal Nursing Staffing action plan

2. Perinatal Mortality Rate

A summary of August and September's data is provided below for Board scrutiny.

During the reporting period, the Trust received a Maternity Outcomes Surveillance System (MOSS) signal following the submission of term stillbirth and neonatal death data through the SPEN Portal. In response, a Critical Safety Check was undertaken by the Perinatal Leadership Team, resulting in an overall assurance rating of **Amber/Red**. The clinical safety check was reviewed by Trust Board Executives in line with the national standard operating procedure and submitted to the ICB (appendix 1). The review identified inconsistencies in achieving NICE-recommended decision-to-delivery timeframes for Category 1 and Category 2 caesarean sections, and a deep dive has been commenced to identify any learning from the cases where the timing was not achieved. An action plan will be developed following the deep dive to address the findings and strengthen compliance with national standards.

The following response from the regional team was received into the trust

following the MOSS signal. We were really impressed with the transparency in which this was completed and whilst it was graded an AMBER/RED, we are assured that the trust is now aware of the issue of delayed emergency C/S and is taking appropriate action to understand the route causes of these delays and any associated harm that may have occurred as a result.

This position has been reviewed through established divisional governance processes and will continue to be monitored and escalated in accordance with the Trust's oversight framework.

2.1 Stillbirths and late fetal loss > 22 weeks

There were 2 stillbirths in August. A 29-week stillbirth and a 39-week stillbirth, and 0 late fetal loss reportable to MBRRACE.

There was 1 term 38-week stillbirth in September, 0 late fetal loss reportable to MBRRACE.

Quarter 2 data is being analysed, and the report will be presented at the next meeting.

2.2 Neonatal Deaths

During August there were 0 Neonatal deaths reportable to MBRRACE.

During September, there were 0 Neonatal death reportable to MBRRACE.

Quarter 2 data is being analysed, and the report will be presented at the next QC meeting.

2.3 Learning from the PMRT reviews August and September

1 term stillbirth was reported to the trust Learning from Patient Safety Events (LFPSE), and a Patient Safety Incident Investigation was commissioned.

- TOR to explore the pathway chosen for management, that led to the incorrect timing of delivery advice provided for reduced fetal movements and to review the fetal movements assessments throughout the care pathway.
- Family feedback questions have been are an integral part of the TOR

3. Perinatal Metrics

The Trust maternity metrics have been included in Appendix 2 which were discussed at the Quality Committee.

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

Maternity Outcomes Signal System (MOSS): reviewed August 2026:

- Level one signals last 3 months - 1
- Level two signals last 3 months - 0

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

4. Perinatal Quality Oversight Data Measures

The Trust perinatal oversight data measures have been included in Appendix 2.

These are nationally agreed metrics that should be available to the Trust Board, currently some elements of training compliance are below 90%. due to PROMPT cancellation in September due to last minute faculty sickness. All training dates have been allocated to the relevant staff, and attendance to the allocated training is being monitored. Any staff not attending training are followed up by their Line Manager and repeat non-attendance is escalated to the relevant senior team for a plan.

5. Equalities Dashboard (*New)*

The equalities dashboard (Appendix 3) has been included for the first time for information, this is a national dashboard and will be form part of the board papers every six months. The data is old, currently up to December 2025. The service starting to use this information to develop and improve services for all women and families who access maternity and neonatal services.

6. Ockenden Final Report into Nottingham Maternity Service and Amos report

This report was published on 24 June 2026 and the Amos report was published on 30 June 2026, the service has completed the progress report following receiving feedback from the regional team has been received on 19 October 2026. This is included in the separate paper in detail.

The next submission (progress report) is due to be submitted by 31 December 2026.

6.1 Ten Point Plan for Maternity and Neonatal services

Below is a progress update of the current DBTH position for review and approval prior to submission

Action required	Progress	Action	Responsible (role)	By when
1. Listening to women and their families by rolling out Martha's Rule	Trust wide implementation completed but is not embedded	To strengthen Martha's Rule and engage with the maternity national rollout	DoM	Following the national timeline for maternity
2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	Work in progress	Visit site where patient experience review measures are already embedded	Head of EDI for maternity & women's health	Plan for November 2026
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	CMO core member of Paediatric and Perinatal Mortality and Safety Group		Chief Nurse Chief Medical Officer	Completed
4. 'Amos into action' staff listening exercise	National programme requirement			
5. Addressing inequalities in maternity and neonatal outcomes	Being reviewed	Inequalities dashboard to be viewed by the Trust board	DoM	See appendix

6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	Review by perinatal leadership team			
7.Trusts to review their homebirth services	Following initial position statement in December 2025, updated plan developed to address the working time directive for on calls	Share with Chief Nurse and agree next steps	DoM	To be determined
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Processes in place requires further strengthening	Thematic reviews completed and currently following the governance process Reporting to be strengthened	Governance teams	End of Q4
9. Deliver safe and effective triage in maternity services (already committed by Government)	Process to be reviewed in line with new specification	To identify leads and commence meetings to progress work	DoM and CD	16 November 2026
10. Post death care (already committed by Government)			Chief Medical Officer Chief Nurse	

7. Thematic review

The first quarterly Thematic Report has now been completed by the Perinatal Leadership Team (Appendix 4) for review and has been presented at Quality Committee. The report provides a comprehensive overview of learning, assurance, and progress against actions arising from national and local reviews, in line with the requirements of the Maternity Incentive Scheme.

The report brings together intelligence from MNSI and NHS Resolution Early Notification Scheme reports, local PMRT and PSIRF reviews, Maternity and Obstetric Safety Support (MOSS) critical safety checks, NHS Resolution claims scorecards, and relevant national reviews and reports. In addition, demographic and outcome data have been analysed to identify and better understand any disparities in outcomes and experiences for women, babies, and families. The findings of the report will be used to inform service

improvement priorities, strengthen assurance processes, and support the ongoing delivery of safe, equitable, and high-quality maternity care. Key areas for improvement are:

- Recordkeeping
- Language assessments to be embedded
- Embedding Martha's Rule
- Working collaboratively with the Neonatal Operational Delivery network (ODN) to develop pathways that align maternity and neonates

8. Neonatal nursing staffing

A further review of how funded posts compare with the neonatal nursing calculator has been undertaken and the nurse staffing does not currently meet BAPM standards due to not having a nonclinical coordinator at BDGH as reported last year however mitigations are in place and monitored monthly. The service is fully funded to meet the QIS ratio but not fully recruited to and at DRI we have a funded establishment for 94% of cot capacity not 100%. (currently we are funded for 8 RNs on NNU, however to meet BAPM we should be funded at 8.5). The action plan from last year previously approved at August Quality Committee has now been updated to reflect this for approval (Appendix 5).

9. Recommendation

The Board of Directors are asked to receive this report and take significant assurance from the information provided in this report and the discussion undertaken at the Quality Committee on 6 August 2026 in relation to perinatal safety performance and governance. The Board is also asked to formally record in the Trust Board minutes - as evidence for the Maternity (Perinatal) Incentive Scheme - that the following have been reviewed and approved/noted as appropriate:

- Maternity metrics
- Perinatal Quality Oversight Measures
- MOSS critical safety check
- Thematic review
- 10 point plan progress update
- Neonatal Nursing Staffing action plan

Annex 1: Critical safety check

The **critical safety check** is a rapid, structured review of intrapartum care operations led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the Trust Board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews.

Objective: To conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable Trust Board executive (i.e. Chief Nurse, Chief Medical Officer or executive Trust Board Safety Champion) within 8 working days from a signal (including external peer review in level 2 signals). If a signal is received over the weekend, the timeline starts from the next working day. The check should be agreed/approved face to face or virtually where possible.

After completion and approval: Share with ICBs and regions for oversight and support where a safety issue is identified. ICBs/regions can stand down if a check does not conclude there is a safety issue.

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check:

Publication reference: PRN02098_ii

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable Trust Board executives
Have an early understanding of the causes of death for events over the past 3 months	1. Case ID 104443 – DOD June .2026 - Doncaster Royal Infirmary *Patient identifiable information redacted* Cause of death was recorded as extreme prematurity, PPROM and cord prolapse. 2. Case ID 104701 – DOD July .2026 - Doncaster Royal Infirmary *Patient identified information redacted* An elective LSCS was performed at maternal request. The cause of death is unknown. PM results are outstanding at present. 3. Case ID 104963 – DOD Aug.2026 - Doncaster Royal Infirmary *Patient identified information redacted* . Cause of death is unknown. PM MRI results are outstanding at present. 4. Case ID 105350 – DOD Aug.2026 - Doncaster Royal Infirmary *Patient identifiable information redacted* Cause of death is unknown. PM MRI results are outstanding at present. 5. Case ID 105625 – DOD Sept.2026 - Doncaster Royal Infirmary. *Patient identifiable information redacted* The cause of death is unknown at present. PM and PM MRI were declined. During the initial review of the care pathway the Governance team highlighted that earlier delivery should have been considered, The difference between planned care and guidance is unknown and an investigation has commenced to gather more information.
Commissioned formal investigations where appropriate	Case 5 Escalated to the trust learning from Patient Safety Events Panel due to earlier delivery was indicated prior to the IUFD at 38+1 weeks the panel identified that IOL / LSCS should have been offered 37-37+6 weeks gestation. This case has been commissioned for a Patient safety Incident Investigation. One of the cases above have been escalated to the Trust Learning from Patient Safety Event Panel. Each case is currently following the PMRT review process in addition to the one case which has been escalated for further learning response.

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<table>
<tr><th>Knowledge/process</th><th>Include summary or refer to relevant documents for the attention of accountable Trust Board executives</th></tr>
<tr><td>Involved families in the investigation process where appropriate and listened to their insights and feedback</td><td>
<table>
<tr><th>Case ID</th><th>Verbal PMRT information</th><th>DOC</th><th>Parental Feedback 1</th><th>Parental Feedback 2</th><th>Feedback Received Yes/No</th></tr>
<tr><td>104443</td><td>Yes</td><td>Yes</td><td>26.06.2026</td><td>20.08.2026</td><td>Yes</td></tr>
<tr><td>104701</td><td>Yes</td><td>Yes</td><td>13.07.2026</td><td>24.07.2026</td><td>Yes</td></tr>
<tr><td>104963</td><td>Yes</td><td>Yes</td><td>04.08.2026</td><td></td><td>No – did not wish to provide any feedback</td></tr>
<tr><td>105350</td><td>Yes</td><td>Yes</td><td>01.09.2026</td><td></td><td>No – have indicated they may provide feedback in the future before PMRT review</td></tr>
<tr><td>105625</td><td>Yes</td><td>Yes</td><td>17.09.2026</td><td>24.09.2026</td><td>Yes</td></tr>
</table>
</td></tr>
</table>

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Emerging and known safety themes with any timelines of action plans to address	No previous MOSS signals **MNSI Quarterly Meeting:** - Discussions around referring cases to MNSI that do not meet their criteria following a recent case referral from DBTH that does not meet criteria but accepted due to exceptional circumstances. LNMS representative questioned that referrals need to be consistent for all families. - New draft report to go live in December 2026 - DBTH referral rate remains low - Safeguarding meeting held in June 2026 - Head of EDI Maternity and Women's Services - New national MEWS chart has been embedded within maternity and rollout in progress for use in other hospital areas - Transitional Care launched on 7th September **Hypertension Thematic review** - Escalation of recurring hypertension management issues within care pathways - Extensive action plan created all but 3 actions outstanding o Staff survey to explore the barriers to hypertension management completed further actions from analysis needs creating. o MDT – Hypertension – Home BP monitoring SOP o MDT – Hypertension – Review the data collected from triage regarding women transferred in from the CMW with raised BP and then normal on admission and review themes. **Claims Scorecard / Learning from incidents complaints and claims**

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Knowledge/process	Include summary or refer to relevant documents for the attention of accountable Trust Board executives

Claims Scorecard April 15 – Aug 25

Top injuries by volume:	Top injuries by value:
• Fatality (10) → • Unnecessary pain (8) → • Adtnl/ unnecessary operations (6) ↓ • Loss of baby (6) ↓ • Stillborn (6) ↓	• Cerebral palsy (5) ↑ • Loss of baby (6) ↓ • Brain damage (3) ↑ • Spinabifida (1) → • Fatality (10) →
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (9) → • Failure / delay diagnosis (9) → • Fail antenatal screening (5) → • Fail to make resp to abnrm FHR (7) ↑ • Fail to warn / informed consent (3) new	• Failure to Make resp to Abnrm FHR (7) ↑ • Fail antenatal screening (5) → • Failure to perform tests (2) → • Birth defects (2) • Failure / Delay diagnosis (9) ↑

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Themes Q1 26/27

- Hyperstimulation of uterine activity
- Antibiotic prescription and reviews when repeated doses required
- VTE calculation of risk and prescription of anti-coagulant
- Guideline not followed when patient presented repeatedly with a worsening, unexplained rash (syphilis)

Complaints Q1 26/27

- Postnatal care/ Missed suture removal / delay in care or discharge
- Communication regarding results
- Comfort not maintained
- Consent

Learning Q1 26/27

- Documentation issues:
  - Regarding perineal protection
  - Safety netting advice
  - Infant feeding support
- VTE learning shared through education, governance newsletter and K2 popups
- Multi trust AAR regarding Syphilis diagnosis and management – communications around pathways and process was the main action

Incidents Q1 26/27

Unexpected admission to NNU
PPH > 1500mls
Unexpected birthweight below 10th centile
Third- or fourth-degree tears

Action Plan Q1 26/27

QI project to improve neonatal optimisation	EM	
Continue cultural work – (communication / consent)	LM/ EE	
Improve face to face reviews & care planning	Team	
Lead Card medic project implementation / pt info	JG	
Business case for carbetocin	LM	

Advice for completing the check:

- Do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first.
- Section 2 does not need to be completed if the service has completed this in relation to a previous signal in the past 3 months.
- The completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed.
- Italicised text should be deleted before completing.

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Section 1 – MOSS pre-completion check

This section provides accountable Trust Board executives with additional context that may explain the signal, whether the pre-requisites for implementing MOSS are in place and if there was a recent signal which allows perinatal leadership teams to skip section 2.

MOSS pre-completion check		
Questions	**Answer**	
	Yes/No	**Description**
Have you identified an issue with the data displayed by MOSS (for example, the event was not at term or care/delivery did not take place at the site displayed)?	No	*If you have raised a data issue here, please can you email the details to the MOSS project team at england.moss@nhs.net so it can be investigated.* *Perinatal leadership teams should remain curious and proceed with the critical safety check as part of good practice.*
Is the trust site that signalled a NICU plus cardiac surgery centre?	No	*Whilst it is acknowledged that sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death, perinatal leadership teams should remain curious and still proceed with the critical safety check as part of good practice.*
Were any of the events in MOSS that occurred over the last 3 months avoidable? Please state why.	Yes	*Perinatal leadership teams should remain curious and proceed with the critical safety check as part of good practice.* *Case 5 – Was escalated to the trust learning from patient safety events panel, and a Patient Safety Incident Investigation (PSII) was commissioned initial review identified that delivery should have been instigated between 37-37+6 weeks gestation which would then likely have prevented the IUFD.*
Are the pre-requisites for implementing MOSS in place (page 5-6 of Standard Operating Procedures)?	Yes	*Maternity services must establish the pre-requisites to implement MOSS effectively. If maternity services are still working towards this, perinatal leadership teams should still proceed with the critical safety check in the best way possible.*

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Have you completed a critical safety check previously for a signal that has occurred within the last 3 months?	No	*If 'yes', go to section 3 and do not complete section 2 as this is likely to repeat a similar response.*

Section 2 – Are key safety elements of your intrapartum service in place?

Please complete this section focussing on the activity of your intrapartum service **over the last 3 months**. This section does not need to be completed if you have completed it previously for a signal that occurred within the last 3 months.

Safety culture - conversations with staff and service users		
Questions	**Answer**	
	Yes/No	**Brief description with any action taken** (bulleted only)
1. Are the perinatal leadership team, accountable Trust Board executives and staff (on labour ward, triage and birth centre) working well together?	Yes, this is working well	- Safety champion walk arounds - Ward to board pathways embedded - Governance structures in place for escalation and feedback - Phycological safe working - Safety huddles - Maternity Oversight Group reporting. - Shared decision-making forum
2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?		– **Staff Survey**: The Trust-wide staff survey will launch on 18 September 2026 and includes specific questions relating to organisational culture, psychological safety, teamwork, and staff experience within maternity services. Across all maternity services the key themes are: o Increasing staff involvement in decision-making and service improvement through focus groups, suggesting schemes and regular meetings o Improving communication and feedback between staff and leaders o Addressing workforce and staffing challenges through recruitment, retention and workforce planning initiatives o Supporting staff wellbeing through protected breaks, wellbeing check-ins, annual leave promotion, flexible working and access to support services o Improving recognition and appreciation through Star of the Month schemes, gratitude boards, thank-you initiatives and sharing positive patient feedback

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		○ Enhancing opportunities for professional development, appraisals and career progression ○ Promoting positive culture, teamwork and psychological safety, including support for Freedom to Speak Up and improved governance feedback. – **Culture Surveys**: Targeted culture surveys have been undertaken across a range of staff groups within DBTH, including a dedicated Maternity Safety Culture Survey, to identify areas of good practice and opportunities for improvement. ○ Rambutan leadership and culture programme – All Band 7 leaders, aspiring band 6's attending the course. ○ Perinatal equity and anti-discrimination programme (PEADP) ○ COIN (Context, observation, impact and next steps) – having constructive challenging conversations – **Safety Champion Walk rounds and Culture Improvement Work**: Monthly Safety Champion walk rounds are undertaken to gather staff feedback and assess cultural and teamworking issues. Feedback from M1 identified concerns relating to trust between colleagues, staff feeling empowered to undertake their roles, and opportunities to strengthen shared decision-making. In response: ○ A Shared Decision-Making Group has been established to co-design and implement improvement actions with staff for labour ward co-ordinators. With plans to expand once established. ○ Management across the M1 and M2 has been strengthened with the appointment of an additional ward manager who was appointed on 23 July 2026. The appointee is an experienced staff member who has been seconded to M1 for a 12-month period to support team development, improve communication, strengthen multidisciplinary working, and embed a positive workplace culture. ○ The culture in the unit seemed very positive – **Maternity and Neonatal culture plan:** A new perinatal culture improvement plan has been developed for MIS and is embedded within the Perinatal Leadership Team and Divisional Governance structures.
3. What have service users/MNVP Leads fed back that they feel could be improved?		**1. Feeling unheard and poor communication:** One of the most prominent themes was women reporting that they were not always listened to, experienced poor communication, or encountered a lack of compassionate care from some staff. This was added to the service user improvement plan with a dedicated workstream and actions

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		Feedback also highlighted concerns about communication when babies were separated from parents for treatment, with parents reporting inadequate updates and information regarding their baby's location and care. Transitional care has now been launched which will reduce some cases of separation 2. **Lack of personalised and woman-centred care:** Service users reported concerns around personalised care and continuity of carer, suggesting that some women did not feel their individual needs, preferences and circumstance were consistently recognised throughout their maternity journey Feedback indicated that antenatal education did not always prepare women for their actual birth experiences, suggesting a gap between expectations and reality – there has been a review of the parent education programme 3. **Insufficient emotional support and birth reflection:** Feedback identified a lack of opportunity to discuss labour and birth experiences afterwards. Women reported difficulty accessing postnatal debriefs and birth reflection conversations, which are recognised as important for emotional recovery and wellbeing. Staffing pressures were acknowledged as a barrier to providing more in-depth birth reflection conversations 4. **Inconsistent infant feeding support:** Women reported that feeding support was often below expectations, particularly while admitted to postnatal wards and following discharge Feedback suggests inconsistency in the quality of infant feeding support provided by staff across services and sites, leading to concerns about reliability and continuity of advice 5. **Delays and missed care:** Women reported delays in triage, delayed discharge processes and occasions where care or information was missed during transitions between services. These experiences can undermine confidence and trust in the service.

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4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		Staff report that when shifts are adequately staffed, there is a strong shared commitment to providing kind, compassionate, safe and effective care to all women. The escalation rota for specialist midwives has helped to mitigate some of the challenges associated with staffing pressures and provides additional support when required. Staff also report robust provision of mandatory training, with protected time available to complete the required study sessions, supporting staff competence and safe practice. Staff are often appreciative of the ability to divert services to the other trust site and recognise cross-site collaboration as a positive in the delivery of safe care.
b) What do staff feel could be improved to achieve better outcomes?		**SC walkaround:** Skill mix and workforce flexibility: Staff highlighted challenges in maintaining an appropriate skill mix on Central Delivery Suite, with flexible working arrangements occasionally impacting staffing balance across shifts. This has been escalated to the Matron and Deputy Director of Midwifery for review. A flexible working review is ongoing to support sustainable workforce planning and ensure appropriate skill mix is maintained. Theatre capacity for elective caesarean sections: Staff reported that limited theatre capacity for elective LSCS can impact service delivery. To address this, a business case was developed and submitted through the Trust processes. As of 23.07.2026, the business case has received full sign-off. The additional elective caesarean slots (an additional 5slots across site) will commence weeks commencing 2nd November 2026. **Matron walk around:** Staff report that staffing levels have a direct impact on service delivery and outcomes, including the timely facilitation of elective procedures such as elective LSCS and inductions of labour. High sickness levels have resulted in delays to planned activity and an accumulation of elective work. Sickness levels often have a direct impact on skill mix and this can often be challenging when managing high acuity. Staff working in the intrapartum area also reported additional pressure arising from limited LSCS capacity, which affects the management of elective lists and increases pressure on the provision of safe and timely intrapartum care.

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<table>
<tr><th colspan="3">Are you achieving safety timelines for these care pathways?</th></tr>
<tr><td>5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?</td><td>Yes - plans are already in place to maintain/improve this</td><td>Suggest include reporting as a percentage over the past 3 months

<table><tr><td></td><td>June</td><td>July</td><td>Aug</td></tr><tr><td>Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency.</td><td>84%</td><td>92%</td><td>92%</td></tr></table></td></tr>
<tr><td>6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for induction (from home or ward)</td><td>N/A</td><td><table><tr><td>Month</td><td>June</td><td>July</td><td>August</td></tr><tr><td>Delays to induction >6 hours</td><td>0</td><td>3 – due to high ward activity</td><td>0</td></tr></table></td></tr>
</table>

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<table>
<tr>
<td>7. Is the maternity service achieving category 1 caesarean sections as soon as possible and usually within 30 minutes of the decision to deliver?</td>
<td>No - we are putting plans in place to improv e this and are on track</td>
<td>
Suggest including reporting as a percentage over the past 3 months
<table>
<tr><th>Activity Indicators</th><th>Trust</th><th>DRI</th><th>BDGH</th><th>Trust</th><th>DRI</th><th>BDGH</th><th>Trust</th><th>DRI</th><th>BDGH</th></tr>
<tr><td>Delay in delivery of Category 1 C. Section (>30 minutes from decision to delivery)</td><td>23</td><td>11</td><td>12</td><td>19</td><td>9</td><td>10</td><td>12</td><td>5</td><td>7</td></tr>
<tr><td>Delay in delivery of Category 2 C. Section (>75 minutes from decision to delivery)</td><td>21</td><td>13</td><td>8</td><td>19</td><td>16</td><td>3</td><td>15</td><td>8</td><td>7</td></tr>
</table>
<table>
<tr><td>Month</td><td>June</td><td>July</td><td>August</td></tr>
<tr><td>Compliance with cat 1 LSCS within 30-minute time frame</td><td>32 Category 1 LSCS

11 undertaken beyond recommended 30 minutes (34.3%)

65.6% completed within recommended time frame</td><td>26 Category 1 LSCS

9 undertaken beyond recommended 30 minutes (34.6%)

65.3% completed within recommended time frame</td><td>19 Category 1 LSCS

5 undertaken beyond recommended 30 minutes (26.3%)

73.6% completed within recommended time frame</td></tr>
</table>
</td>
</tr>
</table>

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<table>
<tr>
<td>8. Is the maternity service achieving category 2 caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?</td>
<td>No - we are putting plans in place to improve this and are on track</td>
<td>Suggest include reporting as a percentage over the past 3 months

<table>
<tr><td>Month</td><td>June</td><td>July</td><td>August</td></tr>
<tr><td>Compliance with cat 2 LSCS within 75-minute time frame</td><td>41 Category 2 LSCS

13 undertaken beyond recommended 75 minutes

68.3% completed within recommended timeframe</td><td>44 Category 2 LSCS

16 undertaken beyond recommended 75 minutes

63.6% completed within recommended timeframe</td><td>30 Category 2 LSCS

15 undertaken beyond recommended 75 minutes

50% completed within recommended timeframe</td></tr>
</table>

The compliance of caesarean sections will have a deeper dive outside of the MOSS safety check, there is no national or local threshold for compliance. The perinatal leadership team identified that a deeper dive into the percentage compliance if required to identify any themes or issues which require action planning.</td>
</tr>
<tr>
<td colspan="3">Are you achieving regular multi-disciplinary team (MDT) communication of known and/or emerging risk factors on the labour ward?</td>
</tr>
<tr>
<td>9. Are you achieving at least one MDT huddle every day on the labour ward based on NHSI guidance?</td>
<td>Yes - this is already in place</td>
<td>Two MDT huddles are scheduled each day across both sites, with a morning huddle at 10:00 and an evening huddle at 17:15.

They occur every day with a range of the MDT team. The compliance regarding MDT team is outlined in the box below.</td>
</tr>
<tr>
<td>10. Do your huddles always include a consultant obstetrician,</td>
<td>Yes - this is already in place</td>
<td>Across the three-month period (June to August), attendance was consistently higher at morning huddles than evening huddles. Coordinator and paediatric team attendance generally demonstrated the strongest engagement, while obstetric and ward representation was more variable, particularly at DRI.

At DRI, coordinator attendance at morning huddles remained consistently high (86% in June, 83% in July and 87% in August), although evening attendance was substantially lower (30%, 19% and 16% respectively). Paediatric team attendance was</td>
</tr>
</table>

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anaesthetist, midwifery co-ordinator and member of the neonatal team?		excellent at morning huddles throughout the period (96%, 96% and 100%), however evening attendance remained low despite some improvement in August (6%, 19% and 25%). Obstetric attendance was particularly low throughout the reporting period, although some improvement was seen in August (6%, 12% and 29% in the morning; 3%, 0% and 16% in the evening). Attendance by Band 6 ward representatives was moderate at morning huddles (53%, 45% and 58%) but remained very low at evening huddles where data were available (3% in July and August). There is improvement work required regarding the non-attendance recording and the reason why.
11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known or emerging risks and involves the MDT?	Yes - this is already in place	MDT handover is collected monthly. This handover captures handover from midwifery staff to obstetric staffing using an SBAR handover which is well embedded within clinical practice. Attendance at twice-daily Labour Ward MDT ward rounds was generally stronger in the morning than the evening across DRI. Consultant and Labour Ward Coordinator attendance remained consistently high throughout the reporting period, demonstrating strong senior leadership and oversight within the MDT process. Across both sites, consultant morning attendance was consistently above 80%, with Labour Ward Coordinator attendance typically between 87% and 100%. Registrar attendance was more variable and showed a declining trend over the six-month period. SHO attendance remained good overall, although DRI experienced a gradual reduction in attendance across the reporting period. Evening ward round attendance was lower across all professional groups. Consultant attendance remained relatively robust, particularly at DRI, but coordinator, registrar and SHO attendance was less consistent. Anaesthetic representation remained the most challenging area, with attendance frequently impacted by competing clinical commitments and often significantly lower than other professional groups.
Are your teams carrying out appropriate risk assessment and escalation?		
12. Is the service achieving compliance with element 4 of the	Choose an item.	DBTH remains compliant with element 4 of Saving Babies Lives and is fully implemented. Training compliance has improved and all core governance processes, competency assessment, audit and monitoring arrangements are established. There were no PMRT issues relating to fetal monitoring in quarter 1 Fresh eyes compliance remains high at 96.4% at Doncaster

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current version of the Saving Babies' Lives Care Bundle?		92.8% of women had hourly risk assessments completed throughout their labours, with 100% of identified risks receiving appropriate method of fetal monitoring. 99% received escalation when required. There was one case of suspected chorioamnionitis/maternal sepsis where deterioration was recognised but escalation did not occur. This case was escalated and reviewed through Governance Patient Safety Event Response Panel meeting.
13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at: • Fetal monitoring training • Multi-professional maternity emergencies training • Neonatal resuscitation training	Yes - this is already in place	**All training above 90% compliance** Fetal Monitoring: Consultants 100% All other obstetric doctors 94.44% Midwives 98.35% PROMPT: Consultants 94.11% All other obstetric doctors 100% Midwives 97.94% Maternity Support Workers: 96.92% Anaesthetic consultants 100% All other anaesthetic doctors 100% NLS: Neonatal consultants 100% Neonatal junior doctors 100% Neonatal nurses 93% ANNP 100% Midwives 91.36%
Is there a stable workforce offering safe and effective care during labour and birth?		
14. Have staff been redeployed or non-clinical	Yes	There is an escalation SOP and rota in place for the use of specialist midwives in times of escalation within the unit 06.07.2026 Roster:

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midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum **midwifery safe staffing levels** as per your Trust safe staffing policy?		There were three occasions where specialist midwives were utilised to support with staffing due to current activity in the unit. Two of these occasions were to support with taking patients to theatre for caesarean sections. The other occasion was for the bereavement midwife to care for a recently bereaved family. All these occasions were at Doncaster. 03.08.2026 Roster: There were six occasions where specialist midwives were utilised to support with staffing due to current activity in the unit. Three occasions were to support with staffing in antenatal clinic at Doncaster. The other occasions were to support with Delivery Suite and the inpatient ward at Doncaster. 31.08.2026 Roster: Currently on this roster there have been three occasions where specialist midwives have been utilised, and both were to support staffing in Antenatal Clinic at Doncaster. Two out of the three occasions were due to there being no trained vaccinator in Antenatal Clinic and therefore a specialist midwife was pulled to administer Flu vaccinations.
15. Have there been **obstetric staffing shortfalls** impacting on safe care delivery?	No	July Data: Current ongoing business case to increase current elective caesarean section capacity In June 2026 we had 6 short term locums booked and they were all compliant In July 2026 we had 1 short term locum booked and they were all compliant Consultant Attendance: Rolling compliance from April is 88.8% at the end of August 2026.
16. Have there been any **anaesthetic staffing shortfalls** as per RCoA guidance impacting on safe care delivery?	No	DRI Anaesthetic Workforce: In August 2026 there was a duty anaesthetist available 24/7 and trained anaesthetic assistance available 24/7.

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Section 3 – Is there any additional information that accountable Trust Board executives should pay attention to?

Please use this section if there is anything not captured above that you feel executives should pay attention to, explaining potential safety issues in your intrapartum service over the last 3 months.

- The caesarean sections for this three-month period will be reviewed to identify if there are any trends or avoidable delays in proceeding to category 1 and category 2 caesarean sections. Due to the need to review and deep dive the data the perinatal leadership team have highlighted the MOSS safety signal should be AMBER /RED as this has been identified for deeper review from the MOSS critical safety check.

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Section 4 – Conclusion from this critical safety check

This section is used to summarise the outcome of the critical safety check for accountable Trust Board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	Answer
How would you summarise the outcome of this critical safety check?	AMBER/RED - There is at least one known safety issue in our intrapartum service, but a plan of action is not in place.

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Section 5 – Recommendation from this critical safety check

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
***GREEN** – No safety issues in our intrapartum service have been identified.*	• No action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and Director of Quality) and regional colleagues (Regional Chief Nurse, Midwife, Obstetrician and Medical Director) for awareness.	☐
***GREEN**/**AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • The perinatal leadership team should continue to report to the Trust Board on plans as required. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement get plans back on track within 12 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER**/**RED** - There is at least one known safety issue in our intrapartum service, but a plan of action is not in place.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☒
***RED** – At least one new safety issue in our intrapartum service has been identified which requires a plan of action.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☐

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DATE: 25/09/2026

AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)
Nicholas Mallaband	Chief Medical Officer
Karen Jessop	Chief Nurse
Simon Brown	Deputy Chief Nurse
Eki Emovon	Divisional Director for Women's and Children's, Consultant Obstetrician and Gynaecologist
Ravinder Pramod	Clinical Director for Children's, Consultant Paediatrician
Tomas Barani	Clinical Director for Maternity and Gynaecology, Consultant Obstetrician and Gynaecologist
Lois Mellor	Director of Midwifery and Gynaecology
Laura Churm	Divisional Nurse Children and Neonates
Danielle Bhanvra	Deputy Director of Midwifery and Gynaecology
Samantha Fawkes	Deputy Divisional Nurse Children's and Neonates
Piya Dhar	Consultant Anaesthetist
Aziza Hussain	Consultant Anaesthetist
Nigel Brooke	Consultant Neonatologist

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Appendix 2 Perinatal Quality Oversight Measures

	2026					
	April	May	June	July	Aug	Sep
1.Number of reported perinatal deaths	3	2	1	1	2	1
2. Number of MNSI cases	1	0	0	2	0	0
2. Safety prompts from completed MNSI investigations		1 report received 0 SR or SP		2reports received* see below for SP and SR	0	0
List of Safety prompts and recommendations as listed above	*July reports received: **Case 1** received 1 Safety Recommendation 1. for the Trust to support staff to complete a full assessment of a mother and baby on admission The trust received 1 Safety Prompt 2. for the trust to ensure staff have access to equipment that is immediately available and easily accessible). **Case 2** received 7 Safety recommendations (4 for the local booking hospital and a further 3 for care partners and the local booking hospital 1. It is recommended that the local Trust implements actions to achieve compliance with safeguarding training targets. This is needed to support staff in developing their professional curiosity to ensure children and young people are safe. 2. It is recommended that the local Trust has processes in place so all mothers are able to give an account of their wellbeing and concerns, and to receive information in their first language without the reliance on using family members for interpretation. This is to ensure that there is a clear understanding between a mother and her care team of her needs and understanding (National Institute for Health and Care Excellence, 2010). 3. It is recommended that the local Trust embeds processes to ensure that a mother is involved in discussions to support informed decision-making in developing management plans for her care. These discussions are needed to ensure that exploration of a mother's concerns and wishes, as well as the risks and benefits of any treatment options, takes place in line with national and professional guidance (NHS England, n.d. and General Medical Council, 2024)					

	4. It is recommended that the local Trust has a process to ensure an unwell pregnant mother in the emergency department receives multi-disciplinary input to agree the actions needed. This is needed to support obstetric oversight of the care of a mother and her baby. 5. It is recommended that each provider involved in contributing to a patient care record documents language needs, including the mother's preferred written language, any literacy support needs and the use of professional interpreters. This is in line with multiple national recommendations to support personalised care and decision making (NHS England, 2018 and Felker et al., 2024). 6. It is recommended that each provider involved in the care of a child/young person develop and implement formal processes to share information to support each care 8 team to have a complete picture of a child/young person's needs. This to ensure the needs of the child/young person are understood and acted on, in line with statutory requirements (Working Together to Safeguard Children, 2023). 7. It is recommended that each provider involved in the care of a child/young person identify how safeguarding processes can be improved across and between the multi-agency teams and implement the changes identified. This is to safeguard children/young people in line with statutory requirements (Working Together to Safeguard Children, 2023). 2 safety prompts: 1. The investigation learned that telephones needed to access interpreters are not easily available in each clinical area at the local hospital. Those that are available are not always able to be moved to a private area or a patient's bedside. 2. The investigation learned that escalation to a senior doctor took place when it was thought that a CT scan had been declined. This did not lead to a review by a more senior doctor to explore the mother's understanding of the risks and benefits of a CT scan, or of other options for tests.					
Report on: 2a. The number of patient safety incidents logged and what actions are being taken /themes.	149 Incident reviewed through MGPSERP 1.2 due to PPH management 2.3 mortality cases 3.2 with concerns regarding an instrumental delivery 4.DCC admission 5.Congenital Syphilis case (Service to Service) 6.Eclampsia **Learning:** 1.Hyperstimulation – timing of Terbutaline administration	149 Incident reviewed through MGPSERP 1.Return to theatre and ITU admission, secondary PPH 2.C-Diff case attributed to M1 3.3 neonatal deaths 4.Incorrect VTE and administration of Dalteparin in the antenatal period **Learning:** Multiple courses of antibiotics and requirement for review	154 Incident reviewed through MGPSERP 1.Two 4th degree tears 2.Two neonatal deaths 3.Neonatal collapse at home 4.15/40 miscarriage 5.One low cord gases case **Learning:** 1.Documentation of safety netting advice 2.Hypertension 3.Documentation of feeding support and feeds	167 Incident reviewed through MGSERP 1.Facial trauma following instrumental delivery 2. Two intrauterine fetal deaths 3.One neonatal death 4.Two cases with CTG management concerns 5. One return to theatre 6. One ITU admission **Learning:** 1.CTG management of pathological traces	147 Incident reviewed through MGSERP 1.29-week IUFD 2.Neonatal collapse **Learning:** 1.Use of NEWTT 2 observation charts rather than NAS charts 2.Registered clinicians chasing outstanding patient results to reduce the risk of abnormal results being filed as normal ICE	184 Incident reviewed through MGSERP 1 off pathway at BDGH 2.38-week IUFD 3.39-week IUFD 4.3 PPHs 5.1 twin ATAIN case 6.32-week IUFD – Scunthorpe PMRT case, had AN care at DRI **Learning** 1.CTG interpretation

	2.Hypertension management 3.Guideline not followed when patient presented repeatedly with a worsening, unexplained rash	2.Incorrect classification of VTE/calculation of VTE without an accurate weight/BMI in this pregnancy 3.Clarity for process following a loss with religious beliefs		2. Assessment of language needs at booking 3. Recognition and escalation of the deteriorating patient	3.Hypertension management and escalation of raised BP at the booking appointment	2.Recording of cumulative blood loss in PPH cases 3.Advice following triage contact with pain 4.timing of delivery
	 2026 Action Plan.docx Ongoing AP from Incidents reviewed through MGPSERP and thematic reviews:	 2026 Action Plan.docx		Ongoing AP from MG PSERP		
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (%) **Prompt**						
Consultants / SAS drs %	84.21	77.78	94.44	94.73	94.11	94.11
Drs %	80	84.38	90.91	100.00	100	40.91
Midwives %	94.72	94.65	96.75	95.14	97.94	95.14
MSW's %	92.65	89.71	88.06	93.94	96.92	93.55
Consultant anaesthetists %	100	94.12	88.24	94.12	100	88.24
Anaesthetic drs %	96.30	100	100	100	100	83.33

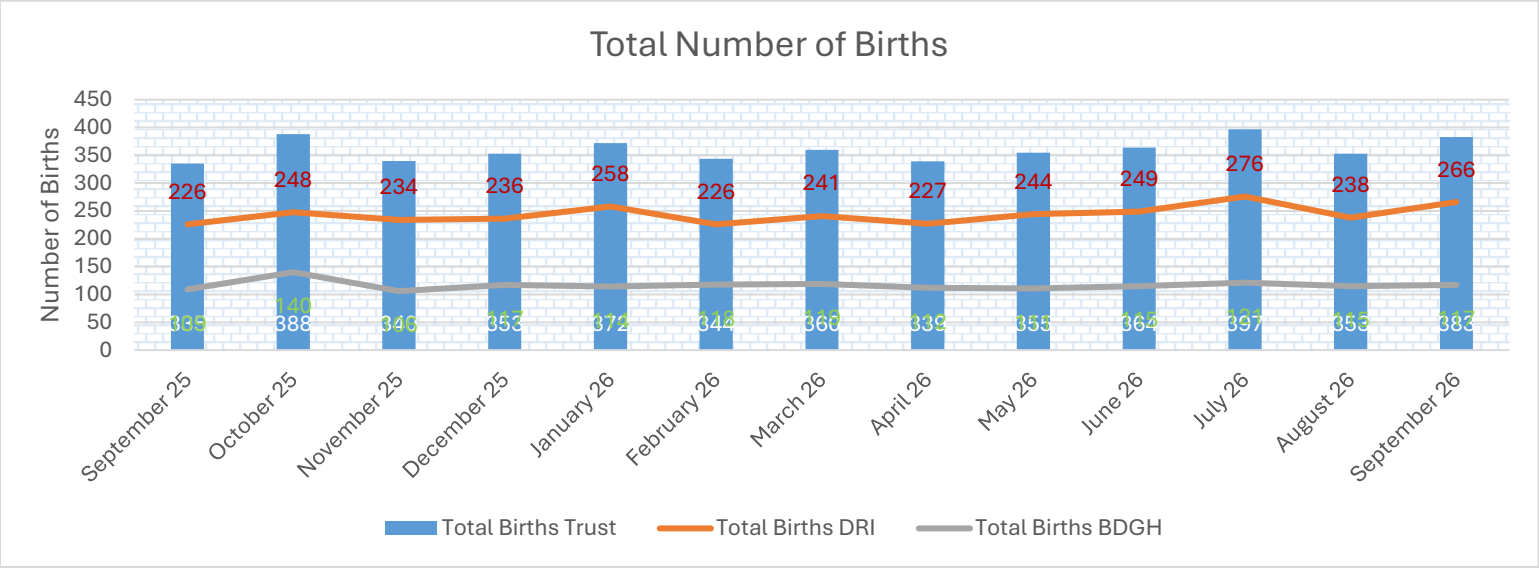
Fetal Monitoring and surveillance						
Consultants / SAS drs SD / CA %	84.9	77.7	94.4	94.7	100	100
Drs SD/CA %	90	83.3	80	88.89	94.44	75
Midwives SD/CA%	87.80	89.30	94.72	96.76	98.35	95.14
Neonatal resus training						
Consultants %	95	95	95	95	100	84
Drs %	100	100	100	100	100	100
Nurses %	91	89	85	93	93	95
ANNP %	100	100	100	100	100	100
Midwives %	93	90.53	92.28	91.50	91.36	86
2c. Minimum safe staffing in maternity services: midwife minimum safe staffing planned cover versus actual prospectively (%)	**DRI** MW – 100.25% MSW – 77.62 **BDGH** MW – 90.69 MSW - 76.33	**DRI** MW – 102.31% MSW – 71.8 **BDGH** MW – 80.83 MSW – 75.54	**DRI** MW – 101.75% MSW – 68.29 **BDGH** MW – 94.77 MSW – 76.09	DRI MW – 91.56% MSW – 67.10 **BDGH** MW – 92.91 MSW – 74.51	DRI MW 90.39 MSW 78.41 BDgH MW 90.09 MSW 86.30	**DRI** MW-86.33 MSW 77.43 BDGHMW 86.36 MSW 72.94

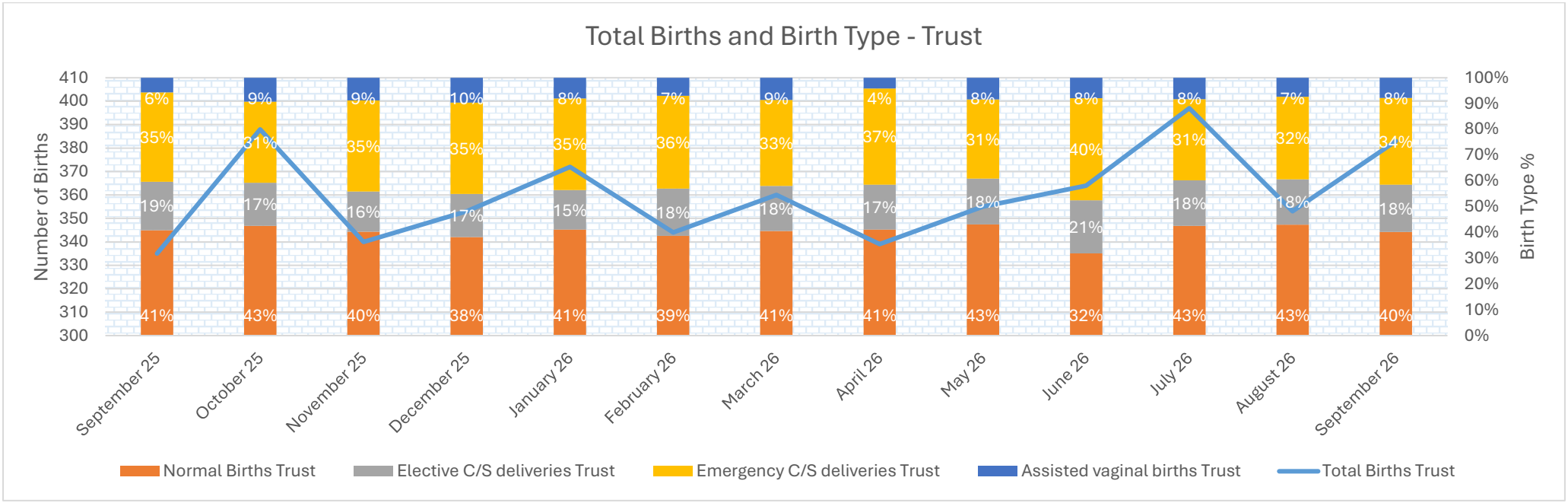
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas (all rota gaps are covered with locum, therefore % of locum cover)	0	0	0	0	0	0
3.Service User Voice Feedback – Themes	1Missed diagnosis 2.Cause of pain not considered 3.Discharged from ward too early	1.Delay in treatment/care/discharge/medical review 2.Comfort not maintained 3.Consent not obtained correctly	1.Use of SBAR communication. 2.Infant feeding support. 3.Introduction of pump "quick start" guidance 4.Civility and communication training.	1.Care of the woman on the postnatal ward 2.Cause of pain not considered 3.Lack of information to the patient	1.Care of woman and baby (CDS, M1 and M2) 2.Lack of information to patient (M1 and M2) 3.Abruptness/rudeness/dismissive staff attitude (M1, M2 and CDS)	1.Care of Women 2.Delay in Treatment 3.Lack of Information
4.Staff feedback from frontline champion and walk-abouts – themes	Skill mix related to flexible working contracts		Access to timely medical reviews on M1/2 by doctors Heat on NNU – hot during the day and cold at night			
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made	0	0	0	0	0	0

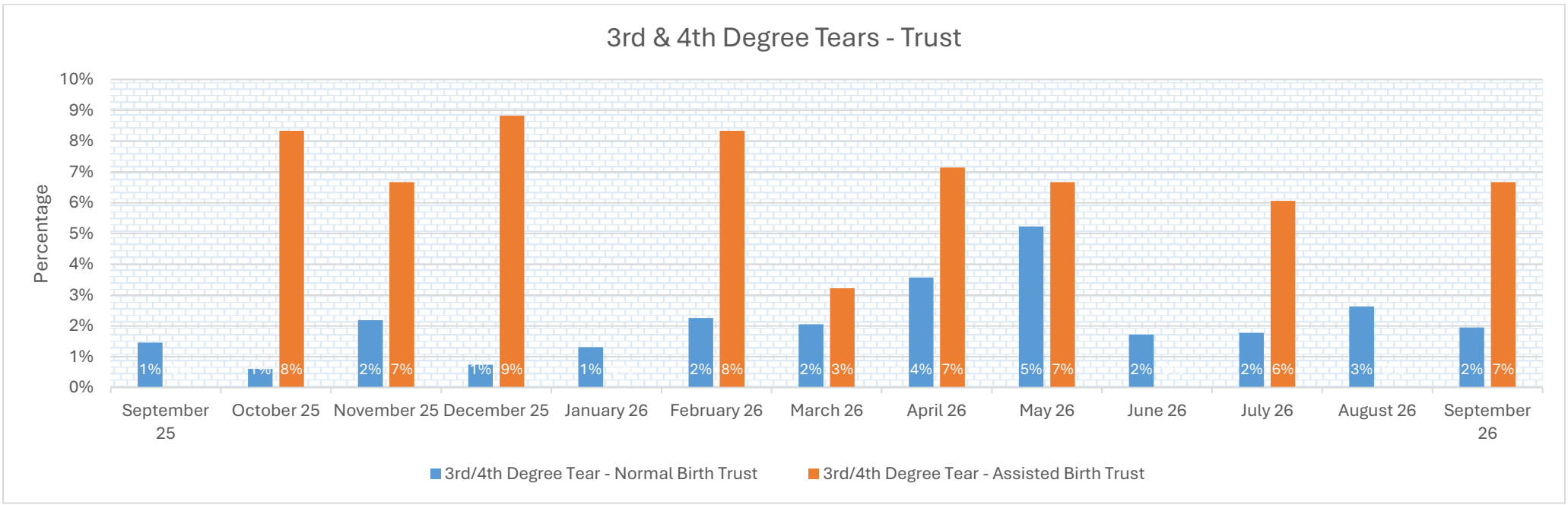
directly with Trust						
6.Coroner Reg 28 made directly to Trust	-	-	-	-	-	-
7.Progress in achievement of MIS Year 8 6 safety actions from April 26 (reset April annually)	0/6 3/27 sub actions)	0/6 2/27 sub actions	0/6 2/27 sub actions	0/6 9/27 sub actions	0/6 15/27 sub actions	0/6 18/27 sub actions

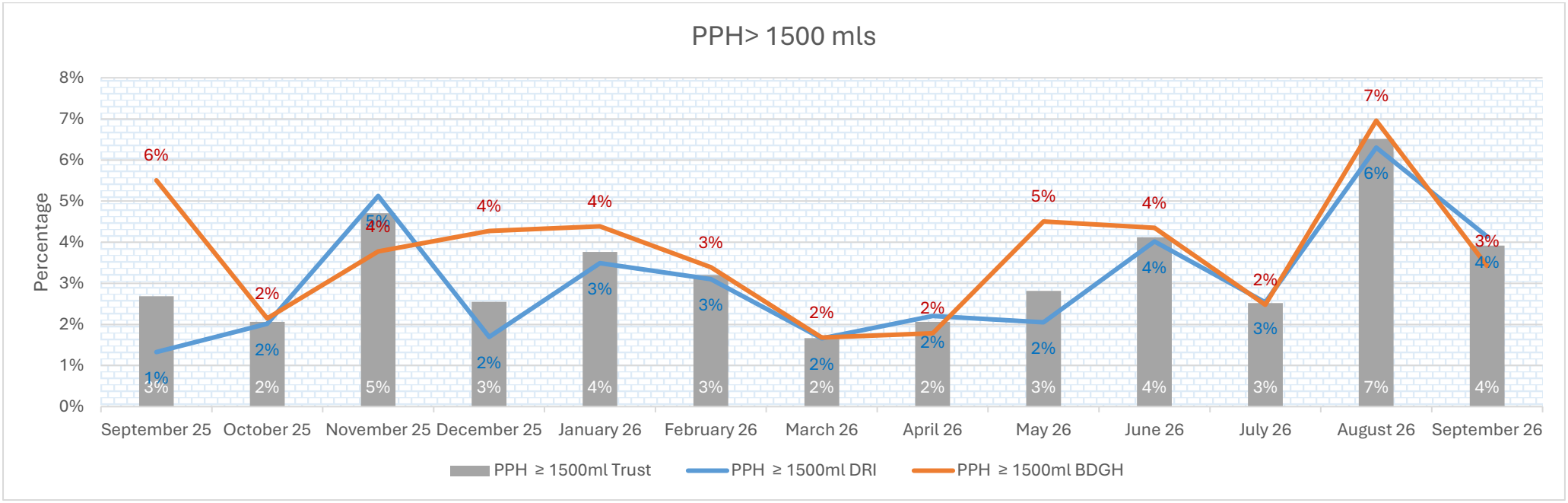
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually 2025 – 71%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually 2025 – 50%

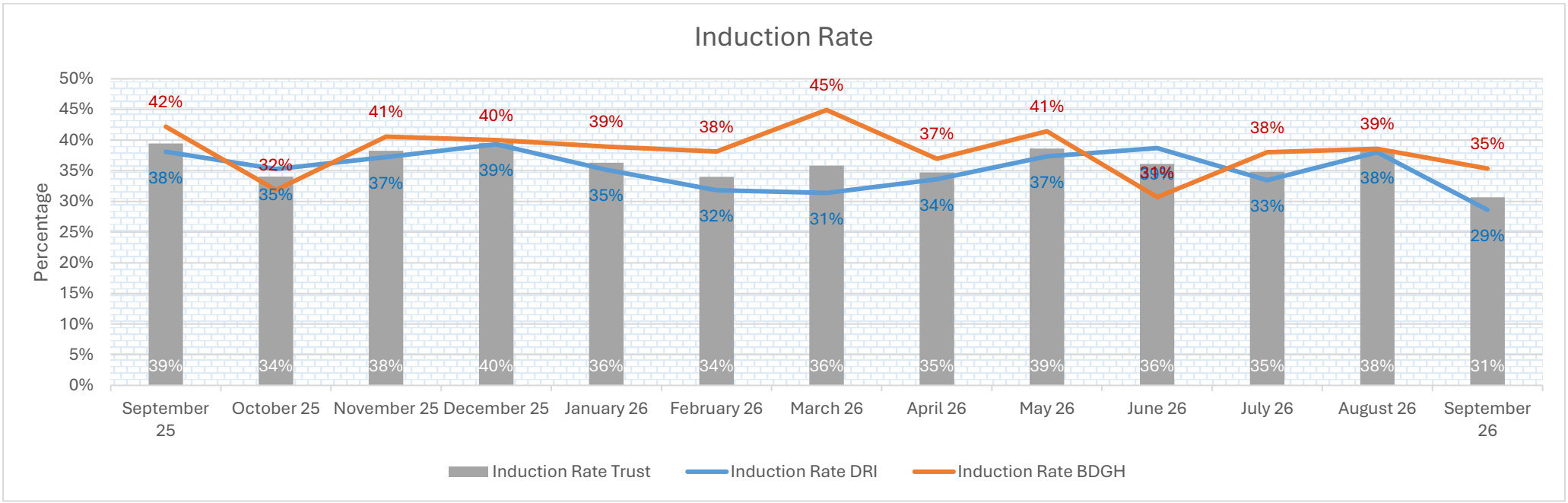
Maternity Metrics

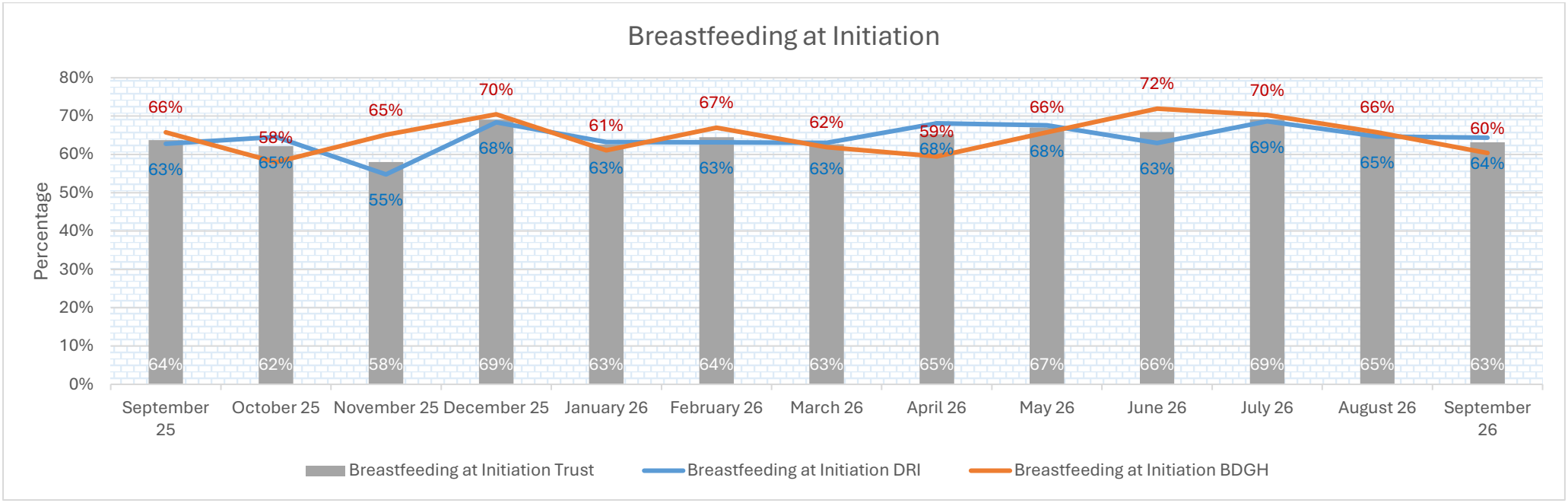


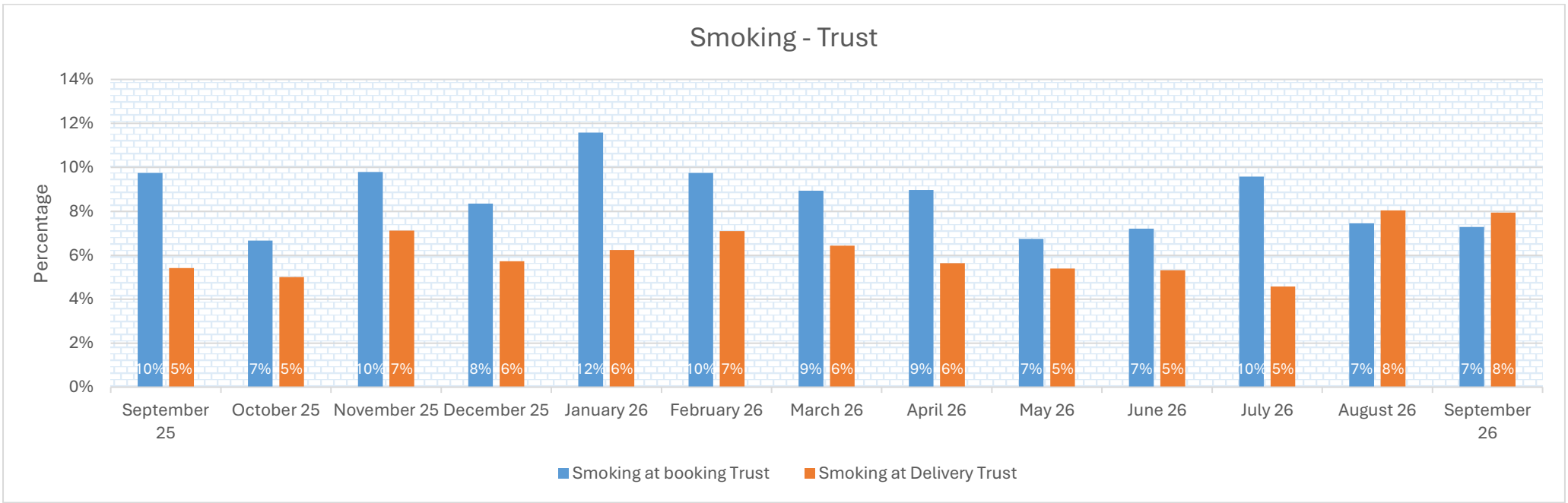

Total Births and Birth Type - Trust
Number of Births
Birth Type %
410
400
390
380
370
360
350
340
330
320
310
300
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
6% 9% 9% 10% 8% 7% 9% 4% 8% 8% 8% 7% 8%
35% 31% 35% 35% 35% 36% 33% 37% 31% 40% 31% 32% 34%
19% 17% 16% 17% 15% 18% 18% 17% 18% 21% 18% 18% 18%
41% 43% 40% 38% 41% 39% 41% 41% 43% 32% 43% 43% 40%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
Normal Births Trust
Elective C/S deliveries Trust
Emergency C/S deliveries Trust
Assisted vaginal births Trust
Total Births Trust

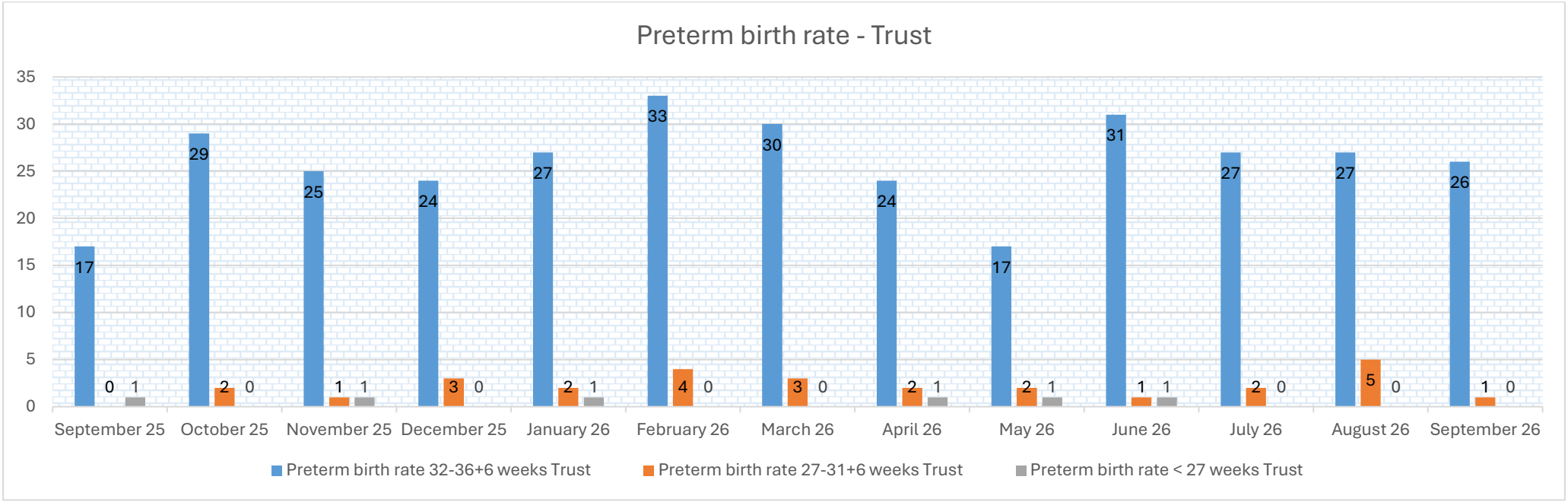

3rd & 4th Degree Tears - Trust
Percentage
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
1% 1% 8% 2% 7% 1% 9% 1% 2% 8% 2% 3% 4% 7% 5% 7% 2% 2% 6% 3% 2% 7%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
3rd/4th Degree Tear - Normal Birth Trust
3rd/4th Degree Tear - Assisted Birth Trust

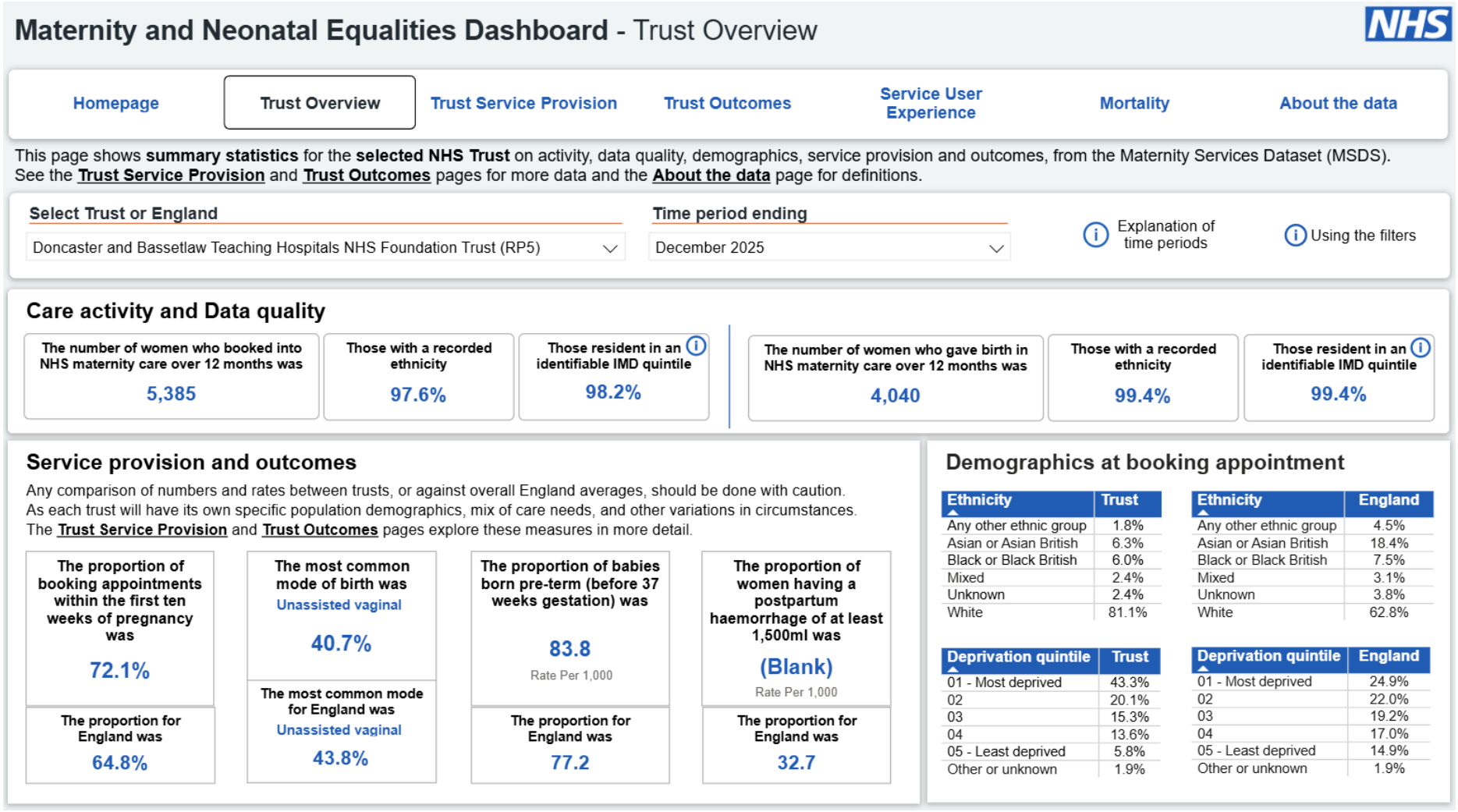

PPH> 1500 mls
Percentage
8%
7%
6%
5%
4%
3%
2%
1%
0%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
PPH ≥ 1500ml Trust
PPH ≥ 1500ml DRI
PPH ≥ 1500ml BDGH


Induction Rate
Percentage
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
Induction Rate Trust
Induction Rate DRI
Induction Rate BDGH


Breastfeeding at Initiation
Percentage
80%
70%
60%
50%
40%
30%
20%
10%
0%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
66%
58%
65%
70%
61%
67%
62%
59%
66%
72%
70%
66%
60%
63%
65%
55%
68%
63%
63%
63%
68%
68%
63%
69%
65%
64%
64%
62%
58%
69%
63%
64%
63%
65%
67%
66%
69%
65%
63%
Breastfeeding at Initiation Trust
Breastfeeding at Initiation DRI
Breastfeeding at Initiation BDGH


Smoking - Trust
Percentage
14%
12%
10%
8%
6%
4%
2%
0%
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
10% 5%
7% 5%
10% 7%
8% 6%
12% 6%
10% 7%
9% 6%
9% 6%
7% 5%
7% 5%
10% 5%
7% 8%
7% 8%
Smoking at booking Trust
Smoking at Delivery Trust


Preterm birth rate - Trust
35
30
25
20
15
10
5
0
17
0
1
29
2
0
25
1
1
24
3
0
27
2
1
33
4
0
30
3
0
24
2
1
17
2
1
31
1
1
27
2
0
27
5
0
26
1
0
September 25
October 25
November 25
December 25
January 26
February 26
March 26
April 26
May 26
June 26
July 26
August 26
September 26
Preterm birth rate 32-36+6 weeks Trust
Preterm birth rate 27-31+6 weeks Trust
Preterm birth rate < 27 weeks Trust



Maternity and Neonatal Equalities Dashboard - Trust Overview

NHS

Homepage | Trust Overview | Trust Service Provision | Trust Outcomes | Service User Experience | Mortality | About the data

This page shows **summary statistics** for the **selected NHS Trust** on activity, data quality, demographics, service provision and outcomes, from the Maternity Services Dataset (MSDS).
See the **Trust Service Provision** and **Trust Outcomes** pages for more data and the **About the data** page for definitions.

Select Trust or England: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (RP5)

Time period ending: December 2025

Explanation of time periods | Using the filters

Care activity and Data quality

The number of women who booked into NHS maternity care over 12 months was	Those with a recorded ethnicity	Those resident in an identifiable IMD quintile
5,385	97.6%	98.2%

The number of women who gave birth in NHS maternity care over 12 months was	Those with a recorded ethnicity	Those resident in an identifiable IMD quintile
4,040	99.4%	99.4%

Service provision and outcomes

Any comparison of numbers and rates between trusts, or against overall England averages, should be done with caution.
As each trust will have its own specific population demographics, mix of care needs, and other variations in circumstances.
The **Trust Service Provision** and **Trust Outcomes** pages explore these measures in more detail.

The proportion of booking appointments within the first ten weeks of pregnancy was	The most common mode of birth was	The proportion of babies born pre-term (before 37 weeks gestation) was	The proportion of women having a postpartum haemorrhage of at least 1,500ml was
72.1%	Unassisted vaginal 40.7%	83.8 Rate Per 1,000	(Blank) Rate Per 1,000
The proportion for England was 64.8%	The most common mode for England was Unassisted vaginal 43.8%	The proportion for England was 77.2	The proportion for England was 32.7

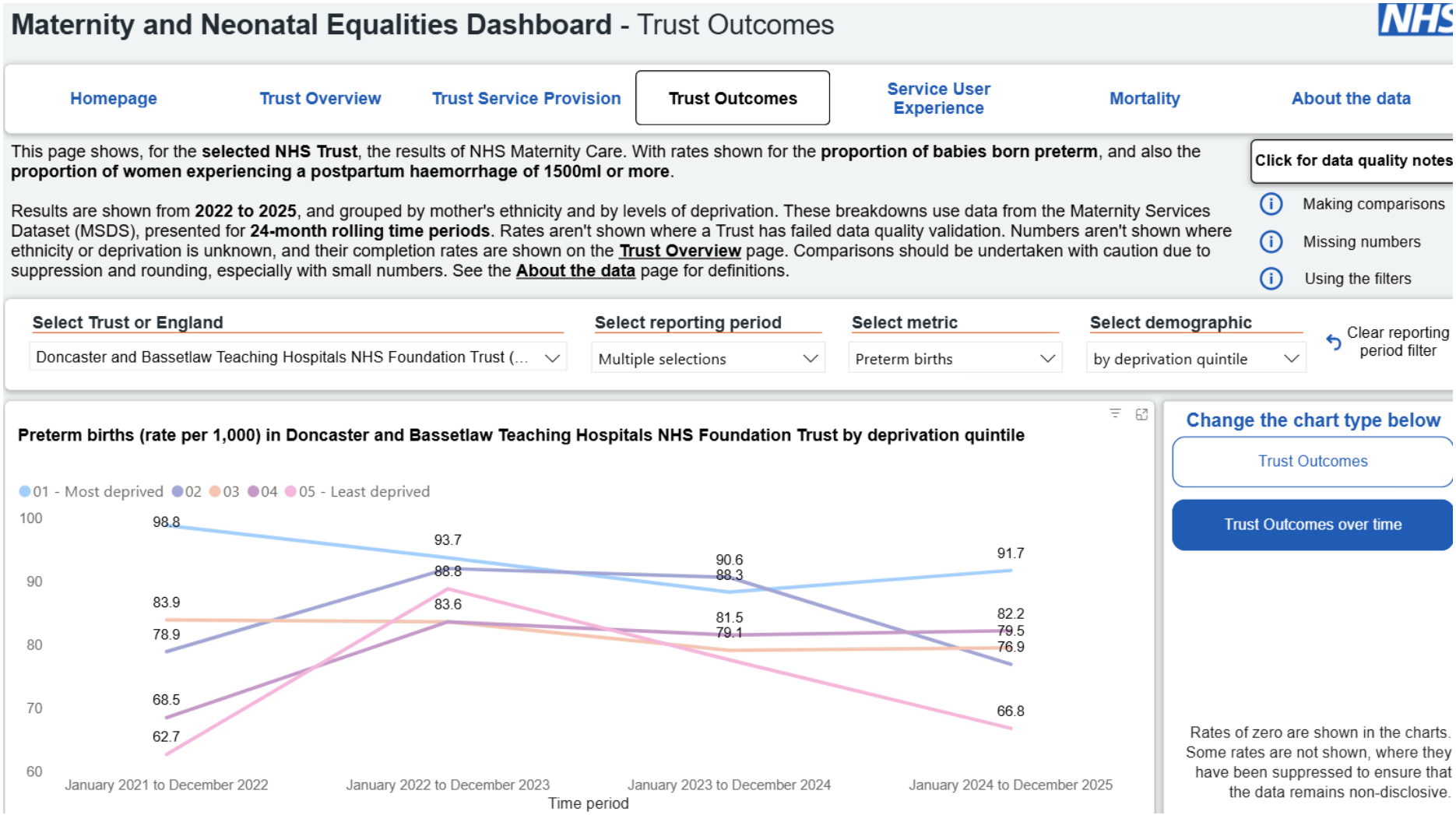
Demographics at booking appointment

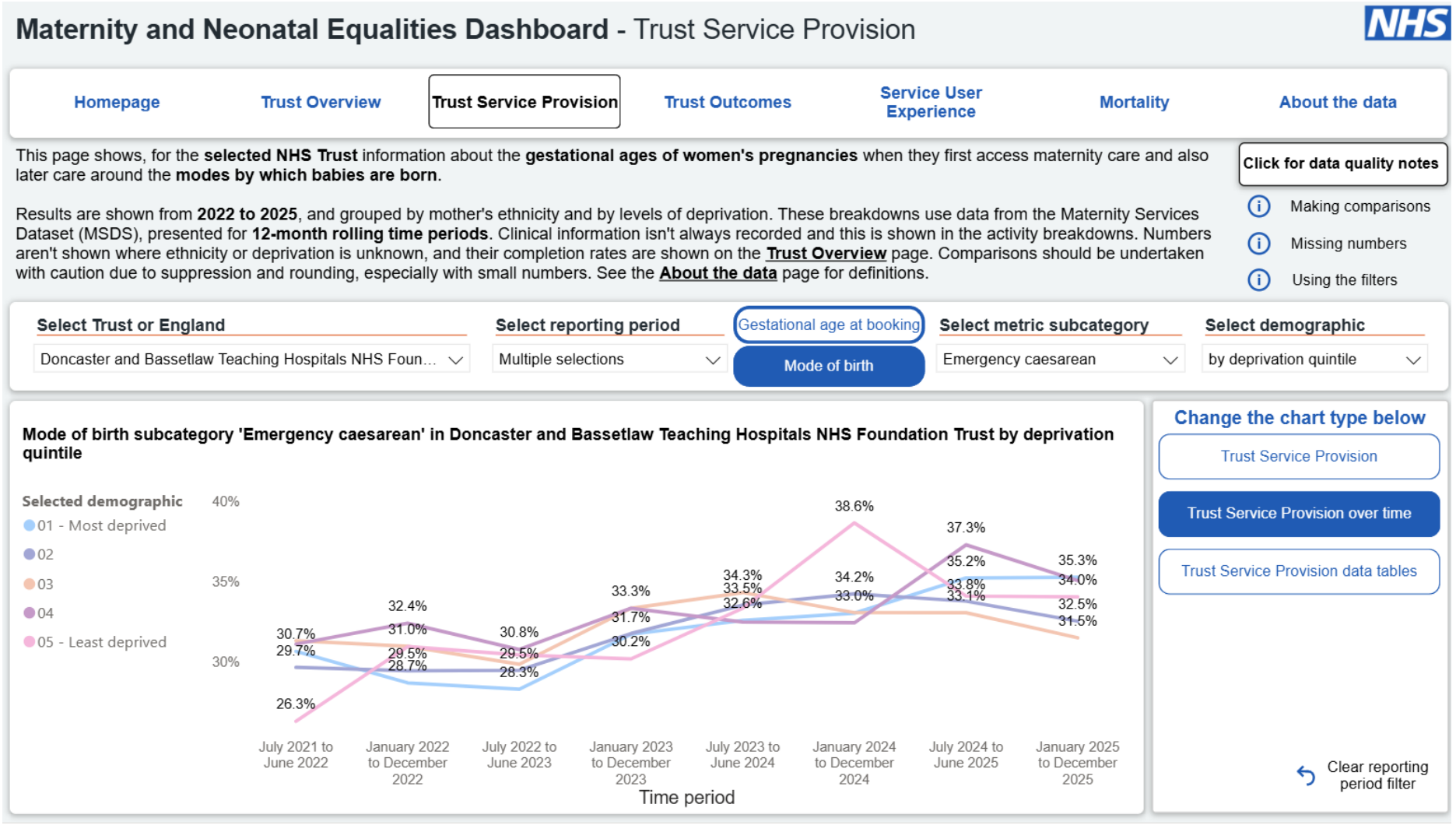
Ethnicity	Trust
Any other ethnic group	1.8%
Asian or Asian British	6.3%
Black or Black British	6.0%
Mixed	2.4%
Unknown	2.4%
White	81.1%

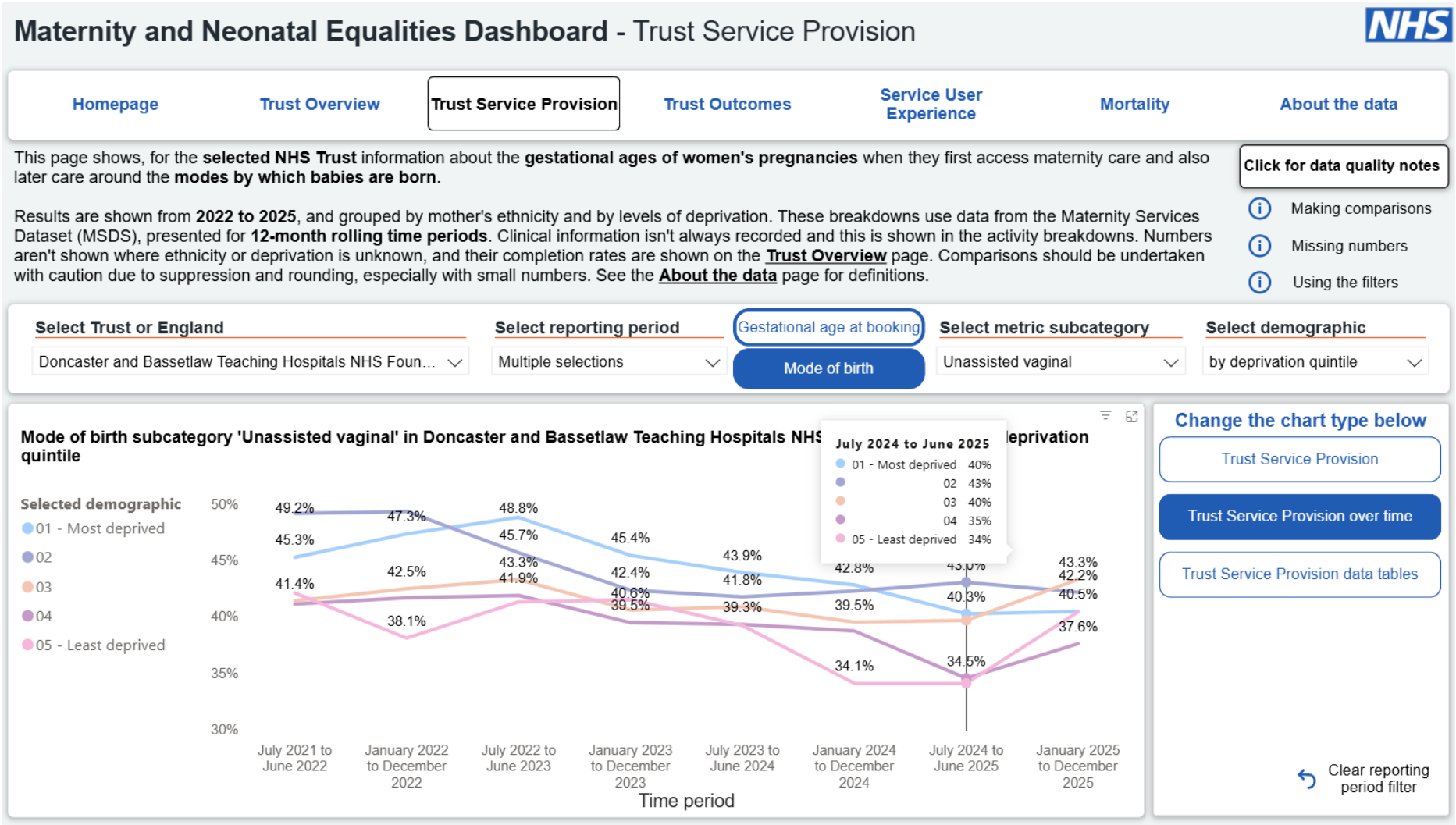
Ethnicity	England
Any other ethnic group	4.5%
Asian or Asian British	18.4%
Black or Black British	7.5%
Mixed	3.1%
Unknown	3.8%
White	62.8%

Deprivation quintile	Trust
01 - Most deprived	43.3%
02	20.1%
03	15.3%
04	13.6%
05 - Least deprived	5.8%
Other or unknown	1.9%

Deprivation quintile	England
01 - Most deprived	24.9%
02	22.0%
03	19.2%
04	17.0%
05 - Least deprived	14.9%
Other or unknown	1.9%


Maternity and Neonatal Equalities Dashboard - Trust Outcomes
NHS
Homepage
Trust Overview
Trust Service Provision
Trust Outcomes
Service User Experience
Mortality
About the data
This page shows, for the selected NHS Trust, the results of NHS Maternity Care. With rates shown for the proportion of babies born preterm, and also the proportion of women experiencing a postpartum haemorrhage of 1500ml or more.
Results are shown from 2022 to 2025, and grouped by mother's ethnicity and by levels of deprivation. These breakdowns use data from the Maternity Services Dataset (MSDS), presented for 24-month rolling time periods. Rates aren't shown where a Trust has failed data quality validation. Numbers aren't shown where ethnicity or deprivation is unknown, and their completion rates are shown on the Trust Overview page. Comparisons should be undertaken with caution due to suppression and rounding, especially with small numbers. See the About the data page for definitions.
Click for data quality notes
Making comparisons
Missing numbers
Using the filters
Select Trust or England
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (...
Select reporting period
Multiple selections
Select metric
Preterm births
Select demographic
by deprivation quintile
Clear reporting period filter
Preterm births (rate per 1,000) in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by deprivation quintile
01 - Most deprived
02
03
04
05 - Least deprived
100
90
80
70
60
98.8
93.7
90.6
91.7
88.8
88.3
83.9
83.6
81.5
82.2
78.9
79.1
79.5
76.9
68.5
66.8
62.7
January 2021 to December 2022
January 2022 to December 2023
January 2023 to December 2024
January 2024 to December 2025
Time period
Change the chart type below
Trust Outcomes
Trust Outcomes over time
Rates of zero are shown in the charts. Some rates are not shown, where they have been suppressed to ensure that the data remains non-disclosive.


Maternity and Neonatal Equalities Dashboard - Trust Service Provision
NHS
Homepage
Trust Overview
Trust Service Provision
Trust Outcomes
Service User Experience
Mortality
About the data
This page shows, for the selected NHS Trust information about the gestational ages of women's pregnancies when they first access maternity care and also later care around the modes by which babies are born.
Results are shown from 2022 to 2025, and grouped by mother's ethnicity and by levels of deprivation. These breakdowns use data from the Maternity Services Dataset (MSDS), presented for 12-month rolling time periods. Clinical information isn't always recorded and this is shown in the activity breakdowns. Numbers aren't shown where ethnicity or deprivation is unknown, and their completion rates are shown on the Trust Overview page. Comparisons should be undertaken with caution due to suppression and rounding, especially with small numbers. See the About the data page for definitions.
Click for data quality notes
Making comparisons
Missing numbers
Using the filters
Select Trust or England
Doncaster and Bassetlaw Teaching Hospitals NHS Foun...
Select reporting period
Multiple selections
Gestational age at booking
Mode of birth
Select metric subcategory
Emergency caesarean
Select demographic
by deprivation quintile
Mode of birth subcategory 'Emergency caesarean' in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by deprivation quintile
Selected demographic
01 - Most deprived
02
03
04
05 - Least deprived
40%
35%
30%
30.7%
29.7%
26.3%
32.4%
31.0%
28.7%
30.8%
29.5%
28.3%
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32.5%
31.5%
July 2021 to June 2022
January 2022 to December 2022
July 2022 to June 2023
January 2023 to December 2023
July 2023 to June 2024
January 2024 to December 2024
July 2024 to June 2025
January 2025 to December 2025
Time period
Change the chart type below
Trust Service Provision
Trust Service Provision over time
Trust Service Provision data tables
Clear reporting period filter


Maternity and Neonatal Equalities Dashboard - Trust Service Provision
NHS
Homepage
Trust Overview
Trust Service Provision
Trust Outcomes
Service User Experience
Mortality
About the data
This page shows, for the selected NHS Trust information about the gestational ages of women's pregnancies when they first access maternity care and also later care around the modes by which babies are born.
Results are shown from 2022 to 2025, and grouped by mother's ethnicity and by levels of deprivation. These breakdowns use data from the Maternity Services Dataset (MSDS), presented for 12-month rolling time periods. Clinical information isn't always recorded and this is shown in the activity breakdowns. Numbers aren't shown where ethnicity or deprivation is unknown, and their completion rates are shown on the Trust Overview page. Comparisons should be undertaken with caution due to suppression and rounding, especially with small numbers. See the About the data page for definitions.
Click for data quality notes
Making comparisons
Missing numbers
Using the filters
Select Trust or England
Doncaster and Bassetlaw Teaching Hospitals NHS Foun...
Select reporting period
Multiple selections
Gestational age at booking
Mode of birth
Select metric subcategory
Unassisted vaginal
Select demographic
by deprivation quintile
Mode of birth subcategory 'Unassisted vaginal' in Doncaster and Bassetlaw Teaching Hospitals NHS
eprivation quintile
July 2024 to June 2025
01 - Most deprived 40%
02 43%
03 40%
04 35%
05 - Least deprived 34%
Selected demographic
01 - Most deprived
02
03
04
05 - Least deprived
50%
45%
40%
35%
30%
49.2%
47.3%
48.8%
45.3%
45.7%
45.4%
43.9%
42.8%
43.3%
42.5%
43.3%
41.8%
42.2%
41.4%
41.9%
42.4%
40.3%
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July 2021 to June 2022
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Time period
Change the chart type below
Trust Service Provision
Trust Service Provision over time
Trust Service Provision data tables
Clear reporting period filter

Perinatal Quarterly Thematic Analysis and Safety Recommendations Report

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1.0 Background

The purpose of this review is to identify recurring themes across maternity and neonatal safety intelligence and to ensure learning arising from investigations, reviews and patient feedback is translated into measurable safety improvement. The review supports compliance with Maternity Incentive Scheme Year 8 requirements and reflects national expectations that organisations demonstrate effective triangulation of safety learning.

2.0 Investigation Process and Methodology

Initial findings were identified through established maternity and neonatal governance, incident reporting and patient safety review processes. Safety intelligence was drawn from multiple sources, including Patient Safety Event Response Panel reviews (PSERP), Perinatal Mortality Review Tool (PMRT) reviews, Avoiding Term Admissions into Neonatal Units (ATAIN) reviews, Complaints, Datix reports and Claims intelligence.

A reflexive thematic analysis approach was used. A deductive coding was undertaken using the PSIRF contributory factors framework, whilst inductive coding enabled the identification of additional themes emerging from the data. The coded data were subsequently reviewed by two reviewers to identify recurring patterns and areas of learning. Findings were then presented to the Perinatal Thematic Analysis Oversight Group, where themes were reviewed, refined and triangulated across maternity and neonatal services to identify common system-level issues and improvement opportunities. Safety recommendations were developed based on the contributory factors identified and aimed at reducing the likelihood of recurrence.

The analysis adopted a systems-based approach, considering organisational, environmental, task and human factors that may have influenced safety outcomes. Whilst individual reviews contain case-specific findings, this report focuses on cross-cutting themes and organisational learning to support directorate-wide improvement and provide Board assurance.

The Perinatal Thematic Analysis Oversight Group met on 16 July 2026 and 30 July 2026 to complete the analysis, agree the overarching themes and approve the associated safety recommendations and action plan. Both meetings were quorate and attended by the required multidisciplinary representation in line with the group's Terms of Reference.

3.0 Limitations

This review represents a thematic analysis of available safety intelligence for Quarter 1 2026/27 and is dependent on the quality and completeness of source data. The findings identify recurring patterns across multiple review streams but do not establish causality. In addition, a small number of cases remain under review and may generate further learning not reflected within this report.

4.0 Analysis: Quarter 1 2026/27

Review	Cases	Key Finding
MGPSERP	27	Predominant themes related to process reliability, documentation, escalation and guideline compliance.
Neonatal PSERP	5	Themes focused on equipment availability, documentation, communication and staff education. Positive learning and effective escalation were also identified.
ATAIN	42	9 admissions classified as avoidable. Opportunities identified around fetal surveillance, escalation and clinical decision-making.
PMRT	4	Learning primarily related to communication, care planning and coordination rather than direct clinical care failures.
Claims		Themes related to decision-making, guideline adherence, communication and documentation.
Maternity Complaints		Communication, access to care and patient experience were predominant themes.
Neonatal Complaints	0	N/A
Datix Reports		Communication, escalation, workforce pressures, equipment issues and medication errors identified across maternity and neonatal services.

4.1 Patient Safety Event Response Panel (PSERP)

4.1.1 Maternity and Gynaecology PSERP

27 cases were reviewed through the MGPSERP. Thematic analysis identified recurring factors relating to process reliability, communication, documentation and escalation. Common issues included non-adherence to clinical guidelines, incomplete escalation pathways, delays in review, and variable documentation of clinical decision-making, consent and safety-netting advice. Staff knowledge and decision-making were identified in relation to hypertension management, VTE assessment, syphilis screening and instrumental delivery management. Organisational factors included referral pathways, interpreter services and access to specialist tertiary services. Overall, the findings suggest that the predominant contributors to risk are organisational systems and process reliability, particularly in relation to escalation, documentation, referral pathways and adherence to established maternity guidelines.

4.1.2 Neonatal PSERP

During Quarter One, five neonatal cases were reviewed. Several examples of effective multidisciplinary working, timely escalation and positive patient care were identified and shared across services to support organisational learning. Opportunities for improvement centred on equipment availability, documentation, communication and staff education, particularly in relation to neonatal emergencies and rare metabolic conditions. The review identified generally effective escalation and governance processes, with actions focused on strengthening equipment availability, documentation standards and simulation-based learning to support safe and timely clinical intervention.

4.2 Avoiding Term Admissions into Neonatal Units (ATAIN)

42 neonatal admissions were reviewed, of which nine were classified as avoidable. Two cases remain under review. Thematic analysis identified recurring factors associated with fetal surveillance, CTG interpretation, hypertension management, neonatal jaundice pathways and escalation processes. Deficiencies in documentation, clinical decision-making and recording of rationale for changes in management were also identified. A notable finding was that the majority of avoidable admissions were associated with factors occurring before birth, particularly failures in fetal surveillance, recognition of deterioration, escalation of concerns and the timeliness of delivery decisions.

4.3 Perinatal Mortality Review Tool (PMRT)

Four cases were reviewed through the local Perinatal Mortality and Morbidity process during Quarter One. The main themes related to communication with families, care planning, post-discharge follow-up, documentation quality, care coordination and equipment availability. Importantly, the reviews identified very few direct clinical care failures contributing to outcomes. Most cases were graded as Category A or B, indicating that care was largely delivered in accordance with expected standards. Learning opportunities were primarily associated with communication, family engagement and post-loss support pathways rather than clinical treatment concerns.

4.4 Claims Intelligence

Analysis of claims closed during the quarter identified recurring themes relating to variability in clinical decision-making, inconsistent escalation thresholds, guideline non-compliance, documentation quality and communication, particularly in relation to consent processes and informed decision-making. The findings align with themes identified through incident reviews and demonstrate consistency across multiple sources of safety intelligence.

4.5 Complaints

4.5.1 Maternity Complaints

Analysis of maternity complaints using the PSIRF contributory and mitigating factors framework identified communication and information sharing as the predominant theme. Additional factors included organisational and administrative processes, access to care, professional behaviours and coordination across services. Unlike incident-review data, which was largely characterised by themes relating to escalation, fetal surveillance and guideline compliance, complaint themes were more strongly associated with patient experience, communication and professionalism.

4.6 Datix Reports

4.6.1 Maternity

Review of Datix reports identified workforce and work environment pressures, communication failures, guideline non-compliance and delays in escalation or clinical review as the predominant contributory factors. Several mitigating factors were also evident, including

effective incident reporting, multidisciplinary working, governance oversight and timely escalation during emergencies.

4.6.2 Neonatal

The predominant themes within neonatal Datix reports related to equipment faults, skin integrity referrals and medication errors. Whilst relatively low in volume, these themes highlight the importance of maintaining equipment assurance processes, medicines governance and ongoing monitoring of neonatal harm prevention initiatives.

5.0 Thematic Analysis

Theme	PSERP	ATAIN	PMRT	Claims	Complaints	Datix
Communication	X	X	X	X	X	X
Documentation	X	X	X	X		X
Language Need	X				X	

5.1 Theme One: Communication Reliability and Documentation

5.1.1 Contributory Factor

Analysis across incident reviews, claims, complaints and PMRT reviews identified recurring issues relating to the quality and completeness of clinical documentation. Common findings included poor recording of decision-making, care plans, consent discussions and safety-netting advice, as well as limited documentation of the rationale for changes in clinical management. These issues reduced the visibility of shared decision-making, affected continuity of care and contributed to patient experience concerns.

5.1.2 Safety Recommendation

- Implement a multidisciplinary programme to strengthen documentation standards across maternity and neonatal services.
- Improve recording of consent discussions, shared decision-making and care planning.
- Introduce audit and feedback processes to provide assurance regarding documentation quality and compliance.

5.2 Theme Two: Equitable Communication and Language Needs

5.2.1 Contributory Factor

Several reviews identified barriers to effective communication with women and families whose first language was not English. Findings included incomplete language needs assessments, inconsistent use of interpreter services and inadequate documentation of discussions, understanding and agreement. These factors create a risk that women and families may not receive information in a way that fully supports informed choice and participation in decision-making.

5.2.2 Safety Recommendation

- Embed a standardised language needs assessment process at booking and throughout the maternity pathway.
- Strengthen compliance with interpreter service guidance and documentation requirements.
- Monitor implementation through routine audit and governance processes.

5.3 Theme Three: Patient-Centred Communication and Shared Decision-Making

5.3.1 Contributory Factor

Review findings demonstrated occasions where concerns raised by women and families were not fully explored or documented, with limited evidence that risks, options and care plans were consistently understood. Complaints data highlighted that communication, involvement in decision-making and feeling listened to were key determinants of patient experience. Missed opportunities to explore concerns may also reduce understanding of the wider clinical, social and personal factors influencing care.

5.3.2 Safety Recommendation

- Implement a standardised shared decision-making framework across maternity, gynaecology and neonatal services.
- Promote patient-centred communication approaches that support understanding, involvement and informed choice.
- Ensure care plans, risks, options and patient concerns are clearly discussed, documented and escalated where appropriate.

6.0 Conclusion

Communication emerged as the predominant cross-cutting theme across all sources of safety intelligence reviewed during Quarter 1. The findings suggest that the greatest opportunities for improvement lie in strengthening documentation standards, supporting equitable communication through effective language assessment and interpreter use, and embedding a consistent approach to shared decision-making. Collectively, these interventions are expected to improve patient safety, patient experience and organisational assurance.

7. 0 Action Plan

Action No.	Contributory Factor	Action	Progress	Lead	Target Date	Completion Date	RAG
1.	Record Keeping	Implementation of daily plans of care questions, completed daily by the coordinator on the neonatal unit alongside the parents.	Implemented into the neonatal unit	Neonatal Ward Manager (JA)	30.7.26	30.07.26	
2.		MDT approach to reviewing documentation. Audit of current examples of documentation of consent to allow specific areas of action to be created	Next meeting planned for September	Matron For Governance (EM)	30.9.26		
3		Attendance at Seminar: The importance of documentation in clinical practice	Session booked with Ian Sprakes Trust Solicitor	Director of M&G (LM)	30.9.26		
4	Language Assessment	Embed the new language assessment proforma into routine practice at the booking appointment	Communication sent to all staff members Language and interpreter action plan in progress and monitored in governance process Maternity Specific guidance for working with interpreters completed	Head of EDI Maternity & Women's Services (JG)	30.9.26		
5 6 7	**Patient-centred communication and informed choice**	To plan and complete a communication week throughout women's and neonates with tea-trolley teaching, safety messages of the day and staff engagement Embed Martha's Rule across Maternity and Neonatal Services Work collaboratively with Y&H ODN to develop care pathways that bridge maternity and neonates	Maternity to link in with neonates' clinical educators to being planning	Governance Midwife (LJ) Divisional Nurse Children and Neonates (LC) Representation to be confirmed	30.9.26 31.8.26 31.1.27		

8.0 Appendices

Appendix one: Maternity and Gynaecology Patient Safety Event Response Panel (MGPSERP):

Theme	Contributory Factors	Examples Identified	Existing/Potential Mitigating Factors
Failure to recognise, escalate or respond to deterioration	Staff factors; Processes and procedures; Situation awareness	Delayed escalation and treatment of severe hypertension (191278); delayed consultant attendance during PPH (191515); uncertainty regarding significance of maternal illness and possible seizures (191278); delayed review prior to repeated antibiotic prescribing (193638)	Reinforcement of escalation pathways, MOEWS compliance audits, consultant attendance triggers, simulation training, hypertension workstream review
Non-adherence to guidelines, protocols or pathways	Processes and procedures; Organisational factors	Syphilis/TORCH screening guideline not followed (192236); hypertension management deviations (191278, 196934); VTE scoring errors (194597); failure to offer TORCH screening despite risk factors (196727)	Guideline education, safety messages, targeted audits, mandatory review checkpoints, inclusion in competency programmes
Documentation deficiencies	Communication factors; Processes and procedures	Lack of documentation of BP control and delivery decisions (191278); poor recording of fetal position and station (193533); inadequate safety-netting documentation (196934); documentation gaps around feeding and neonatal concerns (196727); consent documentation for episiotomy (195520)	Documentation standards refresh, focused feedback to teams, record-keeping audits, documentation training
Senior review and decision-making delays	Team factors; Processes and procedures	Lack of face-to-face obstetric review (191278); uncertainty regarding consultant involvement in PPH (191515); delayed consultant review for persistent rash and itching (192236); questions regarding medical review before discharge (195328)	Defined senior review criteria, consultant escalation triggers, multidisciplinary review processes
Diagnostic bias and narrow clinical focus	Cognitive factors; Situation awareness; Staff factors	Rash repeatedly managed as obstetric cholestasis despite contradictory findings and missed syphilis diagnosis (192236); focus on obstetric causes without considering wider differential diagnoses (192236); uncertainty around sepsis consideration in unwell antenatal patient (191278)	Education on diagnostic uncertainty, wider differential diagnosis prompts, infection screening checklists, multidisciplinary reviews
Communication and information sharing failures	Communication factors; Team factors	Lack of communication regarding delivery decisions (191278); inadequate communication between neonatal/community teams following traumatic delivery (193533); interpreter service failures (195467); insufficient discussion/documentation of safety-netting advice (196934)	Improved handover tools, interpreter escalation process, shared communication pathways, standardised safety-netting documentation
Equipment and resource issues	Work environment factors; Organisational factors	Saturation monitors unavailable/not functioning in neonatal emergencies (193384, 193467)	Equipment replacement programme, routine equipment checks, escalation process for equipment failures
Medication and treatment management	Processes and procedures; Staff factors	Delayed antihypertensive treatment (191278); uncertainty regarding 40 IU Syntocinon administration (191515); multiple courses of antibiotics without adequate review leading to C. difficile infection (193638); inappropriate Dalteparin prescription (194597)	Medicines optimisation reviews, prescribing audits, antibiotic stewardship programmes, decision-support tools

Instrumental delivery decision-making and technical management	Staff factors; Team factors; Processes and procedures	Failed instrumental delivery with delayed terbutaline administration (191644); prolonged instrumental attempts before alternative delivery considered (193533); documentation deficiencies around fetal position and cup placement (193533)	Instrumental delivery training, competency reviews, consultant support, documentation standards
Referral and specialist pathway failures	Organisational factors; Processes and procedures	Vulnerability referral not triggered despite language barriers and missed appointments (195467); missed sexual health pathway involvement (192236); uncertainty around tertiary transfer planning (193467)	Referral pathway reminders, vulnerability screening tools, specialist referral checklists
Patient-centred communication and informed choice	Communication factors; Patient factors interacting with system factors	Admission declined by patients in several cases (194698, 195396, 196934); consent concerns regarding miscarriage management and speculum examination (196515); documentation of risks and options lacking in some cases	Enhanced shared decision-making documentation, professional curiosity training, culturally sensitive communication, interpreter optimisation
Learning from excellence and positive safety behaviours	Mitigating factors across all domains	Timely eclampsia management (192662); excellent documentation and escalation during major PPH (191917); effective MDT working (191917, 192662, 192956); prompt recognition and escalation by community midwife (196727); positive neonatal stabilisation despite complexity (193467)	Continue PSIRF learning from excellence approach, share examples through governance meetings, use positive case reviews in training

SEIPS Domain	Contribution to Incident	Impact
Organisation	Escalation failures, policy non-compliance, communication gaps, training needs	Very High
Tasks	Risk assessment errors, delayed reviews, incomplete documentation, guideline deviation	High
Person	Clinical judgement, situational awareness, professional curiosity	High
Tools & Technology	Faulty saturation monitors, documentation systems, communication tools	Moderate
Physical Environment	Cross-site transfers, tertiary referral challenges, resource availability	Low-Moderate

Appendix 2: Avoiding Term Admissions in Neonatal Units (ATAIN):

Theme	Contributory Factors	Examples Identified	Existing/Potential Mitigating Factors
Fetal Surveillance and CTG Interpretation	Staff factors; Decision-making factors; Processes and procedures	Failure to recognise or appropriately respond to pathological CTGs (194087, 194491, 196967, 197385). Acute bradycardia not acted upon promptly (197385). Delayed response to abnormal CTG and meconium-stained liquor (196967).	CTG competency training, fetal surveillance audits, CTG review education, reinforcement of escalation pathways, consultant review of abnormal CTGs.
Delay in Delivery Following Fetal Compromise	Processes and procedures; Team factors; Situation awareness	Delivery could have been expedited following abnormal CTG (194491, 196967, 197385). Delay following recognition of cord prolapse (196631).	Emergency delivery drills, escalation triggers, multidisciplinary simulation training, consultant oversight of high-risk CTGs.
Management of Intrapartum Emergencies	Staff factors; Processes and procedures	Hyperstimulation not recognised or treated effectively (196631). Delay in responding to acute fetal compromise (197385).	Oxytocin and hyperstimulation training, emergency algorithms, regular PROMPT training.
Maternal Assessment and Monitoring	Processes and procedures; Staff factors	Admission without maternal observations despite diabetes and vomiting (193743). Inadequate hypertension management (193745).	Standardised admission checklists, mandatory observations before discharge/admission decisions, hypertension pathway audits.
Documentation and Clinical Decision-Making Records	Communication factors; Information and documentation factors	No documentation regarding steroid discussions (193743). Lack of theatre documentation including examination findings and blood results (193745). CAT 1 decision reversed with no documented rationale (193745). Remote CTG reviews not documented appropriately (194087).	Documentation audits, consultant feedback, mandatory recording of key clinical decisions, escalation documentation standards.
Guideline Adherence	Processes and procedures; Organisational factors	Steroid administration pathway not clearly followed or documented (193743). Hypertension management concerns (193745). Hyperstimulation management not compliant with guidance (196631).	Clinical guideline refresh, focused governance reviews, safety messages, ward-based teaching.
Timeliness of Neonatal Treatment	Processes and procedures; Team factors	Delay of 3-4 hours commencing phototherapy despite SBR above treatment line (193745). Delay repeating bilirubin level, resulting in escalation of jaundice.	Jaundice pathway education, escalation triggers for SBR results, neonatal audits, electronic alerts where possible.
Appropriateness of NNU Admission Decisions	Decision-making factors; Processes and procedures	Babies admitted for observation or respiratory concerns who may have been safely managed in transitional care (193745, 195524). Additional warming required but prolonged NNU admission followed (194087).	Review of transitional care criteria, neonatal admission avoidance pathways, joint obstetric-neonatal decision making.
Thermal Care of the Newborn	Staff factors; Processes and procedures	Hypothermia potentially preventable through improved postnatal thermal management (194501). Baby admitted for additional warming requirements (194087).	Thermal care education, skin-to-skin optimisation, neonatal temperature monitoring standards.
Communication and Teamworking	Team factors; Communication factors	Unclear communication around CAT 1 decision-making and subsequent change of plan (193745). Concerns regarding remote CTG review processes (194087).	Clear escalation pathways, multidisciplinary debriefs, standard communication tools (SBAR), consultant visibility in decision-making.

Recognition and Escalation of Deterioration	Situation awareness; Staff factors; Team factors	Failure to recognise significance of abnormal CTG features, fetal compromise, hyperstimulation and cord prolapse (196631, 196967, 197385).	Fetal monitoring training, regular scenario-based simulation, human factors education.

SEIPS Domain	Contribution to Admissions	Impact
Person	CTG interpretation, clinical decision-making, situational awareness	High
Tasks	Fetal monitoring, escalation, hypertension management, thermal care	High
Tools & Technology	CTG review practices, documentation systems	Moderate
Organisation	Guideline compliance, escalation processes, governance oversight	High
Environment	Limited contribution, although workload and location of review may have influenced care	Low-Moderate

Appendix 3: Perinatal Mortality Review Tool (PMRT) (cases reviewed in Quarter 1):

Theme	Contributory Factors	Examples Identified	Existing/Potential Mitigating Factors
Documentation and Records Management	Information, communication and documentation factors	PMRT tool incorrectly identified absence of CTG where fetal heart was absent on presentation (AA413). Documentation omissions identified including incomplete partogram, absent preterm birth risk assessment and limited rationale for late booking (AA420).	PMRT correction requested. Good documentation standards evidenced in AA417. Continued documentation audits and feedback to staff.
Postnatal Review and Follow-up Processes	Processes and procedures; Care planning and follow-up	Absence of postnatal medical review before discharge (AA415). Missed opportunity to discuss raised HbA1c, provide debrief and address family questions.	Mandatory post-bereavement medical review prior to discharge. Structured debrief process. Improved communication of significant postnatal investigation results.
Communication with Families	Communication factors; Individual factors; Family and carer factors	Family in AA415 reported distress, confusion and inconsistent communication. Difficult circumstances led to perception of chaotic care. Communication around genetic investigations and reproductive options highlighted in AA420.	Bereavement follow-up services, culturally sensitive counselling, interpreter use, structured communication pathways, documented debrief conversations.
Equipment Availability and Reliability	Equipment and technology factors	Delay associated with faulty triage scanner rollerball requiring alternative scanner for confirmation of intrauterine fetal death (AA417). Difficulty locating equipment during emergency response (AA415).	Escalation of equipment defects, timely repair programmes, access to second scanning devices, sonographer support to delivery suite.
Workload and Competing Demands	Organisational factors; Task factors; Environmental factors	In AA415, simultaneous emergencies on the unit contributed to delays when fetal heart could not initially be located. Staff were required to manage competing clinical priorities.	Staff escalation processes were followed. Emergency buzzer used appropriately. Workforce planning and emergency preparedness reviews.
Diagnostic and Investigation Processes	Processes and procedures; Clinical decision-making factors	Raised postnatal HbA1c identified but not communicated before discharge (AA415). Questions raised about toxicology screening in AA413 but review confirmed appropriate management and no further testing required.	Clear processes for communicating abnormal postnatal results. Review of discharge checklists. Good antenatal investigation pathways identified in AA413.
Access and Engagement with Care	Patient factors interacting with system factors	Multiple DNA appointments during pregnancy in AA415. Family disengagement after loss and unsuccessful attempts at recontact. Late booking identified in AA420 though not contributing to outcome.	Existing DNA policy followed appropriately. Welfare checks undertaken. Exploration of GP support and wider professional involvement to improve re-engagement.
Genetics and Reproductive Counselling	Communication factors; Care planning factors; Cultural factors influencing care	Recurrent fetal abnormalities across three pregnancies (AA420). Family conceived before attending genetics appointment following previous loss. Cultural considerations may have influenced engagement with testing.	Genetics referrals completed. Face-to-face interpreter used. Counselling regarding reproductive options and pre-implantation genetic diagnosis. Family subsequently attended genetics service.
Coordination Between Services	Team factors; Interprofessional communication	Discussion regarding involvement of sonographers attending delivery suite rather than requiring patient transfer (AA417). Consideration of support from GP and external professionals for family re-engagement (AA415).	Strong multidisciplinary working. Positive collaboration between maternity, sonography, bereavement and governance teams.

Learning Systems and Review Processes	Organisational learning factors	PMRT tool artefact identified (AA413). Review discussions highlighted opportunities for improvement in communication, documentation and bereavement follow-up.	Effective PMRT review process. Governance oversight. Ongoing system improvement following incident reviews.

SEIPS Domain	Contribution to PMRT Cases	Impact
Person	Knowledge gaps, guideline compliance, escalation, communication and counselling	High
Tasks	Hypertension, VTE, instrumental delivery, escalation, postnatal review, documentation and follow-up	Very high
Tools & Technology	Monitoring equipment failures, scanner reliability, PMRT tool limitations	Moderate
Organisation	Escalation pathways, referrals, guideline adherence, bereavement pathways, discharge review processes	Very high
Environment	Limited contribution, competing emergencies and family experience	Low

Appendix 4: Claims score card and closed claims this quarter:

Claims Scorecard April 15 – Aug 25

Top injuries by volume:	**Top injuries by value:**
• Fatality (10) → • Unnecessary pain (8) → • Adtnl/ unnecessary operations (6) ↓ • Loss of baby (6) ↓ • Stillborn (6) ↓	• Cerebral palsy (5) ↑ • Loss of baby (6) ↓ • Brain damage (3) ↑ • Spinabifida (1) → • Fatality (10) →
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (9) → • Failure / delay diagnosis (9) → • Fail antenatal screening (5) → • Fail to make resp to abnrm FHR (7) ↑ • Fail to warn / informed consent (3) new	• Failure to Make resp to Abnrm FHR (7) ↑ • Fail antenatal screening (5) → • Failure to perform tests (2) → • Birth defects (2) • Failure / Delay diagnosis (9) ↑

Complaints Q1 26/27

- Postnatal care/ Missed suture removal / delay in care or discharge
- Communication regarding results
- Comfort not maintained
- Consent

Incidents Q1 26/27

Unexpected admission to NNU
PPH > 1500mls
Unexpected birthweight below 10th centile
Third- or fourth-degree tears

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Themes Q1 26/27

- Hyperstimulation of uterine activity
- Antibiotic prescription and reviews when repeated doses required
- VTE calculation of risk and prescription of anti-coagulant
- Guideline not followed when patient presented repeatedly with a worsening, unexplained rash (syphilis)

Learning Q1 26/27

- Documentation issues:
  - Regarding perineal protection
  - Safety netting advice
  - Infant feeding support
- VTE learning shared through education, governance newsletter and K2 popups
- Multi trust AAR regarding Syphilis diagnosis and management – communications around pathways and process was the main action

Action Plan Q1 26/27

QI project to improve neonatal optimisation	EM	
Continue cultural work – (communication / consent)	LM/ EE	
Improve face to face reviews & care planning	Team	
Lead Card medic project implementation / pt info	JG	
Business case for carbetocin	LM	

Appendix 5: Complaints

Theme	Contributory Factors	Examples Identified	Existing/Potential Mitigating Factors
Communication with Patients and Families	Communication factors; Team factors; Information sharing	Recurrent complaints relating to communication (26682, 26108, 26104, 26445, 26437, 25221, 26310, 25447). Concerns regarding clarity of information, updates, explanations and responsiveness.	Communication skills training, patient information standards, structured discussions, duty of candour processes, patient feedback reviews.
Patient Care and Clinical Management	Staff factors; Processes and procedures; Clinical decision-making	Large number of complaints relating to maternity and patient care (26551, 25977, 26682, 26443, 26161, 25447, 26104, 25902, 26445, 25221, 25972, 26528).	Clinical supervision, multidisciplinary review, guideline adherence audits, reflective practice and governance review.
Access to Treatment, Drugs, Equipment or Services	Organisational factors; Resource factors; Access factors	Frequent concerns regarding access to treatment, medications, equipment or services (25584, 26621, 26108, 26257, 26619, 26597, 25902, 26104). Cross-divisional concerns identified.	Service capacity reviews, referral pathway audits, equipment monitoring, waiting list management and escalation pathways.
Diagnosis and Delays in Diagnosis	Clinical judgment factors; Processes and procedures; Diagnostic factors	Complaints regarding delayed, missed or disputed diagnoses (25977, 26445, 25972, 26528). Present across maternity, surgical and emergency pathways.	Diagnostic pathway review, senior clinical review, decision-support tools, diagnostic safety audits.
Trust Administration and Information Governance	Administrative factors; Information management factors	Complaints relating to records, information governance and administration (25788, 26443, 26310, 25447).	Information governance training, records management audits, administrative process improvements.
Values, Behaviours and Staff Conduct	Human factors; Cultural factors; Team factors	Complaints raising concerns regarding staff attitudes, behaviours or professionalism (25977, 26443, 26310, 25447, 26437, 25221, 26585).	Professional behaviours framework, leadership support, restorative conversations, civility and respect programmes.
Appointments, Delays and Waiting Times	Organisational factors; Capacity factors; Scheduling processes	Appointment delays and waiting times (26622, 26443, 25447).	Capacity planning, appointment optimisation, waiting list review, patient communication regarding delays.
Medication Management	Processes and procedures; Staff factors	Medication-related complaints (26310, 25972, 26597).	Medicines governance reviews, prescribing audits, pharmacy support and medication safety education.
Consent and Shared Decision-Making	Communication factors; Processes and procedures	Concerns regarding consent to treatment (25584, 26104).	Enhanced consent documentation, shared decision-making training, patient information provision.
Admissions, Transfers and Discharge Processes	Care coordination factors; Communication factors	Complaints regarding admissions, discharge and transfer arrangements (25977).	Standardised discharge processes, improved handover systems, patient-centred discharge planning.
Privacy, Dignity and Wellbeing	Environmental factors; Human factors	Privacy and dignity concerns identified (26214).	Staff awareness training, privacy audits, patient experience monitoring.
End of Life Care and DNAR Decisions	Communication factors; Clinical decision-making factors	Complaint relating to DNAR and end-of-life care (25972).	Senior review, advanced care planning processes, family communication standards.
Facilities and Environment	Environmental factors; Organisational factors	Facilities concerns raised (26310).	Estates reviews, environmental quality audits, patient experience monitoring.

SEIPS Domain	Main Themes Identified	Impact
Person	Communication, staff behaviours, consent, patient interactions	High
Tasks	Diagnosis, care delivery, appointments, discharge processes	High
Tools & Technology	Information governance, records management, equipment access	Moderate
Organisation	Access to services, waiting times, appointment systems, coordination of care	Very High
Environment	Privacy, dignity and facilities concern	Low-Moderate

Appendix 6: Datix

SEIPS Domain	Factors Identified	Examples from Incident Themes	Impact on Safety Outcomes	Potential Mitigations
Person	Knowledge gaps, situational awareness, decision making, guideline familiarity, communication skills	Failure to recognise VTE prophylaxis requirement; failure to identify baby requiring hypoglycaemia pathway; delayed escalation of fetal growth restriction; inconsistent breastfeeding support.	Missed interventions, delayed treatment, inconsistent care delivery.	Targeted education, simulation training, competency assessments, safety briefings, human factors training.
Tasks	Complex maternity pathways, multiple handovers, high cognitive load, competing priorities, surveillance requirements	Growth surveillance failures, missed referrals, missed postnatal reviews, delayed observations, delayed medications, incomplete risk assessments.	Increased risk of omissions, delays and variation in care.	Simplified pathways, electronic prompts, standardised checklists, escalation triggers, task allocation reviews.
Tools & Technology	Equipment functionality, medication systems, documentation systems, monitoring equipment, identification processes	CTG/FSE monitoring issues; expired Prostin stock; incorrect baby labels; unfamiliarity with Resuscitaire equipment; Inditherm equipment concerns.	Reduced ability to monitor, identify or treat patients safely.	Equipment standardisation, maintenance schedules, barcode systems, electronic prescribing alerts, equipment orientation programmes.
Organisation	Staffing levels, workload, leadership, governance, policies, service capacity, referral processes	Red acuity staffing concerns; delayed theatre access; SCBU capacity issues; missed referrals; poor continuity between community and hospital services; repeated guideline deviations.	Delays in care, increased workload pressure, reduced ability to follow best practice.	Workforce planning, escalation policies, governance oversight, pathway audits, strengthened referral systems.
Physical Environment	Ward layout, theatre access, capacity constraints, availability of clinical space, unit geography	Delays due to unavailable theatres; neonatal staff unable to locate theatre quickly; overcrowded wards; inability to answer buzzers promptly.	Delayed reviews, treatment delays and reduced workflow efficiency.	Capacity planning, improved wayfinding, emergency response drills, environmental redesign where feasible.

APPENDIX 7: Thematic Analysis – Top 10 Datix throughout the Division

Theme	Contributory Factors	Examples Identified	Existing/Potential Mitigating Factors
Work Environment & Staffing	Staffing shortages, high workload, competing clinical priorities, capacity pressures, inadequate skill mix	Delayed observations, medications, discharges and care due to red acuity and insufficient staffing on A2 and M1; delays to theatre access and retained placenta management; SCBU capacity delaying transfer.	Escalation of staffing concerns, use of escalation policies, acuity-based staffing reviews, flexible redeployment of staff, enhanced maternity flow management, business continuity planning.
Communication & Handover	Ineffective handovers, poor SBAR communication, incomplete documentation, failure to transfer critical information between teams	Hypoglycaemia pathway missed during transfer from labour ward; no SBAR for deteriorating patient transferred to labour ward; communication failures with community follow-up; poor documentation of neonatal resuscitation and admission.	Structured SBAR handovers, safety huddles, standardised transfer documentation, electronic alerts, multidisciplinary debriefs, improved documentation standards.
Processes, Policies & Guideline Compliance	Failure to follow local/national guidelines, missed surveillance, pathway deviations, incomplete risk assessments	Missed VTE prophylaxis, inappropriate FGR management plans, missed growth surveillance, delayed dexamethasone administration, neonatal hypo pathway omissions, missed diabetic follow-up.	Guideline refresher training, safety audits, electronic prompts, pathway compliance monitoring, consultant review of high-risk cases.
Recognition, Escalation & Clinical Review Delays	Delayed review by senior clinicians, delayed escalation of abnormal findings, delayed specialist input	Delayed paediatric review for hypoglycaemia; delayed transfer for retained placenta; delays in recognising hypertension and fetal growth concerns; delayed response to neonatal concerns.	Early warning systems, escalation bundles, senior review triggers, multidisciplinary safety huddles, real-time escalation monitoring.
Equipment, Resources & Medicines Management	Equipment failures, medication management errors, stock shortages, identification errors	Expired Prostin stock, CTG/FSE monitoring failures, incorrect neonatal labels, medication prescribing and administration errors, unavailable medications.	Stock checking processes, equipment maintenance programmes, medicines safety reviews, barcode identification systems, pharmacy oversight.
Education, Training & Competence	Knowledge gaps, unfamiliarity with policies/equipment, inconsistent practice	Paediatric staff unfamiliar with Resuscitaire location/equipment; staff unaware of neonatal hypoglycaemia requirements; inconsistent breastfeeding support; missed vaccination discussions.	Simulation training, neonatal and maternity emergency drills, mandatory updates, competency assessments, induction improvements.
Referral, Follow-Up & Continuity of Care	Missed referrals, incomplete follow-up pathways, poor continuity between services	FMU referral not made for abnormal scan; missed community postnatal follow-up; hepatitis B notification not actioned; missed growth and diabetic reviews.	Automated referral systems, community-hospital communication pathways, tracking systems for outstanding reviews, governance oversight.
Neonatal Transition & Unexpected NNU Admissions	Respiratory adaptation issues, hypoglycaemia management, jaundice management delays, observation gaps	Recurrent unexpected admissions for grunting, hypoxia, hypoglycaemia, jaundice above treatment thresholds, inability to maintain saturations.	Enhanced transitional care pathways, improved risk assessment antenatally, escalation criteria for neonatal review, neonatal outreach support.
Patient Experience & Family Communication	Limited communication, delayed information sharing, lack of explanation or debriefing following incidents	Parents reporting poor communication after neonatal admission; delays in pain relief; inadequate breastfeeding support; lack of explanations regarding care plans.	Birth afterthoughts services, structured debriefs, communication training, patient information tools, family-centred care initiatives.
Organisational Learning & Safety Culture	Incident reporting identifies recurring system vulnerabilities but learning not consistently embedded across services	Repeated incidents involving staffing pressures, guideline deviations, communication failures, medication management and neonatal admissions.	PSIRF reviews, thematic governance meetings, quality improvement projects, learning newsletters, multidisciplinary case reviews and audits.

Supporting Documents

- NHS England (2022). SEIPS Quick Reference and Work System Explorer
- NHS England (2022), Top Tips for Completing a Thematic Review
- NHS England (2020). Patient Safety Incident Response Framework Contributory and mitigating factors classification
- Samantha Machen (2023) *Thematic reviews of patient safety incidents as a tool for systems thinking: a quality improvement report.* BMJ Open Quality, doi: https://bmjopenquality.bmj.com/content/12/2/e002020
- Six Phases of Reflexive Thematic Analysis

QIS nurses NNU			
Action	Lead	Timeframe	Update
Continue to review QIS ratios and forward plan as part of the monthly grip and control meetings	Sam Fawkes/ Laura Churm	Ongoing	Currently ongoing
Develop an education framework to develop our own staff on the neonatal unit	Janette Swinwood	Jul-26	Completed
Continue to recruit into vacant band 6 roles through the grip and control process and recruitment process.	Sam Fawkes/Laura Churm/Lisa Amey- Wood	Jun-27	4 QIS staff due to qualify in September, however 3 x QIS staff have been recruited by NLAG
Report staffing monthly via PRM and governance meetings	Sam Fawkes/Laura Churm/Lisa Amey - Wood	Ongoing	Currently embedded and monitored via the risk register
Undertake cot review for neonates (currently we are funded for 8 RN's on NNU, however to meet BAPM we should be funded at 8.5)	Laura Churm/Sam Fawkes/Lisa Amey-Wood	Ongoing	To be added to the BAPM Nurse staffing risk and the execs are aware

Non clinical coordinator on SCBU (BDGH)24/7
The plan is to continue monitoring compliance monthly and not seek further investment at this stage. Approval was given by the Quality Committee on behalf of the Trust Board at the October 2025 meeting supporting this approach subject to reviews and compliance not falling below 85% on a sustained basis.

2611 - E2 MATERNITY & NEONATAL 10 POINT PLAN & TRIAGE SPECIFICATION PROGRESS UPDATE

Decision Item | Karen Jessop, Chief Nurse & Nick Mallaband, Chief Medical Officer | 11

Lois Mellor, Director of Midwifery & Tomas Barani, Clinical Director Obstetrics & Gynaecology
10 minutes

REFERENCES

Only PDFs are attached

- E2 - Maternity & Neonatal 10 Point Plan & Triage Specifiction Progress Update.pdf
- E2 - Appendix 1 - DBTH Regional feedback from September Submission.pdf
- E2 - Appendix 1 - DBTH Regional feedback from September Submission.xlsx
- E2 - Appendix 2 - maternity-and-neonatal-services-reporting-template PROGRESS UPDATE.pdf
- E2 - Appendix 2 - maternity-and-neonatal-services-reporting-template PROGRESS UPDATE.xlsx
- E2 - Appendix 3 - maternity-triage-specification-benchmarking-audit-tool October 2026.pdf
- E2 - Appendix 3 - maternity-triage-specification-benchmarking-audit-tool October 2026.xlsx
- E2 - Appendix 4 - maternity-triage-specification-benchmarking-audit-tool - BDGH October 2026.pdf
- E2 - Appendix 4 - maternity-triage-specification-benchmarking-audit-tool - BDGH October 2026.xlsx

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Maternity and Neonatal 10 Point Plan and Triage Specification Progress Update**			
Sponsor:	Karen Jessop, Chief Nurse Nick Mallaband, Chief Medical Officer			
Authors:	Lois Mellor, Director of Midwifery Danielle Bhanvra, Deputy Director of Midwifery			
Appendices:	Appendix 1 - Feedback template from the Regional team Appendix 2 - Maternity and neonatal services progress update template for the 10 point plan Appendix 3 - Benchmarking tool for Maternity triage specification for DRI Appendix 4 - Benchmarking tool for maternity triage specification tool BDGH			
Purpose of the report	**Assurance**	**Approval/decision**	~~Information~~	~~Discussion~~
Proposed assurance Level (For assurance papers only)	***Moderate Assurance***			
Assurance Rationale	The Board is asked to take Moderate Assurance against the progress report for the 10 point maternity and neonatal plan. The Trust has established governance, workforce and safety controls identified by the 10 point plan and MIS Year 8. However, several important requirements remain only partially implemented or are not yet evidenced, particularly in relation to maternity inequalities, triage assurance, and demonstrable improvements arising from learning from complaints and incidents. Improvement plans are in place with evidence of progress, but further work is required following this baseline assessment exercise as outlined in the supporting paper.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7			
For decision papers only: Is this in line with Current risk appetite YES/NO	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested			

Avoid	Minimal	Cautious	Open	Seek	Mature
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

This paper presents the Trust's progress against the national maternity and neonatal 10 point plan and the maternity triage specification, following the NHSE letter received on 30 June 2026 and publication of the benchmarking tools on 12 August 2026. The review has been completed by the Director of Midwifery, with oversight from the Chief Nurse, and is submitted to Board for assurance and approval ahead of submission to NHSE by 31 December2026.

The 10 point plan assessment is supported by an evidence log and corresponding evidence folders. The baseline position has been reviewed by the regional team (Appendix 1) with a letter dated 19th October 2026. identifying two areas for strengthening

- To strengthen evidence for Martha's rule rollout
- Strengthen evidence for monthly integrated intelligence cycle

The progress update (appendix 2) has been completed using this information, this needs to be reviewed by the trust board prior to submission on 31 December 2026. The progress updates state the position on 20 October to be able to be submitted to the board prior to the December submission. However work will continue between the board on 3 November to the submission date on 31st December 2026, therefore approval is sought for the Trust

Board to delegate to the Chief Executive the final sign off and submission of the updated position by 31 December 2026.

The progress report has RAG rated four areas red, eight amber and twelve green. The red elements are;

- 2.3 - data analysis for ethnicity and deprivation, limited and completed manually
- 5.2 - Acting on the National equalities Dashboard
- 9.2 - Oversight of triage performance, data collected manually in the clinical area and not complete
- 9.3 - Estates challenges related to meeting the maternity triage specification on both sites

Two maternity triage specification tools have also been completed, one for DRI (Appendix 4) and one for BDGH (Appendix 5). The assessments identify areas requiring further support to meet the specification, including data analysis capacity, call recording for audit and quality assurance, maternity support worker capacity at BDGH, separation of antenatal and gynaecology pathways, suitable confidential space for triage calls, larger clinical spaces to support open access requirements, and support from primary care colleagues. Building and digital costs have not yet been fully quantified due to the timescale for completing the assessment and will need to be developed through the appropriate business planning route.

Overall, the assessment supports a Moderate Assurance rating. There is evidence of established governance, safety and workforce controls, and improvement plans are in place; however, the progress report identifies important areas where compliance is incomplete or not yet sufficiently evidenced. The Board is asked to approve the completed returns for submission to NHSE, note the gaps and further work required, and receive continued oversight via the Quality Committee ahead of the progress submission due by 31 December 2026.

n.b. Action 4 is the NHS wide staff engagement and culture programme that is being led nationally by NHSE and therefore has been excluded nationally from the return

Recommendations
For the Trust Board to: - Note and take moderate assurance against the progress report for the 10 point maternity and neonatal plan. - Delegate responsibility to the Chief Executive for approving the submission to NHSE by 31 December 2026.

Healthier together – delivering exceptional care for all	
Patients	*Supports safer maternity and neonatal care through baseline assessment against national requirements, evidenced gaps and agreed improvement actions.*
People	*Identifies workforce requirements and deployment gaps, including neonatal workforce compliance and maternity triage capacity.*
Partnerships	*Requires continued work with NHSE, the ICB, regional teams and primary care partners to meet the 10 point plan and triage specification.*
Pounds	*Highlights potential resource, digital and estates implications that require quantification through business planning.*
Health Inequalities	*Identifies the need for stronger maternity inequalities data to evidence variation in outcomes and target improvement.*
Legal/ Regulation:	CQC regulation 12 providing safe care and treatment
Partner ICB strategies	

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

1. Introduction

Following the publication of the Baroness Amos report and Donna Ockenden's independent review of maternity services at Nottingham the trust received a letter from Sir Jim Mackey on 30 June 2026 with a 10 point plan of urgent actions for maternity and neonatal services. A maternity triage specification was published at the same time, and a benchmarking tool was published for both on 12 August 2026. A baseline assessment against these tools was considered by Trust Board at the last meeting held in public.
NHSE have asked for these templates to be completed and returned for a progress update on 31 December 2026. The 10 point plan template needs to be approved by the trust board prior to submission. This is to ensure that the actions are progressing at pace, risks are managed appropriately and significant concerns are escalated to the ICB and regional teams.

2. Benchmarking Process

Three benchmarking tools have been completed by the Director of midwifery, and the Deputy Director of Midwifery with oversight from the Chief Nurse. Evidence has been sourced from the leads for the relevant areas, together with the Quality Committee and Trust Board Minutes.

10 Point Plan Progress Report
A Progress report assessment has been undertaken by the Director of Midwifery and reviewed by the Chief Nurse. This has been done utilising the NHSE reporting template (appendix 2) and collating the relevant evidence available for each element required. This tool and evidence has been reviewed by the regional team and feedback given on 19 October 2026 via a letter. Two areas for strengthening

- To strengthen evidence for Martha's rule rollout
- Strengthen evidence for monthly integrated intelligence cycle

The progress report has RAG rated four areas red, eight amber and twelve green. The red elements are;

- 2.3 - data analysis for ethnicity and deprivation, limited and completed manually
- 5.2 - Acting on the National inequalities Dashboard (included in the papers for board for the first time)
- 9.2 - Oversight of triage performance, data collected manually in the clinical area and not complete
- 9.3 - Estates challenges related to meeting the maternity triage specification on both sites
-

Outstanding Assurance requirements:

- There is limited data available to support review of maternity inequalities and identification of variation in outcomes (2.3, 5.2)
- Learning from complaints and concerns is not yet demonstrably evidenced by outcomes. (8.2)
- Neonatal workforce compliance in progress but not complete (6.3)

3. Maternity triage specification Benchmarking

There are two separate tools, one for the DRI site (Appendix 3) and one for the BDGH site (Appendix 4). This has been populated as per the requirements with the Board support required to meet the triage specifications.

The identified requirements remain;

- A data analyst to support the requirements in the specification for data collection and analysis (this is wider than triage and would support the wider maternity analysis required)
- The ability to record triage telephone conversations for quality assurance and audit purposes
- A maternity support worker to support the triage service at BDGH
- Support to separate the ante natal and gynaecology clinics at BDGH which would assist in separating the day unit and triage service at BDGH
- Support to create a quiet office space on both sites, for taking triage calls at DRI, and for confidentiality at BDGH

- Support for larger spaces on both sites to accommodate the open access required in the specification
- Development of a defined triage specific patient experience feedback approach across both sites
- Support with primary care colleagues to meet the specification requirements for pathways of care

4. Next Steps

The completed benchmarking tools represent the Trust's update report position. Following Board approval, the returns will be submitted to NHSE by 31 December 2026. The identified gaps and support requirements will be considered by the Divisional leadership team and a plan made for what can be achieved within existing resources and a case developed for elements that need trust board support.

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template							To be completed by regions			
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments	Regional Compliance Rating	Baseline vs Regional Compliance Match?	Comments	Follow up actions and improvements required
1. Listening to women and families by rolling out Martha's Rule										
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	EV 01 - 04 EV53	Launched on 13 July at DBTH, and is not embedded, evaluation planned.	Review in February (6 months) to assess whether embedded/ review any calls & actions taken	Waiting for national documents, and then will review against current process in place	Compliant	No	Rollout commenced across maternity and neonatal services. Upgraded by region.	National Marthas Rule team will collect the data.
2. Listening to women and families by ensuring that every woman has a personalised care and support plan										
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	EV 05- 11 EV 64-65				Partially compliant	No	Lack of ongoing analysis and reporting across all feedback routes.	Further evidence is required to demonstrate a systematic monthly triangulation process that brings together maternity and neonatal experience outcomes data, FFT, CQC survey intelligence, MNVP feedback and targeted engagement activity, demonstrating accessible feedback routes.
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV- 12 - 15 EV 54-57	Reports taken to quality committee as a delegated authority from the board (as per MIS standards)		Confirm whether this has to be board or can be another delegated meeting in line with the MIS standards	Partially Compliant	Yes	Quality Committee acting on behalf of Trust Board receives integrated perinatal safety, quality, workforce and experience intelligence, with actions, mitigations and escalation explicitly reviewed. Trust Partially compliant rating is upgraded regionally.	Trust to provide evidence of how information flows from Quality Committee to Board.
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust information team to identify how data can be accessed and reported and incorporate into TB reports		Non-compliant	Yes	The Trust reports ethnicity-specific outcomes and targeted engagement, and the thematic report is intended to analyse demographic/outcome disparities. However, the evidence does not yet demonstrate a mature recurring report of outcome and [illegible]	Trust to provide an update
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	QC Mins (Aug) EV58	None			Compliant	Yes	Joint executive accountability and Board/delegated oversight are evidenced through the perinatal governance route and Board Safety Champions. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV 17 - 19	The clinical director has been unable to attend meetings due to clinical commitments. This has been discussed and is being addressed	meeting dates have been shared with the clinical director and arrangements are being made to ensure his attendance at relevant meetings	The director of midwifery has attended board since 2021, since 2026 the full maternity papers goes to Quality Committee (as a delegated duty) and interim papers go to the public board, the DoM attends both	Partially Compliant	Yes	Board evidence demonstrates Director of Midwifery and limited clinical leadership participation in maternity/neonatal discussions.	Please provide an update of Maternity and Neonatal leaders attendance at Board
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	EV 20-22				Compliant	Yes	Evidence confirms PEADP cohort participation across relevant multidisciplinary groups, including service-user involvement. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust Information team to identify how data can be accessed and reported and incorporate into Board reporting		Non-compliant	Yes	Targeted inequality work, demographic intelligence and governance oversight are evidenced, but a completed six-monthly maternity/neonatal inequalities dashboard review with actions and	Trust to provide an update
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	EV 23- 24				Compliant	Yes	Quality Committee, acting on behalf of Trust Board, is asked to approve the MCB plan with milestones, responsibilities and timescales to March 2027 and quarterly review. Trust Compliant	No further action identified from the evidence reviewed.
6. Ensuring 24/7 safety and responsiveness of services										
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV 25-28	Current audit shows > 80% attendance in the year			Compliant	Yes	Rolling audit performance remained above the >=80% requirement, although July showed deterioration and requires continued monitoring. Trust Compliant rating supported.	Trust to continue monthly audit and demonstrate sustained >=80% performance, with action on the July deterioration.
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	EV 29				Compliant	Yes	The Trust-specific register evidences ongoing certification, induction and eligibility monitoring of short-term tier 2/3 locums. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	EV 30 -32	Plan agreed and business case in progress.			Partially compliant	Yes	The Trust explicitly records that relevant BAPM neonatal medical standards are not met at both sites and neonatal nursing standards are not fully met, with action plans in place. Trust Partially compliant rating supported.	Trust to provide an update
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	EV 33- 38				Compliant	Yes	Recent Birthrate Plus evidence and funded-establishment review demonstrate the required baseline and professional-judgement oversight. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV 39 -41				Compliant	Yes	The Quality Committee report states compliance with both specified ACSA requirements, supported by recurring medical and ODP rota evidence across DRI and BDGH. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV 43- 45 EV 59	People committee receive Bi-annual workforce paper CHPPD metrics for midwifery included within Integrated Performance report reviewed at every Board Operational escalation processes are aligned to Trust OPEL and out of hours arrangements and are routinely escalated through established on-call processes			Compliant	Yes	Board/delegated oversight covers acuity, staffing, capacity, service suspensions, redeployment and cross-site escalation for maternity and neonatal services. Trust Compliant rating supported.	No further action identified from the evidence reviewed.
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	Evidence to be submitted	This work needs to be undertaken and a paper submitted to the trust board with the findings Mechanisms in place for education and training around specialist midwifery activity via the REST programme SOPs and referral guidance in place.	Paper to be completed by the 3.10.26		Partially compliant	Yes	Evidence demonstrates redirection/redeployment of specialist and non-clinical resource during escalation and monitoring of deployment. However, the full review requirement also asks for training/resilience where specialist posts are unavailable and the impact of redeployment; these elements are not comprehensively evidenced. Trust Partially compliant rating supported.	Complete/document the Board review of specialist-cover training/resilience and the measured impact of redeployment across the service. Trust to confirm responsible lead and completion date.
7. Trust review of homebirth services										
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV 46- 47	Further update to be taken to the Trust board to address the working time directive and hours worked by on call midwives		MDT review of women requesting homebirth in place, individual plans made for women and their families. Risk discussed and options explored using the BRAIN process. Documented in the notes. senior midwifery support available 24/ 7 for all community midwives	Compliant	Yes	An urgent executive review was completed and covers 24/7 delivery, training/equipment, risk assessment and governance. The review itself identifies multiple areas requiring strengthening and continued [illegible] closure of these actions is not demonstrated.	Please provide an update
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable		No immediate significant risks identified that need escalation			Compliant	Yes		
8. Responding to incidents, complaints and concerns with humanity and candour										

8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	EV 48- 49	learning shared in board reports from PMRT. Families receive a PMRT outcome letter or identified learning from AARs Patient safety paper to every QC, (includes Obstetrics when relevant) Thematic review of incidents received at Patient safety assurance Group (Oct 25) Updated PSIRP for 2026 is based on an externally commissioned thematic analysis of all Datix reported incidents over the last 2 years and CNST claims and includes a Maternity related priority			Partially Compliant	Yes	PSIRF governance is clearly defined from divisional review through executive oversight and Board assurance; maternity-specific incident review, family involvement, actions and Board reporting are evidenced.	Please provide an update
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	Evidence to be submitted	Themes from the Quarterly and Annual patient experience reports to QC highlight maternity specific themes Digital patient story to QC - Feb 26 - Maternity themed (also on the HIVE for wider learning) First maternity specific thematic review to go to QC in Oct and TB in Nov.			Partially Compliant	Yes	Incident, complaint, claim and service-user themes are triangulated, actions are tracked, and learning/improvement is reported through governance.	Trust to provide an update
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	EV 50	Some debriefing undertaken but not consistent or high quality, DOC letters sent to timeframe			Partially compliant	Yes	The policy provides compassionate engagement, Family Liaison Officers/key contacts, Duty of Candour, support and trained engagement leads; perinatal reporting shows family involvement. Evidence does not fully demonstrate an embedded	Provide sampled maternity/neonatal implementation evidence for compassionate debrief, key contact, feedback use and early senior Duty of Candour, including associated training.
9. Deliver safe and effective triage in maternity services											
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	EV 60- 61	Maternity triage tool completed and on same Board agenda for consideration 1 09 2026	Complete the tool and submit tool by 25.9.26		Partially compliant	Yes	Both sites have completed benchmarking covering staffing, capacity, responsiveness and resources, with gaps identified. The evidence reviewed does not demonstrate completed Board/delegated scrutiny of the final two-site audits plus confirmation of reporting to the NHSE	Provide the final two-site audit approval/scrutiny record, confirmation of regional reporting and consolidated mitigations/actions for identified gaps.
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV 51 EV62	New board paper template adopted, and this data is now reported to the quality committed bi monthly as a delegated committee of the board			Partially compliant	Yes	regular triage and clinical review data, delays/outcomes and improvement actions are reported, but redeployment data were only planned prospectively and site/data gaps remain, particularly at Bassetlaw and for inequalities. Trust Partially compliant rating	Complete routine two-site reporting for all specified triage measures, including redeployment, staffing/capacity, escalation, outcomes, inequalities and site variation, with impact monitoring.
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant		Baseline assessment completed and submitted to board on same date as this tool	Once benchmarking completed then a plan will be developed and submitted to the board for monitoring of progress		Non-compliant	Yes	Benchmarking identifies substantial two-site gaps and the Quality Committee paper records benchmarking/development activity, but a complete two-site implementation plan demonstrating owners,	Provide and begin delivering a Board-approved two-site implementation plan aligned to the national specification, covering all identified gaps with owners, milestones/dates, risks, mitigations,
10. Post death care											
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV 52				Compliant	Yes	The submitted mortuary oversight workbook contains the completed Board Assurance Statement and confirms assurance across the required questions. Trust Compliant rating supported, subject to	Regional reviewer to verify the recorded submission date to NHS England. No further Trust action if confirmed.
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	EV 53	South Yorkshire pathology board undertaking required incident review in progress			Partially compliant	Yes	regular mortuary oversight, PSIRF actions, PAM work and executive responsibility are evidenced. However, the historical incident/HTARI review was still an active 2026 exercise with subsequent declaration/reporting deadlines, so completion at baseline is not	Provide completion evidence for the 2015-2026 incident/HTARI review and resulting declarations/actions, together with continuing Board oversight.

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governa structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission pro Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provi constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may su more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:	Bassetlaw Teaching Hospitals NHS Fo
Report prepared by:	Director of Midwifery
Report date:	1st September 2026
Reporting period covered:	To date

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	1	1	1
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	3	0	1	0	2
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	2	5
7. Trust review of homebirth services	2	1	0	0	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	3	0
9. Deliver safe and effective triage in maternity services	3	0	1	2	0
10. Post death care	2	0	0	1	1

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	EV 01 - 04 EV53	Launched on 13 July at DBTH, and is not embedded, evaluation planned.	Review in February (6 months) to assess whether embedded/ review any calls & actions taken	Waiting for national documents, and then will review against current process in place
2. Liste						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	EV 05- 11 EV 64-65			
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV- 12 - 15 EV 54-57	Reports taken to quality commitee as a delegated authority from the board (as per MIS standards)		Confirm whether this has to be board or can be another delegated meeting in line with the MIS standards
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust information team to identify how data can be accessed and reported and incorporate into TB reports	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	QC Mins (Aug) EV58	None		
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV 17 - 19	The clinical director has been unable to attend meetings due to clinical commitments. This has been discussed and is being addressed	meeting dates have been shared with the clinical director and arrangements are being made to ensure his attendance at relevant meetings	The director of midwifery has attended board since 2021, since 2026 the full maternity papers goes to Quality Commitee (as a delegated duty) and interim papers go to the public board, the DoM attends both
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	EV 20-22			
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Non-compliant	No evidence to submit	Current reports do not contain ethnicity or deprivation data	To engage Trust Information team to identify how data can be accessed and reported and incorporate into Board reporting	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	EV 23- 24			
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV 25-28	Current audit shows > 80% attendance in the year		
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	EV 29			
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	EV 30 -32	Plan agreed and business case in progress.		

6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	EV 33- 38			
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV 39 - 41			
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV 43- 45 EV 59	People committee receive Bi-annual workforce paper CHPPD metrics for midwivery included within Integrated Performance report reviewed at every Board Operational escalation processes are aligned to Trust OPEL and out of hours arrangements and are routinely escalated through established on-call processes		
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	Evidence to be submitted	This work needs to be undertaken and a paper submitted to the trust board with the findings Mechanisms in place for education and training around specialist midwifery activity via the REST programme SOPs and referral guidance in place.	Paper to be completed by the 3.10.26	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV 46- 47	Further update to be taken to the Trust board to address the working time directive and hours worked by on call midwives		MDT review of women requesting homebirth in place, individual plans made for women and their familes. Risk discussed and options explored using the BRAIN process. Documented in the notes. senior midwifery support avaiable 24/ 7 for all community midwives
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable		No immediate significant risks identified that need escalation		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	EV 48- 49	learning shared in board reports from PMRT. Families recieve a PMRT outcome letter or identified learning from AARs Patient safety paper to every QC, (includes Obstetrics when relevant) Thematic review of incidents received at Patient safety assurance Group (Oct 25) Updated PSIRP for 2026 is based on an externally commissioned thematic analysis of all Datix reported incidents over the last 2 years and CNST claims and includes a Maternity related priority		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	Evidence to be submitted	Themes from the Quarterly and Annual patient experience reports to QC highlight maternity specific themes Digital patient story to QC - Feb 26 - Maternity themed (also on the HIVE for wider learning) First maternity specific thematic review to go to QC in Oct and TB in Nov.		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	EV 50	Some debriefing undertaken but not consistent or high quality, DOC letters sent to timeframe		
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	EV 60- 61	Maternity triage tool completed and on same Board agenda for consideration 1 09 2026	Complete the tool and submit tool by 25.9.26	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV 51 EV62	New board paper template adopted, and this data is now reported to the quality committed bi monthly as a delegated committee of the board		
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant		Baseline assessment completed and submitted to board on same date as this tool	Once benchmarking completed then a plan will be developed and submitted to the board for monitorin of progress	
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV 52			
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Partially compliant	EV 53	South Yorkshire pathology board undertaking required incident review in progress		

Submission B: Progress against baseline (December 2026)

This template should be completed and submitted on **Thursday 31st December 2026**. This template reports on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline assessment, trusts should not complete this information again. The baseline status will automatically update and should indicate where any progress updates are required.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Report signed off by Trust Board (named Exec):
Trust Board sign off date:

									To be completed by Regions	
No.	**Deliverable**	**Baseline Compliance Rating**	**Current Status**	**RAG**	**Evidence ID** *Please input reference number as listed in 3. Evidence Log tab*	**Key Gaps / Risks**	**Improvement action required**	**Due Date(s)**	**Regional Compliance Rating**	**Comments**
1. Listening to women and families by rolling out Martha's Rule										
1.1	Is the trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	In progress	Amber		System embedding, and adjustments needed in the EPR.. Mat neo events in progress and data to be collected in line with the requirements	Engagement with the maternity nat neo work surrounding Martha's rule for maternity		Non-compliant	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level										
2.1	Has the trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	Complete	Green						
2.2	Is the trust board continuing to receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	In progress	Amber		Thematic review undertaken, shared with QC				
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant	In progress	Red		Data having to be collected manually, and this work is ongoing				
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	Completed at baseline	Green		No gap				
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	In progress	Green	Oct QC Mins needed	CD now joining the QC and trust board				
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	In progress	Green		Sessions booked by the key individuals, to ensure attendance at the sessions				
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Non-compliant	In progress	Red		National inequalities dashboard to be shared at trust board, PPH data not on dashboard due to a K2 reporting error that is currently being addressed by the company				
5.3	Is the trust board receiving reviewing and acting on (through the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	Compliant	In progress	Green	QC minutes needed (Oct)	MCB been to QC in October				
6. Ensuring 24/7 safety and responsiveness of services										
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	Complete	Green						
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	Complete	Green						
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	In progress	Green						
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	Complete	Green						
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	Compliant	Complete	Green						
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?		In progress	Amber						
6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	In progress	Amber						
7. Trust review of homebirth services										
7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Compliant	Complete	Green			Further paper written about complying with the working time directive for midwives on call. This needs to be reviewed at the most appropriate meeting			

7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable								
8. Responding to incidents, complaints and concerns with humanity and candour										
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant	In progress	Amber			processes being strengthened	Q3 27/28		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	In progress	Amber			processes being strengthened	Q3 27/28		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant	In progress	Amber			processes being strengthened	Q3 27/28		
9. Deliver safe and effective triage in maternity services										
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	In progress	Amber						
9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	In progress	Red		Data analyst support for collecting and analysing metrics for presentation at the maternity governance meetings and trust board. Current collected manually	Analytic / IT support for collecting metrics/ creating a dashboard for meetings			
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Non-compliant	In progress	Red		Significant estates challenges to create enough clinical space for a maternity triage described in the new specification. Triage at DRI nor big enough and is a combined space with maternity assessment at BDGH	Discussion with the estates and facilities team and trust board about what is possible within the current footprint and / or funding to improve the estate			
10. Post death care										
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	Completed at baseline							
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	In progress	Green						

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	1	Staff briefing	Document	07/07/2026	Laura Churm	Evidence folder 1		Strong
EV-02	1	Patient Wellness questions	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-03	1	Escalation Process	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-04	1	Martha's rule posters	Document	25/06/2026	Laura Churm	Evidence folder 1		Strong
EV-05	2.1	Engagement activity spreadsheet	Document	01/01/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-06	2.1	DBTH MNVP Workplan 2026-7	Document	01/04/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-07	2.1	Service Improvement Plan	Document	28/04/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-08	2.1	MNVP SUV Assuracne template	Document	20/05/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-09	2.1	Maternity Experience & Improvment group TOR		new	Janine Grayson	Evidence folder 2.1		Adequate
EV-10	2.1	Neonatal Services Improvement PLan	Document	01/07/2026	Sam Fawles	Evidence folder 2.1		Adequate
EV-11	2.1	Annual Plan for Service user Engagement April 202	Document	02/06/2026	Janine Grayson	Evidence folder 2.1		Strong
EV-12	2.2	Quality Comittee Min 23 April 2026	Document	23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-13	2.2	B3 App1 - service user annual plan		23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-14	2.2	B3 - App 2 Maternity servcie annual survey action		23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-15	2.2	B3 front cover & maternity picker survey report	Document	23/06/2026	Janine Grayson	Evidence folder 2.2		Strong
EV-16	3.1	Aug QC						
EV-17	3.2	April QC Minutes	Document	23/04/2026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-18	3.2	June QC Minutes	Document	04/062026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-19	3.2	May Borad Minutes	Document	05/05/2026	Trust	Evidence folder 3.2	DoM attendance only	Limited
EV-20	5.1	Template for PEAP	Document	07/01/2026	Janine Grayson	Evidence folder 5.1		Strong
EV-21	5.1	Allocation email	Email	08/06/2026	Janine Grayson	Evidence folder 5.1		Strong
EV-22	5.1	Information slides for participants		08/06/2026	Janine Grayson	Evidcent 5.1		Strong
EV-23	5.3	MCB template	Document	08/06/2026	Jordan Dickman	Evidence folder 5.2		Strong
EV-24	5.3	Aug QC mins	Document	08/06/2026	Trust	Evidence 5.2		Strong
EV-25	6.1	Consultant Attendance Audit Report - report June d	Document	07/03/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-26	6.1	Consultant Attendance Audit Report May 26	Document	08/05/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-27	6.1	Consultant Attendance Audit Report July 26	Document	06/03/2026	Stacey Elsworth	Evidence folder 6.1		Strong
EV-28	6.1	sop-consultant-attendance-in-maternity-gynaecology	Document	21/06/2026	Lucy May	Evidence folder 6.1		Strong
EV-29	6.2	Locum Monitoring Audit	Document	ongoing	Stacey Elsworth	Evidence Folder 6.2		Strong
EV-30	6.3	Quality Committe paper	Document	06/04/2026	Lois Mellor	Evidence folder 6.3	Plan for BAPM staffing	Strong
EV- 31	6.3	QC April Minutes	Document	21/04/2026	Trust	Evidence folder 6.3		Strong
EV- 32	6.3	QC June Minute	Document	06/04/2026	Trust	Evidence folder 6.3		Strong
EV 33	6.4	Bi-annual workforce board paper 2025 Q3 and 4 fi	Document	16/04/2026	Danielle Bhanvra	Evidence folder 6.4		Strong
EV -34	6.4	Board of Directors Minutes - 27 January 2026	Document	27/01/2026	Trust	Evidence folder 6.4		Strong
EV-35	6.4	C6 - Birthrate Plus FINAL	Document	21/04/2026	Lois Mellor	Evidence folder 6.4		Strong
EV-36	6.4	Doncaster and Bassetlaw Teaching Hospitals NHS T	Document	Nov-25		Evidence folder 6.4		Strong

EV-37	6.4	FINAL People Committee Minutes - 21 April 2026	Document	21/04/2026	Trust	Evidence folder 6.4		Strong
EV-38	6.4	Public Board of Directors Minutes - 1 July 2025	Document	07/01/2026	Trust	Evidence folder 6.4		Strong
EV- 39	6.5	BDGH On call Rota 27/07/2026	Document	27/07/2026	Sam Smith	Evidence folder 6.5	One rota more avaiable (Anaes)	Strong
EV - 40	6.5	DRI Labour 30/07/2026	Document	30/07/2026	Sam Smith	Evidence folder 6.5	One rota more avaiable (Anaes)	Strong
EV - 41	6.5	ODP July Rotas	Document	Jul-26	Sam Smith	Evidence folder 6.5	One rota more avaiable (ODP)	Strong
EV- 42	6.6	Bi-annual workforce board paper 2025 Q3 and 4 fir	Document	21/04/2026	Danielle Bhanvra	Evidence folder 6.6		Strong
EV- 43	6.6	msg-78-maternity-escalation-and-suspension-plan (	Document	Mar-23	LMNS	Evidence folder 6.6		Strong
EV- 44	6.6	sop-escalation-to-on-call-maternity-manager-and-r	Document	16/07/2026	Julie Scott	Evidence folder 6.6		Strong
EV- 45	6.6	sop-utilisation-of-specialist-midwives-for-escalation	Document		Jordan Dickman	Evidence folder 6.6		Strong
EV - 46	7.1	Executive report Homebirths	Document	Feb-26	Lois Mellor	Evidence folder 7.1		Adequate
EV - 47	7.1	Perinatal QC report	Document	08/06/2026	Trust	Evidence folder 7.1		Adequate
EV-48	8.1	6.2-CORP-RISK-36-v2-Patient-Safety-Incident-Respo	Document	06/09/2026	Trust	Evidence folder 8.1		Adequate
EV-49	8.1	TOR August 2024	Document	24-Aug	Emma Merkushev	Evidence folder 8.1		Adequate
EV- 50	8.3	Patient Safety Incident response policy	Document	06/09/2026	Trust	Evidence folder 8.3	Training defined in policy	Adequate
EV-51	9.2	Aug QC mins	Document	08/06/2026	TBO			
EV- 52	10.1	Mortuary submission	Document	26/06/2026	Nick Mallaband	Evidence folder 9.1		Adequate
EV- 53	10.2	Email HTA Update	Email		Nick Mallaband	Evidence Folder 9.2		Adequate
EV- 53	1	PSAG Martha's ruke implementation highlight repo	Document	Aug-26	Laura Churm	Evidence folder 1		Strong
EV- 54	2.2	Caring group - Maternity Action plan paper	Document	13/03/2026	Janine Grayson	Evidcence folder 2.2		Strong
EV-55	2.2	Patient Experience Annual report	Document	23/04/2026	Kirsty Clarke	Evidence folder 2.2	Includes materniity	Strong
EV-56	2.2	Quarterly patient experience report	Document	06/02/2026	Kirsty Clarke	Evidence folder 2.2	Includes maternity	Strong
EV-57	2.2	Digital stories	Learning page from the trust web pages	01/02/2006	Janine Grayson	Evidence folder 2.2	Video can be sent if required	Strong
EV-58	3.1	Paediatric Perinatal Qulaity and safety group TOR	Document	05/06/2026	Angela Lister	Evidence folder 3.1	Medical director member	Adequate
EV 59	6.6	Safe staffing guideline for Ward & departments	Document	16/12/2025	Kirsty Clarke	Evidence folder 6.6	Midwifery included	Adequate
EV- 60	9.1	Triage benchmarking DRI	Document	02/09/2026	Lois Mellor	Evidence folder 9.1		Adequate
EV- 61	9.1	Triage benchmarking BDGH	Document	02/09/2026	Lois Mellor	Evidence folder 9.1		Adequate
EV-62	9.2	New Board report template	Document	01/07/2026	Angela Lister	Evidence folder 9.2	Used with PQOM	Adequate
EV- 63	6.3	Neonatal workforce highlight report	Document	01/07/2026	Laura Churm	Evidence folder 6.3		Adequate
EV- 64	2.1	End of Year Experience survey for 2025 2026 SCBU	Document	01/07/2026	Lisa Amey- Wood	Evidence folder 2.1		Strong
EV-65	2.1	Patient experience survey neonatal wards	Document	01/07/2026	Lisa Amey- Wood	Evidence folder 2.1		Strong

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	•Board Report •Review report

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Doncaster and Bassetlaw Teaching Hospital

Please enter the **trust site** below:

DRI

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	9%	91%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	30%	50%	20%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	0%	100%	0%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	25%	75%	0%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	40%	40%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	60%	40%	0%	0%	0%	£4,000,000.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	17%	50%	25%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	40%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	29%	71%	0%	0%	£49,800.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Dashboard

Principles menu

Previous | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Next

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with the primary care to team to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self-referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Assistance with creating audio and digital translated version of information	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support to increase the footprint of the maternity triage, creating enough waiting and clinical areas to support an open access policy	
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Fully in place, embedded and evidenced	No further action required	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Increased space will be required to admit women in ante natal and possible post natal beds. There is a suggestion that women in latent (early phase of labour) should be admitted if they wish. There is also limited waiting areas for families in the service	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or paediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or paediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site Partially captures this data	Please outline what support you require from your trust board below Support to recruit data analyst
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site doesn't capture this data	Please outline what support you require from your trust board below support required to recruit data analyst
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site doesn't capture this data	Please outline what support you require from your trust board below as above
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site doesn't capture this data	Please outline what support you require from your trust board below as above

Total estimated cost to implement this principle

£0.00

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Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Fully in place, embedded and evidenced	No further action required	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Fully in place, embedded and evidenced	No further action required	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact; attendance is accepted without judgement; concerns are assessed promptly and without assumptions, including latent labour and apparently non-urgent issues.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Fully in place, embedded and evidenced	No further action required	
Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support with primary care	
Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below assistance to put in place mutual support agreements with neighbouring sites	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.	Site Partially captures this data	Please outline what support you require from your trust board below Data analyst	£0.00

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Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Fully in place, embedded and evidenced	No further action required	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below support with primary care and defining pathways for women between 4 - 6 weeks postnatally	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self-refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone	Fully in place, embedded and evidenced	No further action required	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below We have some open access for the most vulnerable women and need to open access to all	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below agreement for investment to create space for a quiet area	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Recording calls would support the audit of this and the quality of the information given	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Estimated cost to implement this principle
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Fully in place, embedded and evidenced	No further action required An agreed model has been signed off by the regional and national team that provides a broader range of feedback from all groups accessing maternity service using focussed pieces of work one of which will be triage	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Fully in place, embedded and evidenced	No further action required	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below There is no reception for maternity triage the service relies on the intercom system for the ward, and colleagues notifying them that a woman has arrived	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Triage located on CDS, there is limited waiting areas for women and a small footprint. The clinical bays are cramped relocation to another area would provide a better environment	£4,000,000.00
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Fully in place, embedded and evidenced	No further action required	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Fully in place, embedded and evidenced	No further action required	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from data assessment, antenatal clinic and other scheduled care areas.	Fully in place, embedded and evidenced	No further action required	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below The waiting area is small and is near the CDS entrance, there is no play area for small children and the staff do not have direct line of sight of the waiting area	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site doesn't capture this data	Please outline what support you require from your trust board below	£4,000,000.00

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Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Medical oversight / attendance can be sporadic as there is no dedicated doctor especially during the peak periods (4 -10 pm ish) recruitment of further ACPs	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below In place but no evidence at present no training documents / competency booklet yet	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing off staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Not relevant to local pathway/context	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focused on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.		
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language. Why: Helps identify variation and potential inequality in access, experience and outcomes.		

Total estimated cost to implement this principle

£0.00

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Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	£49,800 (Band 5 Analyst)
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and analysis of the data to inform services and improve outcomes for all women and their families	

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Total estimated cost to implement this principle

£49,800.00

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Doncaster and Bassetlaw Teaching Hospital

Please enter the **trust site** below:

BDGH

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	9%	91%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	30%	20%	50%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	0%	100%	0%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	25%	63%	13%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	20%	60%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	20%	30%	50%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	8%	50%	33%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	0%	40%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	29%	71%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below As per DRI requirement Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support with primary care to collaboratively work together to provide a seamless service from booking to 6 weeks postnatal	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self-referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Cost associated with providing accessible facilities e.g disabled toilet, waiting area for wheelchairs etc	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support to increase the footprint of the maternity traige, creating enough waiting and clinical areas to supprt an open access policy	
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Fully in place, embedded and evidenced	No further action required	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below The waiting area is extremely small at the moment and current MADU area is not suitable to deliver high quality triage care	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or pediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or pediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site Partially captures this data	Please outline what support you require from your trust board below Support to recuit data analyst
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site doesn't capture this data	Please outline what support you require from your trust board below support required to recuit data analyst
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site doesn't capture this data	Please outline what support you require from your trust board below as above
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site doesn't capture this data	Please outline what support you require from your trust board below as above

Total estimated cost to implement this principle

£0.00

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Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Fully in place, embedded and evidenced	No further action required	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Fully in place, embedded and evidenced	No further action required	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact; attendance is accepted without judgement; concerns are assessed promptly and without assumptions, including latent labour and apparently non-urgent issues.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support to separate the obstetric and gynae clinics, which would release space to separate the day assessment unit and triage on the BDGH site	
Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Fully in place, embedded and evidenced	No further action required	
Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Signage to the triage area (once it has been fully established after separating the clinics)	
Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support with primary care	
Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below assistance to put in place mutual support agreements with neighbouring sites	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.	Site Partially captures this data	Please outline what support you require from your trust board below Data analyst	£0.00

Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Fully in place, embedded and evidenced	No further action required	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below support with primary care and defining pathways for women between 4 - 6 weeks postnatally	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self-refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst	£0.00

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone	Fully in place, embedded and evidenced	No further action required	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below agreement for investment to create space for a quiet area	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site doesn't capture this data	Please outline what support you require from your trust board below Data analyst
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site doesn't capture this data	Please outline what support you require from your trust board below

Total estimated cost to implement this principle
£0.00

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Fully in place, embedded and evidenced	No further action required d national team that provides a broader range of feedback from all groups accessing maternity service u	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support required from the board to reconfigure the current spaces to give a dedicated space for triage assessment	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below As above to include private areas for assessments	
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Fully in place, embedded and evidenced	No further action required	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from data assessment, antenatal clinic and other scheduled care areas.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below BDGH day assessment and triage occupy the same area, however separation of the clinics will allow these to be located in separate areas	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Fully in place, embedded and evidenced	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site doesn't capture this data	Please outline what support you require from your trust board below	£0.00

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Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Funding for additional healthcare and the additional twilight midwife will be rostered once the NQM start (releasing a more experienced midwife from elsewhere to support triage) - it's currently offered on NHSP	£31400
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Medical oversight / attendance can be sporadic as there is no dedicated doctor especially during the peak periods (4 -10 pm ish)	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below In place but no evidence at present no training documents / competency booklet yet	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing off staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Not relevant to local pathway/context	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site doesn't capture this data	Please outline what support you require from your trust board below	

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Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focused on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.		
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language. Why: Helps identify variation and potential inequality in access, experience and outcomes.		

Total estimated cost to implement this principle

£0.00

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Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all women and their families	£49.800 (Band 5 Analyst)
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all wome and their families	
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all women and their families	
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all women and their families	
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all women and their families	
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Data Analyst to support data collection and utilisation of the data to inform services and improve outcomes for all women and their families	

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Total estimated cost to implement this principle

£0.00

2611 - E3 THIRLWALL INQUIRY REPORT IMMEDIATE ACTIONS

Discussion Item | Karen Jessop, Chief Nurse | 11:45

Laura Churn, Divisional Lead Nurse for Paediatrics
Syam Pramod, Clinical Director Acute Paediatrics
20 minutes

REFERENCES

Only PDFs are attached

E3 - Thirlwall Inquiry Report Immediate Actions.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Thirlwall Inquiry Report Immediate Actions**			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Karen Jessop, Chief Nurse			
Appendices:	Appendix 1 - Original report circulated to Board members			
Purpose of the report	~~Assurance~~	~~Approval/decision~~	~~Information~~	**Discussion**
Assurance Rationale	N/A			
Impacts on Strategic Risks (BAF 1-7)	BAF risk 1			

Executive Summary – Key messages and Issues

The Thirlwall Inquiry report was published on 15 September 2026. As board colleagues are aware NHS trusts were asked to take immediate action in relation to Board consideration of the report, the management of sudden and unexpected child deaths, implementation of the National Bereavement Care Pathway, safe insulin use, CCTV and access controls, and safeguarding assurance.

This paper is to support the required Board discussion, as identified in the letter outlining immediate actions. The initial report circulated to Board colleagues is attached at Appendix 1. Most of the actions were not due prior to board paper submission dates, a brief update on progress to date is provided below.

It is proposed that a discussion is held today, considering initial reflections and areas of exploration by Board members in relation to the published report, further to this it is proposed that a future Board development session is used to be able to dedicate sufficient time and attention to these important findings.

Recommendations

Review the progress update against the immediate actions identified as a result of the Thirlwall Inquiry report, consider adding a dedicated session to a future Trust Board development session and hold an initial discussion regarding initial reflections on the findings of the Thirlwall inquiry report.

Healthier together – delivering exceptional care for all	
Patients	Strengthens patient safety, particularly for babies and children, through safeguarding, safe insulin use, child death oversight and consistent bereavement care.
People	Supports staff safeguarding knowledge and accountability, alongside Board reflection and learning through discussion and a proposed development session.
Partnerships	Supports partnership working with SYICB and NHS England on child death oversight, independent scrutiny and shared learning.
Pounds	CCTV and access-control requirements have potential resource implications; no expenditure approval is sought through this paper.
Health Inequalities	
Legal/ Regulation:	Supports the required Board consideration of the Inquiry findings and oversight of NHS England's immediate actions; compliance remains subject to assurance.
Partner ICB strategies	

Assurance Route	
Previously considered by - including date:	Executive team meeting 23rd September 2026 Circulated to all Trust Board members w/c 28th September 2026
Any outcomes/next steps / time scales	

Progress update on actions following the immediate actions

1. Board consideration of the Thirlwall Inquiry report

The report included at appendix 1 was circulated to all the Trust Board of Directors including the link for the full report.

The amended SUDIC policy has been approved and is now live. The joint communication from the Chief Nurse and Chief Medical Officer has been circulated to all relevant staff, including those working in Emergency Departments and other areas involved in the management of sudden and unexpected child deaths. Divisional Leadership Teams are currently overseeing the process of obtaining confirmation from staff that they have received, reviewed and understood the communication and associated policy requirements. Assurance of compliance will be monitored through divisional governance arrangement.

4. Safe insulin use, CCTV and access control

A gap analysis has been completed against the required CCTV and access-control arrangements and has identified a number of areas requiring further development. Work is progressing to address the identified gaps, including the development of implementation plans and associated governance oversight. A follow-up audit is planned for Quarter 1 2027/28 to assess compliance with the GIRFT Guide to Safe Insulin Use, provide assurance regarding insulin storage arrangements, and confirm that identified actions have been implemented.

5. Safeguarding training and assurance

Safeguarding policies reviewed and adult and children policies updated to include narrative reference to deliberate harm perpetrated by staff members – these are live on the Hive.
Safeguarding liaison meetings continue across Maternity, neonates, paediatrics and ED.
Protocol in development for suspected or deliberate harm by a member of staff

Conclusion

The Trust has reviewed and strengthened its governance and reporting arrangements for child deaths to enhance oversight, with revised reporting pathways now implemented to provide greater visibility of child deaths, associated learning and assurance. In addition, consideration is being given to the role of the Medical Examiner Service and how partnership working could be incorporated to support independent scrutiny, constructive challenge and shared learning across the child death review process.

To further strengthen oversight and organisational learning, the Trust has also expanded its review processes to include significant deterioration events within paediatric and neonatal services that require escalation of care to High Dependency Unit (HDU) or Intensive Care Unit (ITU) level within the organisation. This is in addition to the existing review arrangements for patients requiring escalation of care and transfer to external tertiary centres. This enhanced approach is intended to support earlier identification of themes, improve learning opportunities and provide greater assurance regarding the quality and safety of care provided to children and neonates.

APPENDIX 1

INTRODUCTION

The Thirlwall Inquiry report into the events at the Countess of Chester Hospital between 2015 and 2018 was published on Tuesday 15 September 2026. The Trust recognises the profound impact of the report and its findings and extends its compassion to all those affected, including bereaved and affected families, patients and staff.

In response, the Chief Nursing Officer and Chief Executive Officer visited the Neonatal Unit to support staff and provide visible senior leadership. The Chief Nursing Officer returned the following day and spoke directly to families and staff. The national communication letter response was activated, including letters for patients, families and staff, to provide timely information and signpost available support.

The NHS England letter at Appendix 1 describes the next steps that HM Government intends to take in relation to the report's wider-reaching recommendations; the Trust will respond to this as further national direction is received. Several actions have also been identified for immediate progression by NHS trusts and are set out below, together with the action taken or planned by DBTH to date.

SUMMARY OF ACTIONS REQUIRED NOW (full wording in appendix 1)

1. Board consideration of the Thirlwall Inquiry report

Requirement:
The Trust must consider the Thirlwall Inquiry report and its findings at the next available public Board meeting.

Current position:
The next DBTH Board of Directors meeting in public is scheduled for 3 November 2026.

Proposed action:

- All Board members to read the Thirlwall Inquiry report and consider its implications for DBTH.
- Chief Nurse and Chief Medical Officer to submit a joint briefing paper setting out the relevant findings, the DBTH position and proposed actions to support the Board discussion.

Lead and timescale:
Chief Nurse and Chief Medical Officer - for the public Board meeting on 3 November 2026.

2. Sudden and Unexpected Death in Children (SUDIC)

Requirement:
The requirements relating to the investigation and management of every sudden and unexpected child death must be communicated urgently and explicitly to all relevant staff and to the Board.

Current position:
The Trust policy is in date and was recently reviewed following feedback received from HM Coroner, it does include the relevant requirement, although the wording could be strengthened.

Proposed action:

- Chief Nurse and Chief Medical Officer to write to all relevant staff, including Emergency Department staff, using the explicit wording from the NHS England letter and attaching the Trust policy.

- Divisional Leadership Teams to oversee confirmation that each relevant member of staff has received and read the communication.
- Strengthened wording for the policy will be incorporated by the policy author (and has been agreed by the Child death lead nurse and the Child death lead Doctor.) CNO is executive for policy and will approve as "Chair's action" additional wording which will be placed prominently at the beginning of the policy:
  Sudden and Unexpected Death in Children (SUDIC), all members of staff should be aware of what to do in response to a sudden or unexpected death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within the neonatal unit.

Lead and timescale:
Chief Nurse, Chief Medical Officer and relevant Divisional Leadership Teams - initial communication by 28th September 2026.

3. National Bereavement Care Pathway for stillbirth and neonatal death

Requirement:
The Trust must ensure that the National Bereavement Care Pathway for stillbirth and neonatal death is implemented consistently and that appropriate assurance is maintained.

Current position:
DBTH is in a good position. A Sands audit has been completed (2024) with a positive outcome, and an action plan is in place and being implemented. Progress is monitored through maternity and neonatal reporting arrangements.

Proposed action:
- Continue delivery of the existing action plan.
- Maintain oversight through maternity and neonatal governance and reporting routes.
- Escalate any gaps in compliance, experience or delivery through the established assurance arrangements.

Lead and timescale:
Director of Midwifery, Executive Oversight by CNO - ongoing, in line with the existing action plan and reporting cycle. Timeline linked to Medium Term plan.

4. Safe insulin use, CCTV and access control

Requirement:
The Trust must implement the required CCTV and access-control arrangements, with CCTV in place by 30 November 2026.

Current position:
The Director of Infrastructure is aware of the requirement as part of the wider organisational communication. Digilocks in place only, no access control in place, insulin stored in locked fridges.

Proposed action:
- Confirm the scope, implementation plan and assurance route for the required CCTV and access-control arrangements.
- Divisional Leadership Teams (with Pharmacist) to undertake an audit against the GIRFT Guide to Safe Insulin Use by w/e 30th October 2026.

- Chief Pharmacist to commission a review of insulin storage arrangements in SCBU and NNU by w/e 30th October 2026
- Any gaps identified through the audit to be addressed through a time-bound action plan and reported through the appropriate governance route.

Lead and timescale:
Executive Oversight CMO and CFO (CCTV only)
Director of Infrastructure - CCTV to be in place by 30 November 2026; audit timescale to be confirmed
Chief Pharmacist by w/e 30th October 2026
DLT by w/e 30th October 2026

5. Safeguarding training and assurance

Requirement:
The Trust must maintain clear assurance that staff have the required safeguarding knowledge, training and access to specialist advice, particularly in services caring for children and young people.

Current position:
Safeguarding training compliance is monitored through WEG and the SSG. A report on the Safeguarding Accountability and Assurance Framework is due to Quality Committee in October. Daily safeguarding liaison meetings are established for the Emergency Department and Paediatrics as an additional mitigation.

Proposed action:
- Continue monitoring safeguarding training compliance and delivery of the Safeguarding Accountability and Assurance Framework.
- Use the October Quality Committee report to identify any further gaps or actions required.
- Consider whether safeguarding compliance should also be monitored explicitly through the Performance Review Meeting process to strengthen divisional accountability.

Lead and timescale:
Executive Oversight CNO and CPO (training compliance)
Head of Safeguarding relevant Divisional Leadership Teams - Quality Committee report in October 2026

Conclusion and recommendations

The paper sets out the Trust's proposed response to the five immediate requirements communicated by NHS England, including the responsible leads, timescales and assurance routes. A review of the wider findings and recommendations within the full Thirlwall Inquiry report has also identified further areas for consideration beyond those immediate requirements. These additional findings have informed recommendations 2–5 below, which are intended to strengthen the Trust's wider arrangements for child death oversight, independent scrutiny, out-of-hospital care and safeguarding, acknowledging that there will be further requirements from NHSE in relation to the full recommendations from the Thirlwall report.

Executive colleagues are recommended to:
1. approve the proposed actions, leads, timescales and assurance arrangements set out in this paper;
2. note that the Chief Nursing Officer has engaged with the South Yorkshire Integrated Care Board regarding the expired commissioning arrangements for the child death oversight process at DBTH and agree that the outcome and any required actions should be progressed through the appropriate Governance route;
3. support reconsideration of an external review of paediatric deaths, subject to identifying a suitably qualified independent reviewer;

4. commission a review of the arrangements for authorising ad hoc out-of-hospital placements and visits; and
5. ensure relevant safeguarding policies explicitly address the risk of deliberate harm to patients by staff.

2611 - E4 TACKLING HEALTH INEQUALITIES UPDATE

Discussion Item | Michael Wright, Interim Deputy Chief Executive | 12:05

Dr Kelly Mackenzie, Consultant in Public Health
10 minutes

REFERENCES

Only PDFs are attached

E4 - Tackling Health Inequalities Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Executive Summary – Key messages and Issues

To provide an update on the tackling health inequalities work undertaken since our last report in May 2026.

- Education: 357 staff have completed Change Initiator training and 6,830 (91%) have completed SET+ training. This year's training has supported 32 QI projects with a health inequalities lens.
- Data: The Equity Index and DNA/WNB dashboards are live, and a prototype for health inequalities data in the IQPR has been developed.
- Research: PRAMS-2 has been invited to submit a full application (deadline 18 November 2026), and the PERIOD Project is progressing.
- Self-assessment: The repeat assessment (September 2026) shows improvement in Data, Insight, Evidence and Evaluation (29% to 64%) and Strategic Leadership and Accountability (67% to 83%). Capacity and Capability (88%) and System Partnerships (60%) are unchanged.
- Wider progress: The Trust has achieved Veteran Aware accreditation and the Defence Employer Recognition Scheme Silver Award, and the CQC cited our work as a strength in paediatric services.
- Delivery risks: The BEACON pilot is on hold pending additional data analyst capacity. DNA/WNB work will focus on 1–2 specialties (ENT proposed). Consultant public health capacity will reduce to 0.2 FTE and we are collectively looking at options to ensure the service is not adversely impacted.

Recommendations

The Board of Directors are asked to note progress to date.

Healthier together – delivering exceptional care for all

Patients	Tackling health inequalities will improve care for all our patients.
People	We have identified specific streams of work to reduce health inequalities for our people.
Partnerships	To effectively tackle health inequalities, we need to work with our partners as many of the root causes of inequalities relate to the wider determinants of health which our community/voluntary sector and local authority partners are best placed to support us.
Pounds	By tackling health inequalities and supporting our underserved populations, we aim to reduce demand for our services, particularly within unplanned care pathways.
Health Inequalities	This report provides an update on the health inequalities work due to be/being undertaken by the trust's Health Inequalities team.

<table>
<tr><td>Legal/ Regulation:</td><td>There are 8 CQC Key Lines of Enquiry Measures relating to health inequalities. The information presented in this paper will support the provision of evidence that we are meeting these Key Lines of Enquiry Measures.

Tackling health inequalities is mandated in the Health and Social Care Act 2022 – "…considerations also need to be given to the effects [of decisions] in relation to health inequalities. This applies to ICBs, NHS England and foundation trusts, and trust in England (the relevant bodies)." The information presented in this paper will support the provision of evidence that we are taking action to tackle health inequalities.</td></tr>
<tr><td>Partner ICB strategies</td><td>Tackling health inequalities are strategic objectives of both partner ICBs.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>N/A</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>N/A</td></tr>
<tr><td>Is this in line with Current risk appetite

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

1. Background

Health inequalities are “avoidable, unfair and systematic differences in health between different groups of people”. They mean that some population groups have significantly worse health experiences and outcomes than others. Health inequalities are experienced by our people as well as our patients.

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

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

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

We also provide an updated version of our action plan originally approved by Board in March 2025 (see Appendix 1), which outlines the key actions relating to tackling health inequalities for 2026/27, and the report of our repeat Health Inequalities Self-Assessment completed in September 2026 (see Appendix 2).

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

2. Education and awareness

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

Here are our achievements/areas of progress:

- Health inequalities training in SET+ (launched March 2025) has been completed by 6,830 of our people (91%).
- Continued roll-out of the Change Initiator training, with 357 staff trained to date (up from 230 in May 2026) and a further 7 sessions booked to the end of 2026/27 (an additional 84 places).
    - This Role Specific Training is currently allocated (via ESR) to all Band 7s and above, including those without direct patient contact, reflecting our focus on inequalities experienced by both our patients and our people. We will roll-out to Band 6’s in 2027/28.
    - We have completed “train the trainer” sessions and now have additional capacity to support the delivery of the Change Initiator training.
    - Evaluation shows that 75% of participants reported improved confidence following training, with 97.8% providing positive feedback on the course (see Fig 2).
    - This year's training has supported the development of 32 Quality Improvement (QI) projects incorporating a health inequalities perspective, demonstrating how learning is being translated into practice. Examples include outpatient letters standardisation, overcoming barriers to pulmonary rehab referrals and improving the accessibility, quality and understanding of maternity discharge information.
    - A dedicated Microsoft Teams faculty has been established, attracting 235 members and providing a platform for continued learning, sharing good practice and supporting staff to embed health inequalities into everyday service improvement.

Fig 1: DBTH Tackling Health Inequalities Training Pyramid

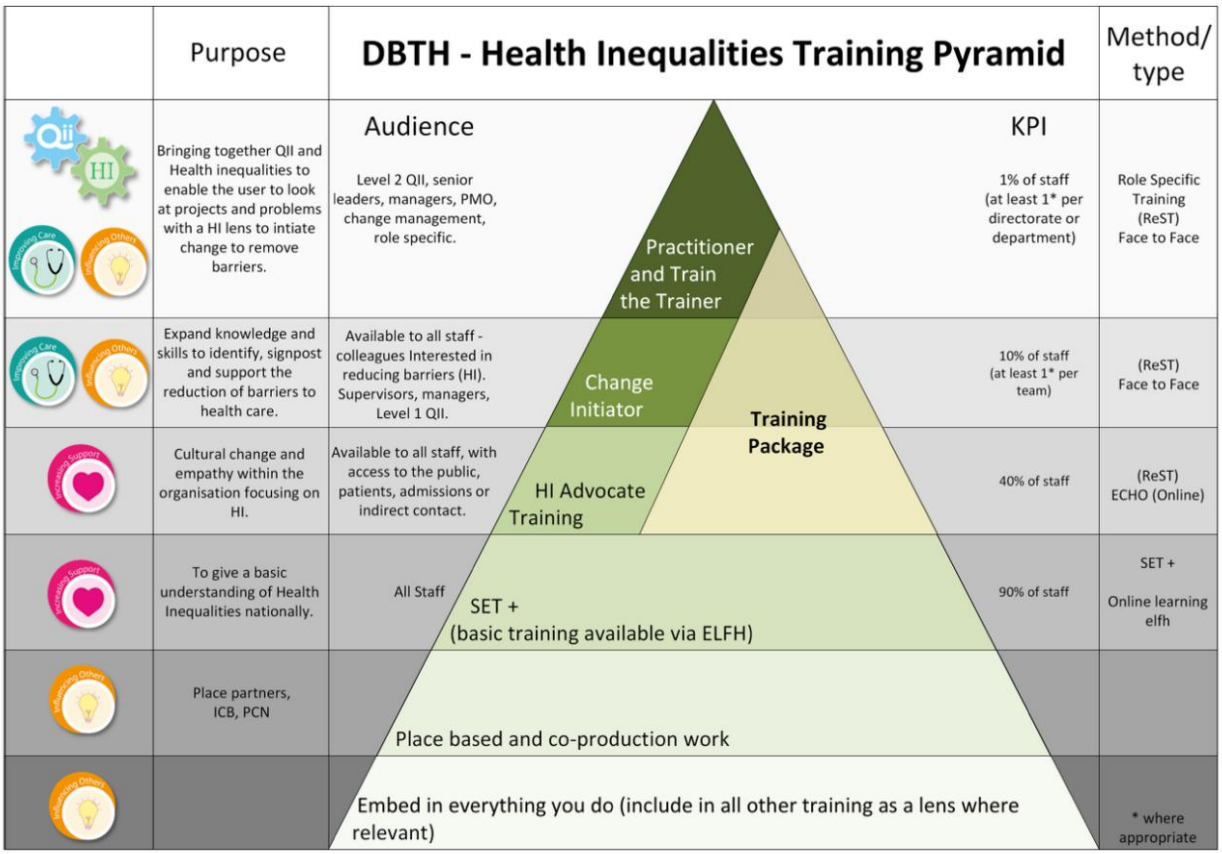
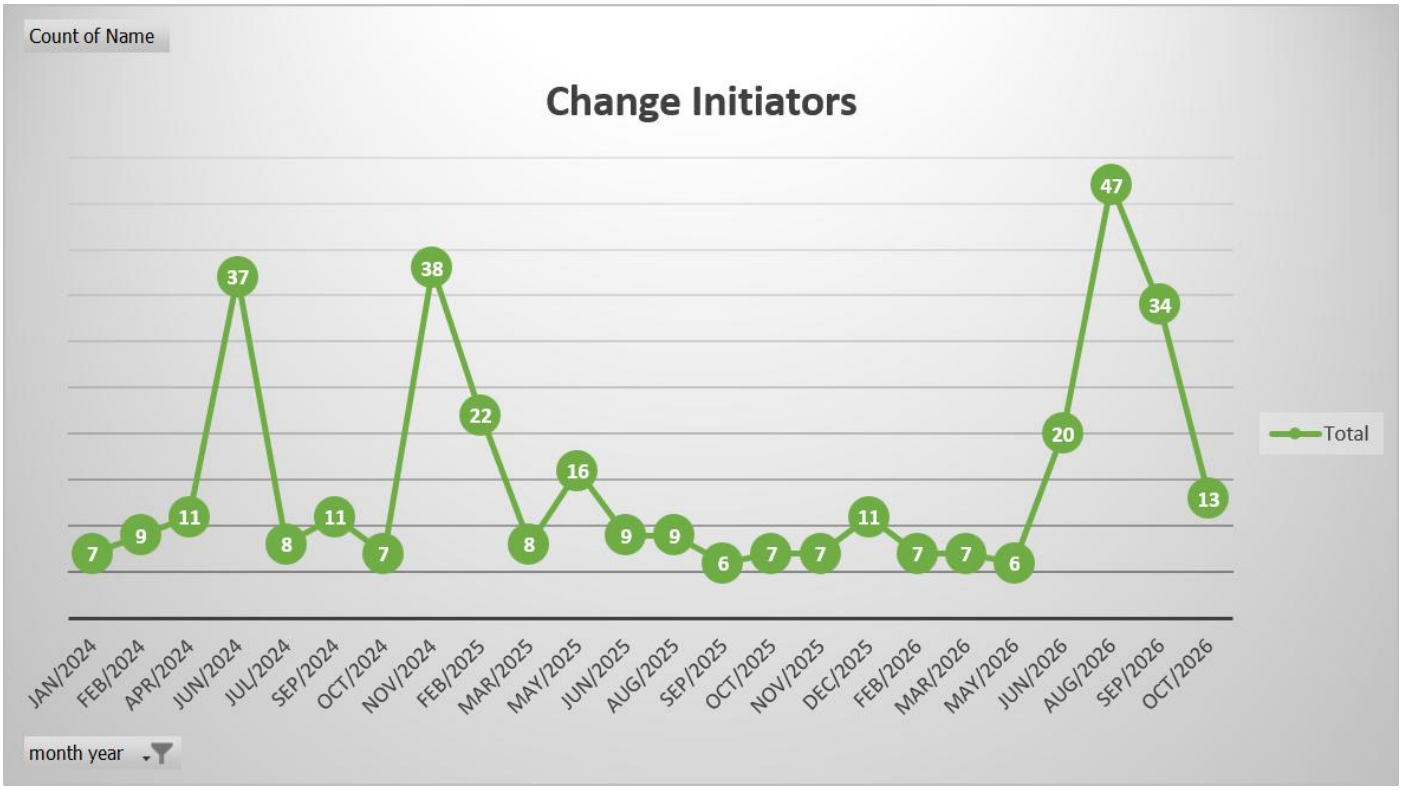


Fig 2: Numbers trained and feedback from Change Initiator training



VISIBLE RESPONSES	AVERAGE RATING	POSITIVE AGREEMENT	CONFIDENCE IMPROVED
92	9.1 / 10	97.8%	75.0%

3. Evidence-based interventions

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

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

  We set-up a working group to support the implementation of BEACON at DBTH, bringing together public health/health inequalities, operations, QI, PMO, data analysts, patient engagement, digital and planning colleagues, plus external partners from primary care and Doncaster and Bassetlaw Place. Barnsley NHS Foundation Trust colleagues are advising on how to implement BEACON in our context at no cost to the Trust. However, progress has been limited by data analyst capacity (0.25 whole time equivalent dedicated to health inequalities work programmes) where the workload has been estimated at 70 actual working days translating to 280 calendar days based on 25% workload allocation. Given the current EPR programme, the only way to progress the BEACON pilot would be to secure additional resource for data analyst time. This programme of work is currently on hold.

- **Targeted Did Not Attend (DNA) / Was Not Brought (WNB) rate reductions**
  We are supporting and developing existing work to reduce DNA/WNB rates to maximise equity. We have undertaken exploratory work to better understand the barriers patients face when accessing hospital services. This includes examining the relationship between deprivation and attendance, alongside the financial and practical challenges of travelling to hospital, including public transport availability, journey times and car ownership. Using local population data, geographical analysis and practical patient journey case studies, this work is helping to identify potential inequalities that may not be visible through routine performance data. The findings will support further investigation and inform opportunities to improve access and reduce inequalities across the Trust.

  A DNA/WNB health inequalities data dashboard has been developed to support this work (see Fig 3). In discussion with the Head of Elective Care, we will focus our work on 1-2 specialities working alongside existing initiatives to reduce DNAs whilst providing that health inequalities lens. ENT is a potential speciality which could benefit from targeted work to reduce DNAs/WNBs – first appointment DNA rates are sitting at 19% for patients in IMD decile 1 (see Fig 4).

  In addition, we are supporting the Trust-wide Patient Appointment Letter Review and Standardisation project to improve the accessibility of patient correspondence.

- **Equity-focused approach to improving access to Women's and Children's services**
  A third workstream will involve an equity-focused approach to improving access to Women's and Children's services, informed by local data and aligned to national and local priorities. The specific focus of this area of work is being developed with colleagues from the Women's and Children's Division. A working group to establish the area of focus will be set-up by the end of December 2026.

- **Research and innovation**
  The PERIOD Project, an NHS Charities Together funded project (approx. £200k) led by Dr Mackenzie and supported by DBTH Charity, aims to understand the prevalence and impacts of period poverty and menstrual health inequalities within the DBTH workforce and to co-produce practical interventions (including an online toolkit) that improve support and workplace culture, using both research and quality improvement methodologies. The project commenced in May/June 2026 and runs to the end of September 2027. A

Project Management Group is now meeting, and project set-up is underway, including recruitment of our PERIOD Panel and submission of the NHS ethics application.

Building on our NIHR-funded intervention development project (approx. £240k) examining barriers to accessing perinatal mental health care for women and pregnant people in South Yorkshire whose needs are not met by existing services, and the system-level Fair Care Framework co-designed through it, an application (PRAMS-2) has been submitted to the NIHR Research for Patient Benefit (RfPB) programme for a feasibility study of the Framework across Sheffield and Doncaster – we have now been invited to submit a full stage application (deadline for submission 18th November 2026).

Fig 3: Health inequalities DNA data dashboard screenshot

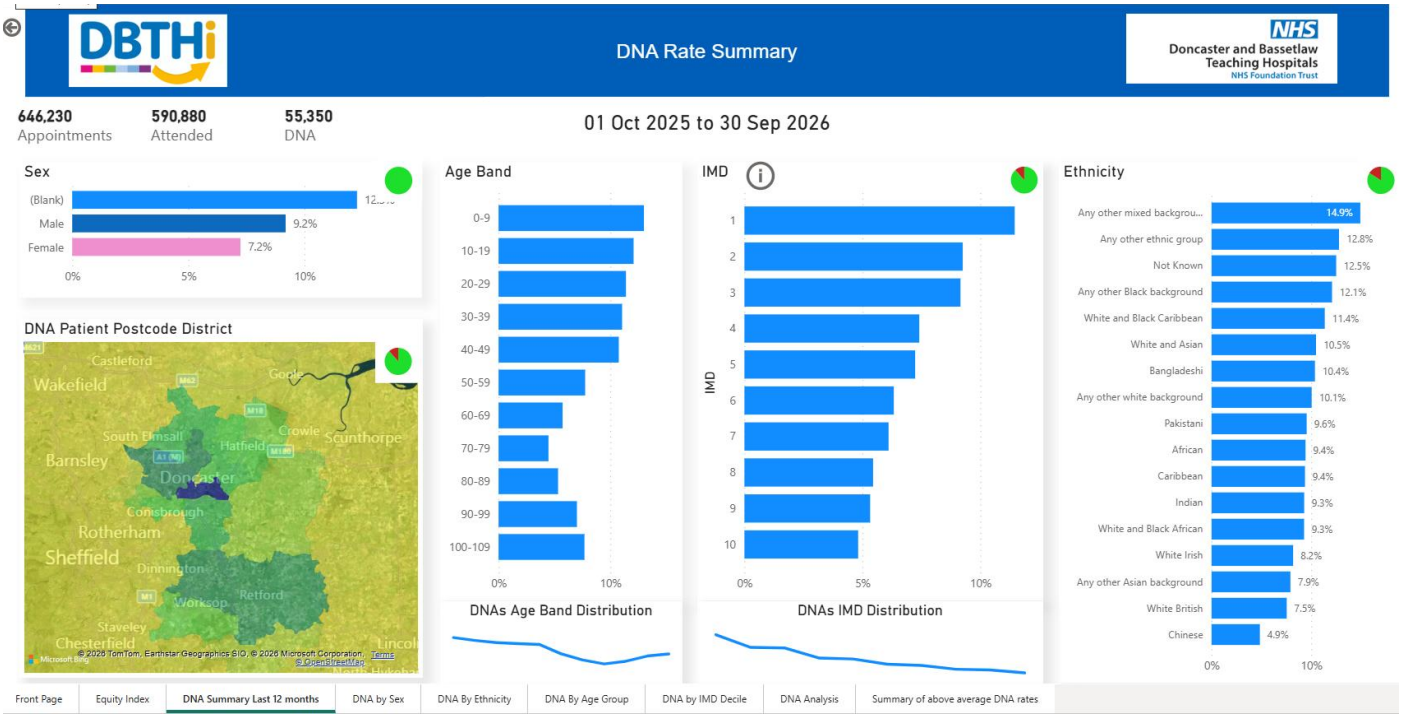
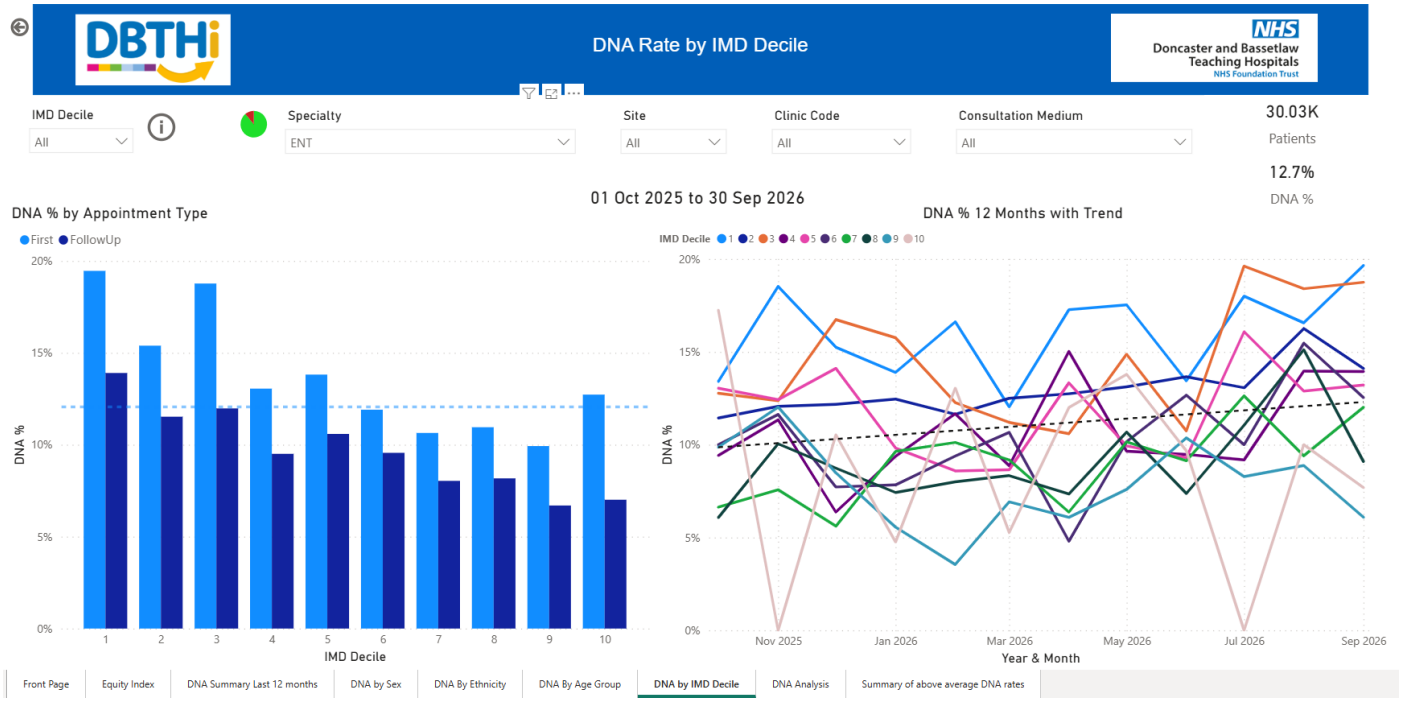


Fig 4: DNA rate by IMD decile for ENT services screenshot



4. Developing a "tackling health inequalities" culture

Governance has been further strengthened over the last 6 months. The Health Inequalities Oversight Group (HIOG) held its first formal meeting in May 2026 and met again on 1 July 2026 (September meeting stood down due to restructure consultation in Deputy Chief Executive's Directorate). Terms of Reference have been finalised, and a clear escalation route to the Hospital Leadership Team and formal six-monthly progress reporting to the Board of Directors established. The Health Inequalities Forum (HIF) continues to provide a broad, inclusive space for stakeholders, partners, and anyone with an interest in tackling health inequalities to share ideas and best practice.

In April 2025, a sub-group of the Board and the HI Team completed the HI Self-Assessment tool, which provided a baseline score for the Trust across four domains. The assessment was repeated in September 2026 (see Appendix 2), again with volunteer Board members supporting completion, and shows:

- Building Public Health Capacity and Capability: 88% (thriving) – **unchanged** from the April 2025 baseline.
- Data, Insight, Evidence and Evaluation: 64% (maturing), **up** from 29% (developing).
- Strategic Leadership and Accountability: 83% (thriving), **up** from 67% (maturing).
- Systems Partnerships: 60% (maturing) – **unchanged** from the April 2025 baseline.

The improvement in the data domain primarily reflects our work on the Equity Index (see Fig 5) and data dashboards, including ethnicity recording now meeting the national 95.3% target across all four datasets. Equity Index and Health Inequalities DNA data dashboards are now live, and we are in the process of determining how best to give colleagues access to these dashboards. The improvement in strategic leadership reflects the strengthened HIOG governance, six-monthly Board reporting and personal pledges from all Board members. System partnerships remain at maturing as recent ICB restructuring has reduced the number of system-level forums through which we would embed an equity lens in cross-organisational work; this will be a focus for 2026/27. The recommended objectives from the tool will be reviewed in detail and, where appropriate, incorporated into our action log, and the assessment will be repeated in September 2027.

An initial step has been taken to include health inequalities data in the IQPR, and routine Board-level reporting of performance data by ethnicity and deprivation is a stated priority for 2026/27. We have developed a prototype for health inequalities IQPR data (see Fig 6) but are also looking to Barnsley Hospital NHS Foundation Trust to consider if we can replicate their approach to health inequalities and IQPR.

Fig 5: Screenshot of our Equity Indices Dashboard

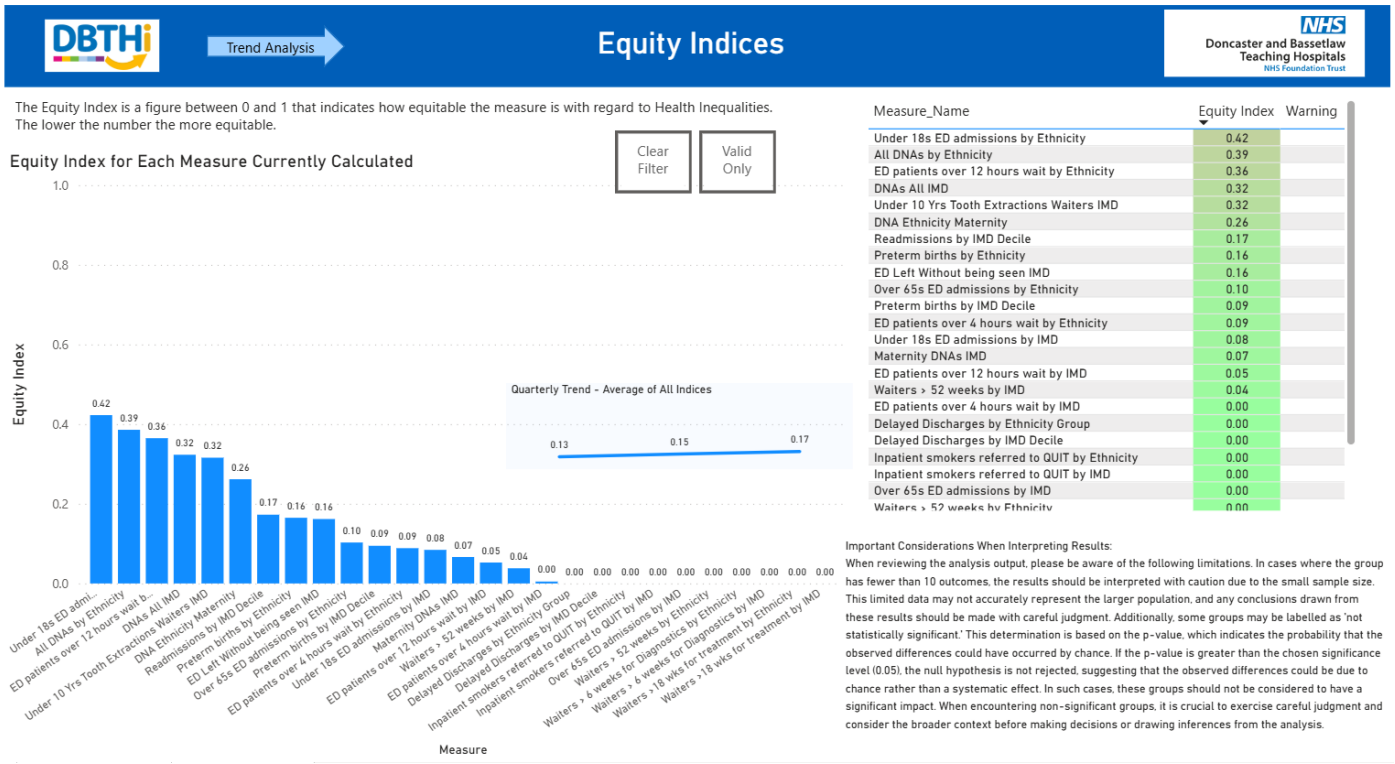
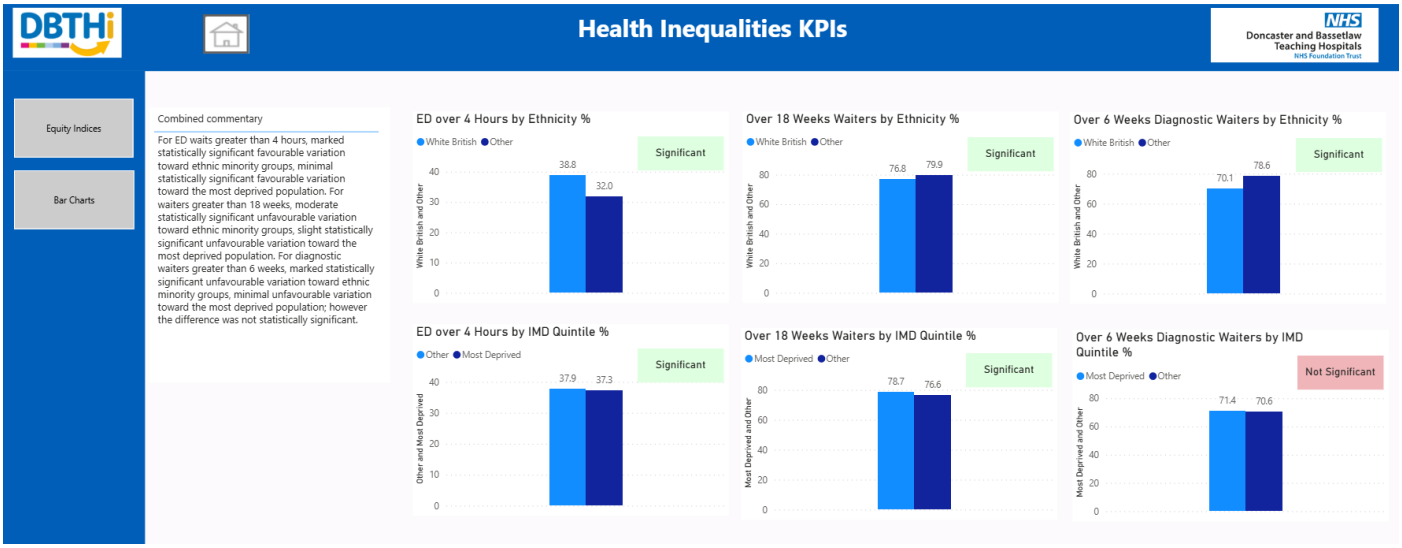
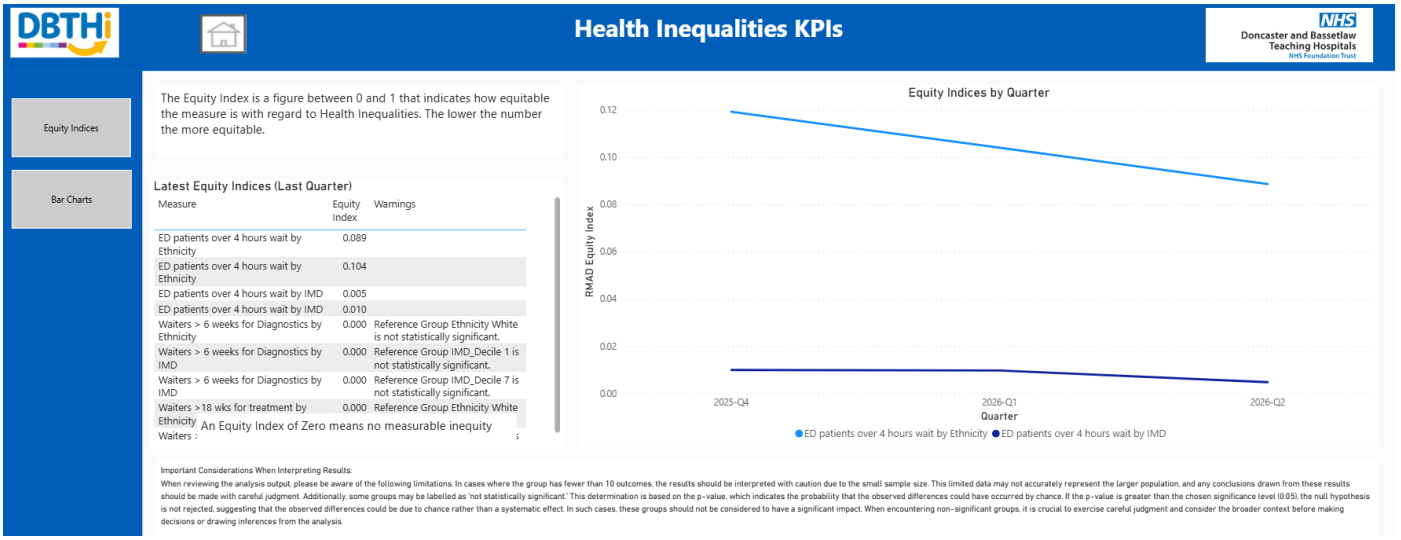


Fig 6: Health inequalities IQPR prototype screenshots





Other notable developments over the last 6 months include:

- **Healthy Hospitals Programme Team**
  We continue to work with the Healthy Hospitals Programme Team to consider how to increase the prevention offer whilst also providing a health inequalities lens. This work has been placed on pause due to the current restructure in the Deputy Chief Executive's Directorate and will be picked up again once this process has been finalised.

- **Veterans work**
  - The Trust has made significant progress in supporting the Armed Forces community, achieving Veteran Aware accreditation and the Defence Employer Recognition Scheme Silver Award.
  - Working alongside veterans and local partners, we have co-produced a Veterans Passport and accompanying patient and staff guides to improve access to care and understanding of veterans' needs. This work is being extended across Doncaster Place through veteran-awareness training for GPs and stronger links with primary care.
  - Charitable funding has also been secured for a dedicated Veteran Peer Support Worker.
  - The programme of work has received further recognition, with five nominations shortlisted across four categories at the upcoming Doncaster Armed Forces Covenant Awards, including Business of the Year, Community Engagement, Unsung Hero and Board Member of the Year.
  - The next phase will focus on embedding these improvements across services and strengthening support for veterans.

- **CQC review of paediatric services**
  The recent CQC review of paediatric services referenced our work to tackle health inequalities as a strength.

- **Community involvement**
  The Trust has continued to strengthen community involvement through the development of the Community Collective (previously known as the Citizen's Panel). Working closely with the Trust's Research and Patient Engagement teams, the Health Inequalities team is helping to create opportunities for local people and community organisations to influence service improvements, contribute to research and share their lived experiences. Work has focused on broadening membership, particularly among underserved and seldom-heard communities, through engagement with local voluntary organisations and community events across Doncaster and Bassetlaw.

  The Community Collective has already contributed to practical developments, including the Veterans Passport and reviews of patient and carer information. This collaborative approach is helping to strengthen links between research, community engagement and service improvement, moving beyond consultation towards meaningful co-production.

- **Specialist advice and support**
  The Health Inequalities team continues to provide specialist advice and support to wider Trust projects and service developments, helping teams consider health inequalities as part of their everyday work. This includes supporting improvements to translation and interpreting services, reviewing Trust-wide patient letters and communications, and advising on accessibility, digital inclusion and barriers to accessing care. This approach is helping to embed a health inequalities perspective into wider organisational decision-making, ensuring that service improvements consider the different needs and circumstances of our patients.

5. Next steps

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

1. Education and awareness – continued roll-out of our Change Initiator training, with 7 further sessions booked to the end of 2026/27 (an additional 84 places).
2. Evidence-based interventions ("top priorities") – involving trust-level quality improvement work, support from the DBTHi team will be sought as well as relevant clinical input:
    a. Fair waiting list pilot on hold for now – need to explore potential for additional data analyst support to progress this work.
    b. Targeted DNA/WNB rate reduction – work with Head of Elective Care to determine which specialities to do some targeted work on.
    c. Equity-focused approach to Women's and Children's services – set-up a working group by end of December 2026 and determine the area of focus by March 2027.
    d. Delivering targeted health inequalities research – progress the PERIOD Project and develop a stage 2 full application to NIHR RfPB for PRAMS 2.
3. Embedding tackling health inequalities into everything we do:
    a. Implementation of the Equity Index and DNA Health Inequalities Data Dashboards across the Trust, and embedding routine reporting of health inequalities data (by ethnicity and deprivation) in the IQPR.
    b. Reviewing the recommended objectives from the September 2026 Self-Assessment and incorporating them into our action log, with particular focus on strengthening system partnerships; the assessment will be repeated in September 2027.

6. Risks and issues

The following risks are ongoing:

- Capacity – the HI Team currently comprises 1 x FTE HI Development Manager (Band 8a) and 0.5 x FTE Consultant in Public Health. However, the current Consultant in Public Health (KM) has been offered an

additional role at the University of Sheffield, reducing availability to 0.2 x WTE. We are collectively looking at options to ensure the service is not adversely impacted.

- Prioritisation – there is no specific ring-fenced budget to support the delivery of agreed HI priorities. Funding for discrete projects and other initiatives would accelerate delivery and impact, yet it is recognised that the financial environment is constrained, and investments would require business cases to support.
- Cultural change and embedding improvements – whilst addressing health inequalities remains a key priority for the organisation, wider changes to working practices, processes and governance will be required to truly embrace the agenda and underpin delivery of the transformative improvements required.
- System change – recent ICB restructuring has reduced the number of system-level forums through which an equity lens can be embedded in cross-organisational work, which may limit the pace of progress on system partnerships.

Appendix 1: Tackling Health Inequalities Work Plan

Programmes of Work	Action	KPIs / Measures	Lead	Timescale	RAG Rating
Education and awareness raising	Deliver Change Initiator Training to staff required to complete	Deliver Change Initiator Training to a further 75 of our people (357 trained to date; 8 further sessions booked to the end March 2027, an additional 84 places)	HI Team with support from Education Team	By end Mar 2027	In progress
	Use a "train the trainer" model to build a faculty to support the delivery of the Change Initiator Training	Deliver 2 x "train the trainer" sessions	HI Team	By end Dec 2026	Done
	Explore roll-out of Health Inequalities Advocate Training as part of Role-Specific Training – **On hold due to national changes in mandatory training**	Discuss with Education Team / Director of Education and Research (ECHO-model Advocate Training pilot completed via Aspiring Matrons Programme)	HI Team and Education Team	By end Jun 2026	On hold
	Continue to work closely with comms team to enhance the profile of health inequalities across the Trust	Deliver comms plan and amend / update as required	HI Team and Comms Team	Ongoing	Ongoing
Fair waiting list pilot	Determine which clinical teams are going to pilot the Fair Waiting List Initiative (BEACON) ensuring a range of teams are included (e.g. medicine, surgery, CSS, and paeds) and set-up a working group to progress the pilot work – **On hold due to data analyst capacity**	Complete pilot work with three specialities	HI Team with support from DBTHi Team	By end Mar 2027	On hold
Equitable DNA / WNB rate reductions	Undertake groundwork to understand baseline DNA / WNB data with a HI lens, current teams involved in managing DNAs / WNBs, and existing work happening across the Trust to reduce DNAs / WNBs.	Develop, implement, and evaluate initiatives to reduce DNAs / WNBs with a HI lens and demonstrate a reduction in the equity indices and overall DNA rates	HI Team with support from DBTHi Team	By end Mar 2027	In progress
An equity-focussed approach to improving access to	Begin initial meetings with key people in the Trust (e.g. Janine Grayson, Lois Mellor, Katherine Simpson etc) to scope out existing work happening in the Trust and with	Set-up a working group to progress work	HI Team with support from DBTHi Team	By end Sep 2026	In progress
		Determine an area of focus	HI Team with support from DBTHi Team	By end Mar 2027	In progress

Women and Children's services	partners to understand current work in this space and how we might want to support	Develop, implement and evaluate initiatives to improve access to Women and Children's services	HI Team with support from DBTHi Team	By end Mar 2028	In progress
Data and evidence	Start using national and local dashboards to report our HI data as part of IQPR and other reports as relevant	IQPR to include HI data (initial slide added to IQPR)	HI Team & Performance Team	By end Sep 2026	In progress
	Equity index and HI DNA data dashboards to go live	Equity index and HI DNA data dashboards to go live and available to relevant staff	Information Analysts with support from HI Team	By end Dec 2026	In progress
Research – The PERIOD Project	Project set-up	Recruit to vacant posts	KM & PERIOD Project Team	By end Sep 2026	Done
	Apply for NHS ethics approval	Secure ethics approval	KM & PERIOD Project Team	By end Sep 2026	Done
	Develop and distribute questionnaire	Questionnaire completed	KM & PERIOD Project Team	By end Jan 2026	In progress
Research – PRAMS2	Complete full stage application	Application submitted	KM and PRAMS2 team	By end Nov 2026	In progress
Leadership and Board action	Re-complete self-assessment tool (small sub-group of the Board) and compare to initial benchmark which was completed in April 2025	Self-assessment tool measures reassessed (completed September 2026 – see Appendix 2)	HI Team, Deputy CE plus other Board member volunteers	By end May 2026	Done
	Incorporate recommendations into action log	Recommendations included and acted upon	HI Team	By end Dec 2026	In progress
Reactive work	Determine the focus of the Healthy Hospitals Programme Phase 2 (HHP2) work and support the roll-out of this – **On hold due to current restructure in Deputy Chief Exec's Directorate**	Have a clear HHP2 plan	HHP Team plus HI and DBTHi Teams	By end Aug 2026	On hold



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DBTH Health Inequalities Self-Assessment Tool Sept 2025

Content

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Introduction

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". They mean that some population groups have significantly worse health experiences and outcomes than others.

This health inequalities self-assessment tool is designed to be used alongside the Reducing Health Inequalities Guide for NHS Trust Board Members. The tool contains 25 questions across 4 domains (as outlined below) and will provide a score and maturity rating for DBTH's position in each of these domains. We completed a baseline assessment in April 2025 and this report refers to a follow-up assessment completed in September 2026. Both times, volunteer members from the Board supported completion of this tool.

At DBTH we want to do all we can to tackle unfair health inequalities. The scores obtained from this tool are for internal use only and will be used as a baseline assessment to support our health inequalities work prioritisation. The tool will be completed on an annual basis to continually assess our progress and help prioritise future work.

Overall scoring

Domains	Score Apr 25	% Complete Apr 25	Level Apr 25	Score Sep 26	% Complete Sep 26	Level Sep 26
1. Building public health capacity & capability	7	88%	Thriving	7	88%	Thriving
2. Data, insight, evidence and evaluation	4	29%	Developing	9	64%	Maturing
3. Strategic leadership & accountability	12	67%	Maturing	15	83%	Thriving
4. System partnerships	6	60%	Maturing	6	60%	Maturing

Recommended objectives

Domain 1: Building public health capacity & capability – Thriving

2.3	NEDs: All NEDs to seek opportunities for personal development on health inequalities
3.3	Chief executive: Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these
3.8	Chief executive: Ensure that board members, senior leaders (Band 9 and Very Senior Managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
4.10	Executive lead for health inequalities: Ensure there are systems in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities
5.6	People: Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles
5.7	People: Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant
10.6	Clinical, quality and research: Build in-house capacity and capability for health inequalities research work

Domain 2: Data, insight, evidence and evaluation – Maturing

3.10	Chief executive: Include equality and health inequalities related impacts and risks in board and committee papers (including minutes), alongside actions for how they will be mitigated and managed
8.2	Operations/delivery: Ensure a trust wide focus on inclusive recovery and operational improvement through an equity lens
8.3	Operations/delivery: Establish a culture of data reporting among staff on health inequalities outcomes, and on the impact of health inequality initiatives. Consider staff training to enable staff to feel confident in asking questions around ethnicity
9.6	Data, digital and information: Consider how digital technology, such as electronic patient record systems, could be used to support health inequalities decision making
9.9	Data, digital and information: Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups)

10.5	Clinical, quality and research: Work with research partners and in partnership with other NHS organisations to ensure participation in relevant research related to health inequalities, to develop an evidence-base on the effectiveness of provider led interventions to tackle inequalities
10.9	Clinical, quality and research: Consider active case finding approaches to reduce health inequalities, such as hypertension case finding and early cancer diagnosis
10.11	Clinical, quality and research: Engage with groups that may not be traditionally involved in research or quality improvement, such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups

Domain 3: Strategic leadership & accountability – Thriving

4.2	Executive lead for health inequalities: Ensure integrated working with HR and equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality
6.2	Strategy: Embed an equity lens across all organisational priorities, strategic documents and annual planning processes
7.2	Finance: Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives

Domain 4: System partnerships – Maturing

4.8	Executive lead for health inequalities: Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems
4.11	Executive lead for health inequalities: Work collaboratively with executive board members leading on the organisation’s anchor institutions work, to ensure alignment with the health inequalities agenda
4.12	Executive lead for health inequalities: Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations
8.6	Operations/delivery: Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms

Scoring and rationale

Domain 1: Building Public Health Capacity and Capability				
	Question	**Response April 2025**	**Response Sept 2026**	
1	Has your board received training and/or development on health inequalities?	Yes – The board have received several session with the Health inequalities (HI) team including two development session over the past two years. Aspirational would be for board members to complete the Change initiators course.	Yes – the Board received a development session in September 2026, alongside regular six-monthly HIOG updates to the Board of Directors. Some Board members have completed Change Initiator training, and all Board members have made personal Health Inequalities pledges. To note – Board members have recently changed so need to review and recognise need to regularly provide Board development sessions.	Yes
2	Does your trust deliver regular training to all staff groups on health inequalities?	Yes – Currently over 4,200 (62.3%) of staff have received at least the basic ELearning for health module on Health Inequalities. The trust made this SET+ in January. Over 150 staff have completed the change imitator training. Please see Training matrix	Yes – 6,830 (91%) staff have completed the Health Inequalities SET+ e-learning module (launched March 2025), and 312 staff have completed Change Initiator training (12 more sessions booked to the end of 2026/27 which equates to an additional 144). A Health Inequalities Advocate Training pilot has also been completed (ECHO model, via the Aspiring Matrons Programme), and the DBTH training model is in discussion for a system-wide 'train the trainer' rollout across South Yorkshire acute trusts.	Yes
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Yes – HI in now included in QII training levels 1 and 2 giving a HI lens to all QII work streams and projects. Specific QI projects with a HI Lens are now underway including Pulmonary rehab.	Yes – HI is now flagged on Monday.com for all QI projects, making HI/QI work easier to identify. In the last 12 months, 30 QI projects have been identified as having a HI element. Workstreams underway include DNA/WNB reduction work, the BEACON fair-waiting-list pilot, and veterans' health. Recent CQC review of paediatric services referenced tackling health inequalities work as a strength.	Yes
4	Does your trust employ public health specialist	Partial – Dr Kelly Mackenzie is the public health specialist for Health inequalities at the trust.	Partial – as previous	Partial

	staff and is the wider workforce encouraged to develop public health expertise?	It was felt that we do not meet the wider workforce Public health expertise mentioned in the question.		
Domain 2: Data Insight, Evidence and Evaluation				
	Question	**Response April 2025**	**Response Sept 2026**	
1	Is your trust's data on patient ethnicity accurate and comprehensive?	Partial – Although data is collected we are aware there are issues with the collection and quality of this data, currently at around 70%. Work is underway to improve the data set and accuracy.	Yes – ethnicity recording now meets the national 95.3% target on a Commissioning Data Sets (CDS) basis across all four datasets: Admitted Patient Care 95.58%, Non-Admitted Care 94.12%, Emergency Care 93.64%, Maternity above 99%. NB: The internal Data Quality reporting at DBTH is aligned to the national CDS methodology, whereby code 'Z' (Not Stated) is treated as valid and therefore contributes to the overall valid performance rate. While this is consistent with the national reporting standards, we appreciate that code 'Z' still represents an unknown ethnicity from a health inequalities perspective. Not Known or Not Stated rates for 2025/26 are: Admitted Patient Care 4.42%, Non-Admitted Care 5.88%, Emergency Care 6.36%, Maternity 0.16% Some groups remain under-represented within standard national ethnicity categories (e.g. Gypsy, Roma and Traveller communities).	Yes ⬆
2	Does your trust board routinely receive performance data broken down by ethnicity and deprivation?	No – Work is underway to incorporate HI data into dashboards and data sets for the trust, but this is not yet reported to board. Initial step to incorporate a slide into the IQPR.	No – An initial step has been taken (a slide added to the IQPR), and health inequalities data is reported to the Board six-monthly via HIOG, but routine board-level reporting of performance data disaggregated by ethnicity and deprivation is not yet embedded. This is a stated priority for 2026/27.	No

3	Does your trust use existing population health data (e.g. population demographics and index of multiple deprivation) in your analysis of trust-level data?	No – The IMD is now built into the Cube but no further work has taken place to utilise this data at a trust level. No data analyst time/ support available at this time to understand the background population to enable accurate interpretation of the wider population data.	Partial – IMD data is linked into the Trust's data warehouse and is used extensively within the Equity Index, which scores inequity by IMD across over 20 KPIs (e.g. ED waits, DNA rates, maternity outcomes). This is a substantial step beyond the April 2025 position. Allocated a partial as data are being used by the Health Inequalities Team. For a "Yes" data needs to be used more widely across the trust.	Partial ⇧
4	Has your trust taken part in any research related to health inequalities?	Partial – This is an emerging area with Dr Mackenzie's role linking research and Health inequalities with several projects in the pipeline and submissions for funding and grants underway. Other work streams have already taken place such as the Babi-D project.	Yes – research activity has expanded significantly: the REFRAME collaboration (NIHR Maternity Disparities Consortium), the PRAMS-2 NIHR RfPB application and feasibility study, the PERIOD Project (NHS Charities Together-funded), alongside the ongoing Babi-D project.	Yes ⇧
5	Has your trust carried out engagement with communities to inform work on health inequalities?	Partial – some links are in place with a handful of inclusion health groups especially where a focused piece of work is taking place. The trust has also become partners with the People Focus group in Doncaster Further work is needed to develop true representation of the community, patients and people.	Yes – the Trust's Citizens' Panel/Community Collective is now operational and providing lived-experience input, alongside continued partnership with the People Focus Group (PFG), and more recent engagement activities with veterans' groups and deaf society. The latter engagement activities have culminated in the development of veterans and deaf peer support roles in the trust. Further work is still needed to ensure true representation of communities and patients.	Yes ⇧
6	Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes?	Partial – several pockets of work and good practice have been introduced across the trust such as the HIUG and Maternity.	Partial – DNA and waiting-list work is underway, including the BEACON fair-waiting-list pilot and the DNA/WNB dashboard. A Women's & Children's services equity improvement workstream is planned for 2026/27, targeting outcomes for women and children in deprived and ethnic minority communities.	Partial

7	Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population?	No – Lots of silo work has been underway but no formal review of accessibility specifically around digital exclusion in relation to the digital transformation agenda. Work needs to be done to understand the current position of the trust whilst taking into account the local population data around digital exclusion.	Partial – a Trust-Wide Patient Appointment Letter Review and Standardisation project is underway to improve accessibility of patient correspondence, and digital exclusion now forms part of Change Initiator training. Local digital exclusion data has been profiled against population deprivation/demographic data, though a formal, trust-wide review of service accessibility against digital and health literacy rates hasn't yet been completed.	Partial ⇧
Domain 3: Strategic Leadership and Accountability				
	Question	**Response April 2025**	**Response Sept 2026**	
1	Does your trust have commitments to reducing health inequalities within its strategy documents?	Yes – The trust has a specific HI and Health inequalities is now one of the 4 key trust objectives.	Yes – as previous	Yes
2	Does your trust have a named board-level Executive Lead for health inequalities?	Yes – Deputy Chief Executive	Yes – as previous	Yes
3	Does your board have health inequalities objectives set in your annual review process?	No – There was some confusion whether this question refers to the appraisal cycle or Business planning cycle. The group decided it was referring to the Appraisal Cycle which HI is currently not part of.	Partial – different perspective taken this time – it was felt that this should be scored as a partial as the trust objectives are being met, foundational work is in place, but still not embedded (e.g. health inequalities data still needs to be embedded into IQPR).	Partial ⇧
4	Is your Executive lead for health inequalities providing strategic leadership and embedding an equity lens into cross-organisational work?	Partial – Although the Executive lead is in place and providing strategic direction, it was felt this was still very new and that embedding an equity lens cross-organisational was not yet in Place across partnership work. It was mentioned that DBTH does have membership at several meeting and committees across Place and that this was a strong starting point for this work.	Partial – as previous. NB: Recent changes to ICB structures have reduced the number of system-level forums for embedding an equity lens into cross-organisational work.	Partial

5	Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight?	Yes – Health Inequalities has a governance structure that has been in place for 18 months, including a HI steering group and reporting into F and P. This is currently being updated and reviewed and an up-to-date TOR is being written. Although a structure is in place the trust needs to ensure oversight is robust at board level and strengthens the challenge to divisions and understands the impacts on Health inequalities on services. Please see proposed governance diagram	Yes, and now strengthened – new HIOG provides six-monthly formal reporting to the Board of Directors, its Terms of Reference have been finalised, and health inequalities case studies were trialled at Public Board in November 2025 with a positive response. All Board members have made personal Health Inequalities pledges.	Yes
6	Does your trust/board use a health inequalities impact assessment tool in your business case process?	Yes – The Health Equity Impact assessment tool has been incorporated into the Business case template. Health Inequalities is also a question within the QPIA on Monday.com Need to monitor if the correct checks are in place for minor and complex business cases/ assurance checks.	Yes, and now strengthened – the Health Equity Impact Assessment (HEIA) remains embedded in the Trust's business case template, and health inequalities is a required question within the QPIA on Monday.com. KM reviews complex business cases to review and provide feedback on completed HEIA. Health inequalities impacts also included in all trust committee cover sheets.	Yes
7	In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?	No – Currently no examples of where trust resources (financial or otherwise) have been used to invest in services with a direct Health Inequalities focus. With the current financial pressures this is not seen as a viable option at the moment. It was acknowledged that KM and RW's posts are resources funded to tackle HI but that this didn't answer the question as it refers to investing in identified opportunities and services.	Partial – we have established our QUIT programme across the trust. Based on quality improvement work with our audiology services, we have invested in greater access to BSL interpreters. It was again acknowledged that KM and RW's posts are resources funded to tackle HI but that this didn't answer the question as it refers to investing in identified opportunities and services.	Partial

8	Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members?	Partial – Although there are several initiatives such as financial support, health and wellbeing initiatives that there is more that can be done to truly understand our people. For example, understand our staffing breakdown to identity HI In the workforce, postcode to IMD data.	Yes – multiple areas of work. The PERIOD Project (NHS Charities Together-funded work on period poverty and menstrual health inequalities in the DBTH workforce) is a concrete example of staff-focused health inequalities work. Wider links between health inequalities, EDI and staff health and wellbeing are ongoing, but a full understanding of workforce-level inequalities (e.g. staffing breakdown by postcode/IMD) is still to be completed. Veterans recognition scheme. Our Change Initiator training programme is now being rolled out to Band 7's (most of whom have management responsibilities) and above including those without direct patient contact and this is because the focus of our training is on inequalities being faced by both our patients and our people.	Yes ⇧
9	Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities?	Yes – The Core20Plus 5 is at the heart of the HI strategy.	Yes – as previous	Yes
Domain 4: Systems Partnerships				
	Question	**Response April 2025**	**Response Sept 2026**	
1	Is your trust represented on appropriate Integrated Care System group(s) to contribute to population health decision making in your region?	Yes – Key staff attend several local and regional meetings that have a focus on Health inequalities/ population health groups.	Yes – as previous, although with changes to ICB many of these meetings have ceased to exist.	Yes
2	Is your trust contributing to anchor institution working?	Partial – We are an Anchor institution by default, and we do as a trust contribute and work to address the key Anchor areas such as sustainability and local procurement, but more work could be done.	Partial – as previous	Partial
3	Does your trust have programmes in place to improve access to	Partial – work underway around pathways to work, inclusive recruitment and work with local schools and colleges.	Partial – as previous	Partial

	employment to underrepresented groups in your organisation?			
4	Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Partial – The trust has engaged in work such as Waterdale and Health on the high street but it was felt that this wasn't purely HI led and that more could be done.	Partial – as previous, programmes are not being done with a focus on health inequalities but mindful of impact on HIs	Partial
5	Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Partial – Some work has been done around education but more work to be done.	Partial – as previous, and now also includes the Veterans work, and collaboration with the deaf society when working to improve audiology services.	Partial

Summary

The self-assessment tool was completed by a sub-group from the Trust Board with support from the Health Inequalities Team.

From the overall scoring (see page 1), there have been improvements in two domains: data insight, evidence and evaluation (64% complete, up from 29%) and strategic leadership and accountability (83% complete, up from 67%). This primarily relates to developments in our data dashboards and Equity Index – ethnicity recording now meets the national 95.3% target across all four datasets, and the Equity Index scores inequity by ethnicity and IMD across over 20 KPIs – alongside strengthened HIOG governance, with six-monthly Board reporting, finalised Terms of Reference, and personal Health Inequalities pledges from all Board members.

Building public health capacity and capability remains Thriving (88%), with 6,830 staff (91%) now having completed HI SET+ training and 312 having completed Change Initiator training. Our health inequalities work was referenced as a strength in the recent CQC review of paediatric services, and 30 quality improvement projects in the last 12 months have been identified as having a health inequalities element. System partnerships remains at maturing (60%) – recent ICB restructuring has reduced the number of system-level forums through which we would embed an equity lens in cross-organisational work, and this will be a focus for 2026/27.

The recommended objectives (see pages 2-3) from the self-assessment tool will be reviewed in detail and where appropriate incorporated into our existing action log.

2611 - F PEOPLE

12:15

2611 - F1 GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 12:15

Dr Mohammad Khan, Guardian of Safe Working Hours
10 minutes

REFERENCES

Only PDFs are attached

F1 - Guardian of Safe Working Hours Quarterly Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Guardian of Safe Working Hours Quarterly Report**			
Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Mohammad I Khan, Guardian of Safe Working Hours			
Appendices:	N/A			
Purpose of the report	**Assurance**	~~Approval/decision~~	~~Information~~	~~Discussion~~
Proposed assurance Level	*Moderate Assurance*			
Assurance Rationale	The Board is asked to take assurance that there are controls and processes in place regarding exception reporting, which ensures that the vast majority of resident doctors can work safely and within the defined contractual hours with any issues being identified and actions taken. However, there are times when resident doctors feel there is inadequacy of clinical support, feel overworked, understaffed in some areas and miss educational opportunities			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2			

Executive Summary – Key messages and Issues

This report includes data for a three-month period between 1 April 2026 and 30 June 2026. All the data has been collected using Healthrota which is the software used to exception report by the resident doctors.

The total number of exception reports (ERs) submitted from 1 April 2026 until 30 June 2026 is 257. The vast majority of ERs were filed by foundation year (FY) doctors or residents in their earlier journey in training (242 vs 15 by ST4 or above) indicating the pressure the doctors early in their careers feel especially in the major busy specialties.

The highest number of ERs have been submitted by trainees working in General Surgery, medical specialties followed by Obstetrics/Gynaecology during this period. The majority of ERs are submitted in relation to additional hours worked, reflecting the high workload of resident doctors, often compounded by rota gaps, vacancies, seasonal pressures, leave, inadequate locum provision/cover and the need for extra cover. There have been 17 reports in relation to missed educational opportunities.

The Board of Directors can be assured that the vast majority of resident doctors are able to work safely and that there are appropriate controls and processes in place for monitoring, with any issues being highlighted and actions taken. Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics. Departments have been requested to identify where this remains a challenge and to support resident doctors to maximise their training opportunities. Departments explore all possible options in supporting resident doctors to maximise their training opportunities. Medical Education team members engage with specialities to safeguard training opportunities for doctors.

Recommendations

The Board is asked to take moderate assurance that there are appropriate controls and processes in place regarding exception reporting, which ensures that the vast majority of resident doctors can work safely and within the defined contractual hours. However, there are challenges that remain to be addressed to make further improvements.

Healthier together – delivering exceptional care for all	
Patients	Resident doctors support the delivery of safe and effective patient care.
People	The Guardian of Safe Working Hours role supports the resident doctors workforce.
Partnerships	The Guardian of Safe Working Hours is part of regional and national networks to share learning and knowledge.
Pounds	The report describes the use of medical bank/agency usage and the application of fines.
Health Inequalities	None identified.
Legal/ Regulation:	**-**
Partner ICB strategies	-
Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

QUARTERLY REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Mohammad I Khan, Guardian of Safe Working Hours

Report date: 03 November 2026

Introduction

This report sets out the information from the Guardian of Safe Working Hours (GOSWH) with regards to the 2016 Terms and Conditions for resident doctors to assure the Board of the safe working of resident doctors. This is Quarterly report for the period 01 April 2026 to 30 June 2026. The report has been modified to follow the national template provided by NHS Employers (NHSE) and will follow the recommendations for both quarterly as well as annual reports. Hence this is the first report for the first quarter of 2026 to follow this template as recommended by NHSE.

1. **Number of exception reports submitted in this quarter**

The total number of exception reports (ERs) submitted in this quarter is 257. The following table shows breakdown of the ERs per specialty, 1 April 2026 to 30 June 2026.

Specialty	Total
Acute	**22**
BDGH Cardio	**8**
BDGH Diabetes & Endocrine	**26**
BDGH Gastro	**5**
Cardio	**1**
Diabetes & Endocrine	**10**
Elderly / Stroke	**16**
Haem	**1**
General Surgery	**53**
Non-restored Dept	**20**
Obs and Gynaecology	**30**
Paediatrics	**9**
Resp	**1**
Renal	**10**
Respiratory	**3**
U & E	**5**
Urology	**26**
Vascular	**11**
Grand Total	**257**

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

2. Categories of Exception Reports

The following table shows the reasons for all ERs being submitted, 1 April 2026 to 30 June 2026.

Additional Hours- an unscheduled early start	1
Additional Hours- an unscheduled late finish	207
Breaches of non-resident on-call patterns	0
Inability to take contractual breaks	26
Inadequacy of clinical support	2
Inadequacy of rostered skills mix	3
Raising concerns of suspected non-compliant rota pattern	0
Detriment or threat of detriment related to exception reporting	0
Information breach	0
Access and completion resolved in time	0
Access and completion breaches	0
Access and completion test	1
Missed educational opportunities	17
Total	**257**

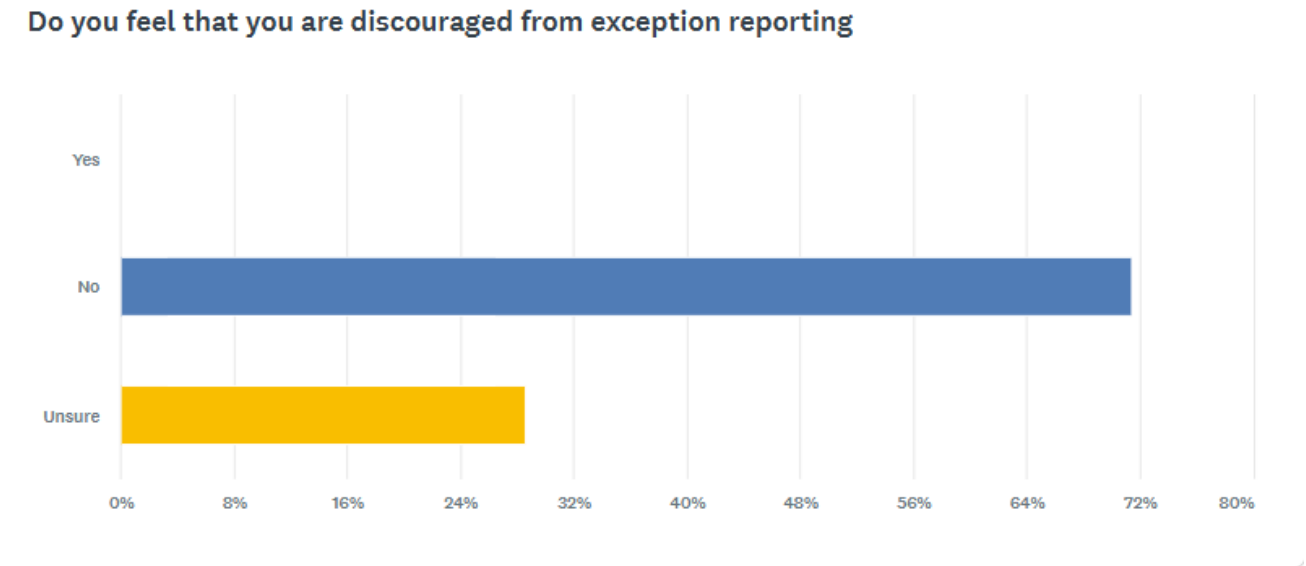
During this two-month period, the vast majority (91%) of ERs were submitted in relation to additional hours worked with or without missed breaks, reflecting the high workload of resident doctors requiring them to stay late in order to ensure patient safety. Seven percent of reports were made in relation to missed educational opportunities, and the most common reason was work pressures (sick patients, busy shift etc) or being understaffed (including sickness, rota gaps, vacancies and inadequate locum cover). There were also 2% ERs for inadequate support/skill mix during the shift from the foundation year doctors on a very busy shift or being responsible for quite a few patients in various locations.

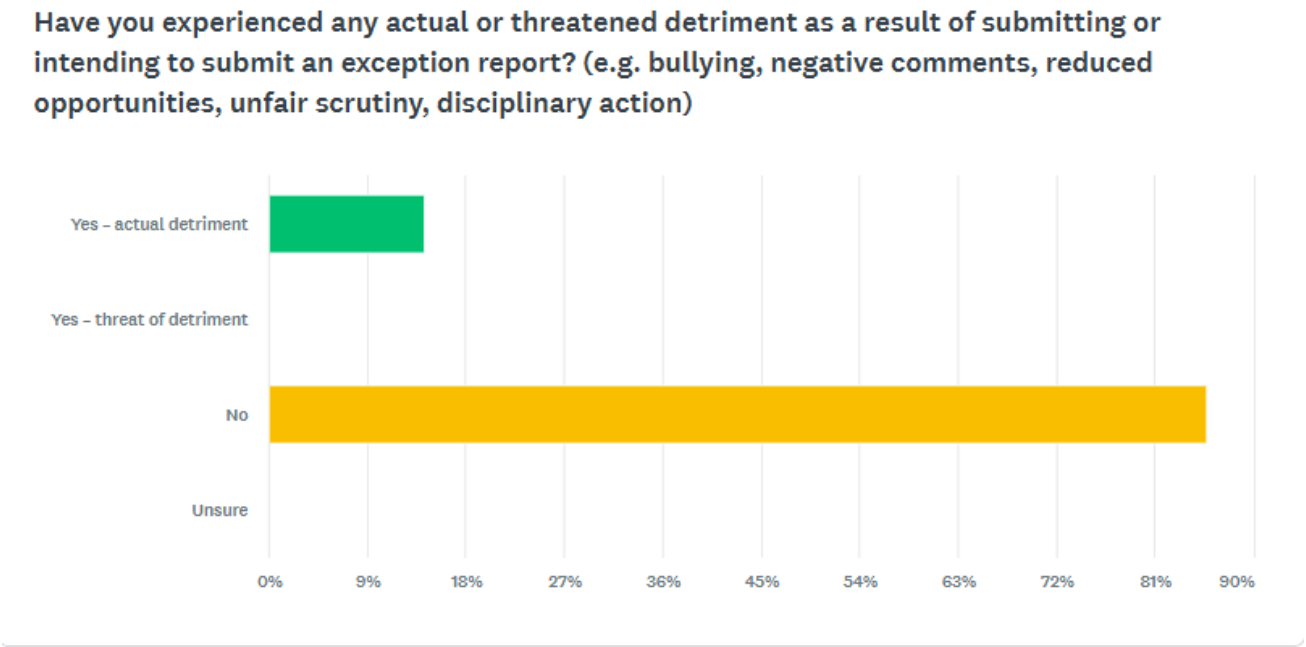
3. Experiences of actual or threatened detriment

As per NHSE requirement, actual or threatened detriment needs to be surveyed on a quarterly basis. A survey was set up and sent to all resident doctors and responses were collected anonymously. The survey was sent to 294 resident doctors and 7 responses were received.

Quarterly response rate	2%
Doctors experiencing actual detriment as a result of exception reporting	14%
Doctors feeling that they are not discouraged from exception reporting	70%

The following graphs show the results of the survey using bar charts:





4. Withdrawals

The total number of withdrawn reports is 46 for this quarter which includes reports withdrawn by the residents or by the Trust on behalf of the resident doctor mainly due to lack of response from the resident doctors when clarifications are needed to look into the ER. The reasons include requesting consent, further details regarding the submitted ER, time date evidence for late finish etc.

5. Access to individual doctors' exception reporting data

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

Number of exception report disclosures over the last quarter	0

6. Number for work schedule reviews related to exception reporting pattern/instances

Number of work schedules reviews requested related to exception reporting patterns or instances	1
Number of work schedules reviews undertaken related to exception reporting patterns or instances	0

A resident doctor in medicine submitted an exception report for missed educational opportunity after being unable to take study leave for a course. The advice given was to arrange a swap for her shift before the study day off could be approved. The doctor concerned requested work schedule review after working on the day and reporting being overstaffed. The doctor could not find a swap and felt leave could have been granted without impacting work. This did not lead to formal work schedule review as advice was given to discuss with the rota co-ordinators and local team members to understand decision making and rules regarding planned leave.

7. Rota Gaps on all shifts

Total number of rota gaps on all shifts this quarter	3152

8. Disbursement of Fines

Fines	Number of fines	Fine paid to RD	Fine paid to GOSWH
Additional hours worked breach	4	£114.37	£259.55
Information breach	0		
Access and completion breach	0		
Missed breaks breach	0		
Total	**4**	**£114.37**	**£259.55**

The money received from fines is kept in a designated fund which is used for the benefit of resident doctors.

Table 1. Number of exception reports by doctors' grade, April 2026 to June 2026

FY1/2	CT1/2	ST1-3	ST4-8	Total
76%	6%	12%	6%	100%

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

Table 2. Comparison for Time off in Lieu vs Payment where applicable, 1 April 2026 to 30 June 2026

Exception Reports with TOIL granted	20%
Exception Reports with payment	80%

9. Locum bookings

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

Table 3. Gaps in respective specialities covered by internal bank along with the cost for this quarter

Specialty	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Acute Medicine	117	1141	£73,143
Anaesthetics and Critical Care	54	639	£43,835
Anaesthetics and Theatres	28	293	£20,393
Care of the Elderly	174	1524	£113,151
Emergency Medicine	621	5588	£396,229
General Medicine	42	331	£18,939
General Surgery	39	420	£21,130
Obstetrics and Gynaecology	151	1428	£108,891
Orthopaedic and Trauma Surgery	343	3495	£219,876
Paediatrics	1	13	£1,000
Paediatrics and Neonates	174	2019	£155,476
Renal Medicine	9	112	£8,360
Respiratory Medicine	48	419	£28,666
Stroke Medicine	28	215	£14,928
Urology	28	290	£11,355
Endocrinology and Diabetes	92	944	£58,410
Gastroenterology	35	316	£24,556
Vascular Surgery	7	47	£1,650
Cardiology (Medical)	33	378	£28,340
Rheumatology	25	311	£23,819
Infectious Diseases	12	132	£9,560
Haematology	3	29	£1,993
ENT	102	1087	£62,950
Podiatric Surgery	1	4	£220
Grand Total	**2167**	**21171**	**£1,446,869**

Table 4. Gaps in respective specialities covered by agency along with the cost for this quarter

Specialty	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Acute Medicine	15	152	£8,761
Care of the Elderly	80	708	£33,889
Emergency Medicine	1057	9418	£774,233
General Medicine	61	509	£22,693
General Surgery	41	488	£28,221
Obstetrics and Gynaecology	63	716	£65,526
Orthopaedic and Trauma Surgery	245	2339	£172,312
Paediatrics and Neonates	91	1083	£97,644
Respiratory Medicine	6	64	£2,850
Breast Surgery	40	440	£20,413
Urology	185	1689	£129,332
Endocrinology and Diabetes	9	85	£3,564
Gastroenterology	2	24	£1,637
Vascular Surgery	38	508	£39,323
Infectious Diseases	2	22	£828
MEOC Orthopaedic and Trauma	5	63	£3,094
ENT	134	1148	£92,624
Grand Total	**2074**	**19451**	**£1,496,941**

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

Table 5. Gaps in respective specialities that could not be filled during this quarter

Specialty	Data Count of Job No	Sum of Estimated Quantity
Acute Medicine	3	24
Anaesthetics and Critical Care	2	17
Care of the Elderly	3	22
Emergency Medicine	7	69
General Medicine	3	27
General Surgery	2	23
Orthopaedic and Trauma Surgery	2	16
Renal Medicine	1	13
Respiratory Medicine	1	13
Urology	6	57
Endocrinology and Diabetes	3	33
Gastroenterology	1	8
Cardiology (Medical)	1	13
Rheumatology	2	25
ENT	2	7
Grand Total	**39**	**365**

Table 6. Reasons for internal bank usage, 1 April 2026 to 30 June 2026

Reason	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Annual Leave	84	756	£56,273
Compassionate/Special leave	8	90	£5,729
Extra Cover	104	885	£51,491
Restricted Duties	14	170	£13,388
Sick	136	1265	£76,494
Study Leave	5	43	£2,201
Vacancy	1045	9978	£662,114
Strike	294	3044	£260,389
Maternity/Paternity leave	27	319	£21,805
Exempt from on calls for health reasons	38	418	£26,851
Entrustability	5	62	£4,420
Induction/Rotation	5	51	£2,778
Additional session	63	621	£39,650
Seasonal Pressures	19	179	£7,604
Vacancy - Less Than FT Trainee Gap	116	1201	£77,781
Vacancy – Deanary Gap	141	1439	£95,148
Created By Job Import	2	25	£1,960
Less Than FT Trainee Gap	44	432	£27,303
Deanarygap-vacancy	12	130	£9,585
Acting Down	5	67	£3,908
Grand Total	**2167**	**21171**	**£1,446,869**

Table 7. Reasons for agency usage, 1 April 2026 to 30 June 2026

Reason	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Annual Leave	57	593	£49,854
Compassionate/Special leave	6	69	£6,337
Extra Cover	70	678	£41,669
Restricted Duties	2	25	£2,125
Sick	34	351	£21,638
Vacancy	1584	14394	£1,158,855
Strike	33	318	£19,239
Maternity/Paternity leave	34	324	£21,032
Exempt from on calls for health reasons	28	336	£15,348
Entrustability	4	49	£4,165
Induction/Rotation	7	87	£6,146
Additional session	11	138	£7,166
Seasonal Pressures	63	569	£31,169
Vacancy - Less Than FT Trainee Gap	42	490	£39,746
Vacancy – Deanary Gap	78	829	£60,136
Created By Job Import	2	24	£1,053
Less Than FT Trainee Gap	18	173	£10,912
Deanarygap-vacancy	1	8	£350
Grand Total	**2074**	**19451**	**£1,496,941**

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

Table 8. Reasons for shifts that remained unfilled, 1 April 2026 to 30 June 2026

Reason	Data Count of Job No	Sum of Estimated Quantity
Annual Leave	2	16
Compassionate/Special leave	2	18
Extra Cover	1	8
Sick	5	50
Vacancy	18	154
Strike	7	75
Exempt from on calls for health reasons	1	13
Seasonal Pressures	1	13
Vacancy - Less Than FT Trainee Gap	1	12
Less Than FT Trainee Gap	1	7
Grand Total	**39**	**365**

Table 9. Breakdown by grade covered by internal bank

Grade	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
SpR 3+	903	9030	£740,483
FY 2	21	225	£11,475
Core Trainee	1192	11470	£677,146
FY 1	51	446	£17,765
Grand Total	**2167**	**21171**	**£1,446,869**

Table 10. Breakdown by grade covered by agency

Grade	Data Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
SpR 3+	1584	14711	£1,273,225
FY 2	27	316	£14,738
Core Trainee	418	3920	£190,345
FY 1	45	505	£18,633
Grand Total	**2074**	**19451**	**£1,496,941**

Table 11. Breakdown of jobs that remained unfilled along with grades

Grade	Data Count of Job No	Sum of Estimated Quantity
SpR 3+	19	188
FY 2	1	13
Core Trainee	17	144
FY 1	2	20
Grand Total	**39**	**365**

10. Vacancies

In this period, monthly rota vacancies have decreased and were at 42 WTE in June 2026.

	VACANCIES (WTE)	Posts	Apr-26	May-26	Jun-26
Medicine	**Specialty Medicine**	**69**	**6.1**	**7.1**	**7.1**
	FY1	**18**	0.2	0.2	0.2
	FY2	**6**	0	0	0
	CT/ST GPST 1-3	**19**	2.4	2.4	2.4
	ST3+	**26**	3.5	4.5	4.5
	Elderly Medicine	**22**	**3.2**	**3.8**	**3.8**
	FY1	**3**	0.2	0.2	0.2
	FY2 (No FY2 placements)	**0**	0	0	0
	CT/ST GPST 1-3	**15**	1.4	1.4	1.4
	ST3+	**4**	1.6	2.2	2.2
	Renal	**7**	**1.2**	**1**	**1**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**6**	0.2	0	0
	CT/ST GPST 1-3	**0**	0	0	0
	ST3+	**1**	1	1	1
U&EC	**Urgent & Emergency Care**	**37**	**7**	**7**	**7**
	FY1	**5**	0	0	0
	FY2	**5**	0	0	0
	CT/ST GPST 1-3	**25**	7	7	7
	ST3+	**2**	0	0	0
Women's & Children's	**Obstetrics & Gynaecology**	**29**	**4.4**	**4.4**	**4.4**
	FY1	**3**	0	0	0
	FY2	**3**	2	2	2
	CT/ST GPST 1-3	**12**	1.4	1.4	1.4
	ST3+	**11**	1	1	1
	Paediatrics	**35**	**2.2**	**1.8**	**1.8**
	FY1	**4**	0	0	0
	FY2	**3**	1.2	1.2	1.2
	CT/ST GPST 1-3	**20**	1	0.6	0.6
	ST3+	**8**	0	0	0

Surgery & Cancer	**ENT**	**8**	**2.8**	**2**	**2**
	FY1	**0**	0	0	0
	FY2	**2**	1	0.2	0.2
	CT/ST GPST 1-3	**3**	0.2	0.2	0.2
	ST3+	**3**	1.6	1.6	1.6
	General Surgery	**27**	**4**	**4**	**4**
	FY1	**10**	1	1	1
	FY2	**2**	0	0	0
	CT/ST GPST 1-3	**7**	3	3	3
	ST3+	**8**	0	0	0
	Ophthalmology	**14**	**0.2**	**0.2**	**0.2**
	ST3+	**2**	0.2	0.2	0.2
	Urology	**7**	**5.6**	**5.6**	**5.6**
	FY1	**2**	0.2	0.2	0.2
	FY2	**3**	1	1	1
	CT/ST GPST 1-3	**0**	0	0	0
	ST3+	**2**	0	0	0
	Trauma & Orthopaedics	**6**	**2.2**	**2.2**	**2.2**
	FY1	**0**	0	0	0
	FY2	**1**	0	0	0
	CT/ST GPST 1-3	**5**	2	2	2
	ST3+	**5**	0.2	0.2	0.2
	Vascular	**8**	**2.2**	**2.2**	**1.2**
	FY1	**3**	0.2	0.2	0.2
	FY2	**1**	0	0	0
	ST3+	**4**	2	2	1
Clinical Specialities	**Anaesthetics**	**16**	**0.9**	**0.9**	**0.9**
	FY1(No FY1 placements)	**0**	0	0	0
	FY2	**0**	0	0	0
	CT/ST GPST 1-3	**11**	0.2	0.2	0.2
	ST3+	**5**	0.7	0.7	0.7
	ICT	**12**	**0.8**	**0.8**	**0.8**
	FY1(No FY1 placements)	**0**	0	0	0
	FY2	**6**	0.4	0.4	0.4
	CT/ST GPST 1-3	**4**	0.2	0.2	0.2
	ST3+	**2**	0.2	0.2	0.2
	Total	**332**	**42.8**	**43**	**42**

Further information

The last Resident Doctors' Forum (RDF) meeting took place on 16 September 2026 which had improved attendance from the resident doctors. The resident doctors raised various points for discussions regarding ER submissions and the challenges they face. There are also concerns raised regarding workload, staffing levels out of hours and supervision in surgical specialities. All the concerns have been escalated to the appropriate channels awaiting decisions on improving resident doctors working patterns especially out of hours.

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

Summary and Recommendation

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

The Board of Directors can be assured that the majority of trainee doctors are able to work safely. Trainees are used to the system of reporting through Healthrota and there is positive feedback on the ease of using the app. Monthly regular meetings run between GOSWH and HR colleagues to action any outstanding ERs and make timely decisions. Supervisors, tutors or departmental leads are only contacted after receiving the trainee's consent for issues raised or to improve services. There are challenges in certain areas regarding workload, staffing levels and supervision which needs attention to benefit working lives for resident doctors.

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

2611 - G GOVERNANCE

12:25

2611 - G1 CONSTITUTION, SCHEME OF RESERVATION & DELEGATION AND STANDING FINANCIAL INSTRUCTIONS

Decision Item | Sam Wilde, Chief Finance Officer | 12:25

Brenda Thomas, Interim Company Secretary
5 minutes

REFERENCES

Only PDFs are attached

- G1 - Constitution, SoRD and Standing Financial Instructions.pdf
- G1 - Appendix 1 - Constitution -v1.5.pdf
- G1 - Appendix 2 - Scheme of Reservation and Delegation.pdf
- G1 - Appendix 3 - SFIs version 1.2 - v2.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report			
Meeting Title:	**Board of Directors**	**Meeting Date:**	**3 November 2026**
Report Title/ Ref:	**Constitution, Scheme of Reservation and Delegation and Standing Financial Instructions review 2026**		
Executive Sponsors:	Sam Wilde, Chief Finance Officer Richard Jenkins, Interim Chief Executive Officer		
Authors:	Brenda Thomas, Interim Company Secretary		
Appendices:	Appendix 1: Constitution including Standing Orders version 1.5 - redrafted following Board review (changes in red, deletions struck through) Appendix 2: Scheme of Reservation and Delegation version 1.5 - redrafted following Board review (changes in red, deletions struck through) Appendix 3: Standing Financial Instructions Version 1.2		
Purpose of the report	~~Assurance~~	**Decision**	~~Information~~ ~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	All BAF risks are positively impacted by governance improvements		
For decision papers only: Is this in line with Current risk appetite YES	Highlight **only** where this report is outside of the Board Risk Appetite and a decision is requested		

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Executive Summary – Key messages and Issues

Purpose

This report sets out the further changes made to the key governance documents for the Trust following the Board of Directors' request for a second review. These were presented to the Audit and Risk Committee at its meeting on 15 October 2026, to consider and decide to recommend to the Board of Directors and in the case of the constitution to the Council of Governors.

Background

The Audit and Risk Committee at its meeting on 23 July 2026 reviewed and recommended to the Board of Directors for approval, the Trust Constitution (including Standing Orders), Scheme of Reservation and Delegation and Standing Financial Instructions.

The Board at its meeting on 1 September 2026 did not approve them and asked that they be reviewed again. The documents have since been benchmarked against the Code of Governance for NHS Provider Trusts, the NHS England model core constitution and the constitutions of other well-governed foundation trusts, to identify areas that should be brought out or made explicit, and to correct administrative errors.

Constitution (including Standing Orders)

The annual governance cycle reviews and updates the key governance documents to ensure these are up to date with the latest legislation and reflect any governance changes within the Trust.

The Constitution (Appendix 1) is a jointly owned document with the Council of Governors and will also require their approval. The approved version will need to be published and shared with NHS England in line with the NHS Provider licence NHS1 Section 4 condition 2a.

The DBTH Constitution was substantially reviewed in 2025 which included the re-incorporation of the Standing Orders for the Board of Directors into its annexes, and alignment to the model trust constitution. Following this, another review was done which saw minor changes, the most notable being a reduction in staff governors from

6 to 4 which is above the minimum 3 staff governors as outlined in the NHS 2006 Act Schedule 7, plus a realignment with governor quoracy for vote requirements for key appointment decisions. This is in anticipation of a greater number of governors engaged following the recent elections, which will support the required proportions of voting governors.

Following a further review requested by the Board, a summary of the changes now proposed to the Constitution and Standing Orders (Appendix 1) are detailed below. The further changes are highlighted in red texts and deletions crossed out, whilst the initial changes made and submitted to the last Board meeting remain tracked.

i. Definitions: Appointed Governors now includes Local Authority Governors; new definitions of Code of Governance, Regulator and Regulatory Framework; Registered Medical Practitioner Act reference, Secretary and Senior Independent Director definitions corrected.

ii. Clarifying that the executive director registered as a medical practitioner or a registered dentist must have a licence to practice (within the meaning of the Dentists Act 1984) (paragraph 25.7).

iii. Independence: at least half the Board (excluding the Chair) are to be independent non-executive directors (paragraph 25.11).

iv. Tenure: the nine-year maximum for the Chair and non-executive directors is now explicit, runs from first appointment to the Board (including time served as a non-executive director before becoming Chair), and extensions beyond six years require rigorous review and, where required, NHS England agreement (paragraphs 28.1 and 28.2; Deputy Chair at 30.2).

v. Members of the Nominations and Renumeration Committee to be fixed and appointed by the Council of Governors (in line with the Code of Governance), rather than appointing different governors for every meeting via email ballot. Also making provision for a meeting of the Committee that would otherwise be inquorate (paragraph 28.8.4).

vi. Audit and Risk Committee: the Audit and Risk Committee's composition is aligned to the Code of Governance - three independent non-executive directors, the Chair not a member, and at least one member with recent and relevant financial experience (paragraph 42.2).

vii. Annual Members' Meeting: the 30 September deadline is stated in the main body (section 13) as well as in Annex 9.

viii. Corrections: Standing Order and paragraph cross-references, committee names, grammar, and the front-page approval and review dates; the contents page is refreshed so headings and page numbers match.

Scheme of Reservation and Delegation to the Board

Appendix 2 shows the changes that are proposed for the Scheme of Reservation and Delegation (SoRD). These are mainly updates to the alignment with the Standing Financial Instructions (SFIs) and the Standing Orders (SO) references, plus updates to executive designations.

The following changes have been made:

Corrected Standing Order references; added reserved matters - 3.3.19 and 3.3.20 (Constitution amendments; Senior Independent Director and Deputy Chair arrangements; tenure review); expanded the Council of Governors responsibilities (9.7 to 9.13); clarified abbreviations and designations (CMO, CN, Quality Committee); cross-references corrected; and corrected typographical errors.

Previous instructions did not include Finance and Performance Committee (F&P). However, as cases are reviewed there ahead of Board, this additional step provides authorisation for those limits within the committee, and only those over the £1m threshold requiring Board approval.

Changes to *Section 8: Detailed Scheme of Delegation and Authorisation* are either tracked (initial review) or shown in red texts with deletions struck through (further review). The main changes relate to delegations limits as follows:

Management of Budgets: Approval of revenue business cases
deletion of *not part of agreed plan*

Cases up to £500,000	Corporate Investment Group
Cases up to £500,000 and below £1,000,000	Finance and Performance Committee
Cases over £1,000,000	Board of Directors

Non-pay Expenditure / Requisitioning / Ordering / Payment of Goods & Services, Requisitions: Authorisations of requestions / non pay expenditure**

Requisitions up to £500,000	CFO and CE
Requisitions between £500,000 and £1,000,000	Finance and Performance Committee
Requisitions over £1,000,000	Board of Directors

Authorisations of contracts for goods and services and subsequent variations to contracts**

Contracts up to £500,000	CFO and CE
Contracts between £500,000 and £1,000,000	Finance and Performance Committee
Contracts over £1,000,000	Board of Directors

**Subsequent revisions to the delegated authority were proposed by the Chief Finance Officer and supported by the Chair of the Audit and Risk Committee. Subject to the Board's approval, a post meeting record of the revisions will be captured in the minutes of the Audit and Risk Committee of 23 July 2026.

Standing Financial Instructions
The SFIs have been updated to reflect changes to designations and values in the procurement thresholds. The Local Security Management Service (LSMS) provides a report to the Finance and Performance Committee, and this was also amended to reflect that position.

Next Steps
The Audit and Risk Committee at its meeting on 15 October 2026, supported the above amendments and recommended to the Board for approval, the Trust constitution (including the Standing Orders of the Board); the Scheme of Reservation and Delegation for the Board; and the Standing Financial Instructions.

If approved by the Board, the Constitution will be presented to the Council of Governors for ratification, and where it affects governor powers or duties, the Annual Members' Meeting, and shared with NHS England. These documents will be made available via the policies process across the Trust.

Recommendations

The Board of Directors is asked to:

a) Approve the Trust Constitution including the Standing Orders (appendix 1) and recommend for ratification (Constitution only) by the Council of Governors.
b) Approve the Scheme of Reservation and Delegation for the Board (appendix 2).
c) Approve the Standing Financial Instructions (appendix 3).

Healthier together – delivering exceptional care for all	
Patients	These governance documents are critical for the statutory responsibility to deliver safe & effective quality care to patients.
People	These governance documents are critical for supporting innovation and transformation, within the constraints of regulatory and statutory requirements.
Partnerships	These governance documents are critical for demonstrating good corporate governance and effective working within the constraints of regulatory and statutory duties.
Pounds	These governance documents are critical for the effective control and direction of the trusts financial position and adherence to its fiscal duties.

Health Inequalities	These governance documents do not have a positive or negative impact on health inequalities; however, they do consider its legislative duty to positively impact on health inequalities through the delivery of its services.
Legal/ Regulation:	These governance documents comply with the regulatory and legislative requirements outlined in the NHS Act 2006, Code of Governance for NHS providers and the NHS Provider licence.
Partner ICB strategies	These governance documents have no positive of negative impact on partner ICB strategies.
Assurance Route	
Previously considered by - including date:	Email correspondence 2 July 2026 for feedback. Council of Governors approval on 13 July 2026 for the Constitution amends. Audit and Risk Committee recommendation to the Board - 23 July 2026. Board of Directors - 1 September 2026: not approved; further review requested. Audit and Risk Committee recommendation to the Board - 15 October 2026.
Any outcomes/next steps / time scales	Recommendation of Constitution to Council of Governors for ratification. Implementation across the Trust.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

CONSTITUTION

Name and title of author/reviewer:	Brenda Thomas, Interim Company Secretary Rebecca Allen, Associate Director Strategy, Partnerships and Governance
Approved by The Board of Directors (subject to CoG and AMM approval):	~~September 2026~~[Date to be inserted]
Approved by The Council of Governors and Annual members Meeting:	~~XX September 2026~~[Date to be inserted]
Date Issued:	~~1 October 2026~~[Date to be inserted on approval]
Date of Next Review:	~~following legislative changes in 2027~~Annually (Annex 8, SO 11.3) and following any relevant legislative change, including that expected in 2027

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1. INTERPRETATION AND DEFINITIONS

In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"the 2022 Act"	means the Health and Care Act 2022 as amended from time to time;
"Accounting Officer"	is the person who from time to time discharges the functions specified in NHS England's NHS Foundation Trust Accounting Officer Memorandum;
"Annual Members' Meeting"	means the annual members' meeting of the Trust as defined in paragraph 13 of this Constitution.
"Appointed Governors"	means ~~the Partner Governors; those Governors appointed by the Partnership Organisations;~~the Local Authority Governors and the Partner Governors; those Governors appointed by the Local Authorities and the Partnership Organisations;
"Area of the Trust"	means the areas of Bassetlaw District and the City of Doncaster (specified in Annex 1 as areas of the public constituency);
"Board of Directors"	means the board of directors as constituted in accordance with this Constitution;
"Chair"	means the chair of the Trust appointed in accordance with paragraph 28 of this Constitution;
"Chief Executive"	means the chief executive officer of the Trust appointed in accordance with the terms of this Constitution;
"Code of Governance"	means the Code of Governance for NHS Provider Trusts published by NHS England, as amended or replaced from time to time;
"Constitution"	means this Constitution and all annexes to it;
"Co-optee" and "Co-opted Governor"	means an individual formally appointed by resolution of the Council of Governors who has reached the end of their elected term of office to participate at meetings of the Council of Governors under the terms specified
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the council of governors in the 2006 Act and the 2012 Act;
"Deputy Chair"	means the non-executive director appointed as deputy chair of the Trust in accordance with paragraph 30 of this Constitution;

“Director”	means an Executive director or a non-executive director on the Board of Directors;
"Elected Governor"	means the Public Governors and the Staff Governors; those Governors elected by the Public Constituencies and the classes of the Staff Constituency;
“Election Scheme”	means the election scheme set out in Annex 4;
“Executive Director”	means an executive director of the Trust who ~~have~~ has voting rights on the Board;
“Fit and Proper Person Requirements (FPPR)”	means those requirements stipulated under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations)
“Financial Year”	means a period of 12 months beginning on 1st April in a calendar year and ending on 31st March in the following calendar year;
“Governor”	means a Governor on the Council of Governors and being either an Elected Governor or an Appointed Governor;
“Health Service Body”	means a body which is a health service body for the purpose of section 9(4) of the 2006 Act;
“Independent Regulator” or “NHS England”	is the body corporate known as NHS England, as provided by Section 61 of the 2012 Act; or any successor regulator.
“Lead Governor”	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England) and ~~to Chair any meetings of Governors when the Chair or Deputy Chair are absent, for whatever reason~~ to preside at meetings of the Council of Governors where required under paragraph 19.1
"Local Authority"	means the local authorities specified in Annex 3, which are local authorities for an area which includes the whole or part of the area of the Trust;
“Local Authority Governor”	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
“Meeting”	Means a meeting of individuals for the purpose of conducting business on behalf of the Trust and where they are authorised to do. This includes face-to-face, virtual and hybrid meeting formats.
“Member”	means a member of the Trust;
"Membership	means membership of the Trust as determined in accordance with the provisions of this Constitution and as specified in ~~Annex 3;~~Annexes 1, 2 and 6;

"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by the Department of Health and Social Care and as currently set out in Annex 4;
"Non-Executive Director"	means a non-executive director of the Trust;
"Partner Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partner Organisation"	means those organisations designated as Partnership Organisations for the purposes of this Constitution specified in Annex 3;
"Public Constituencies"	means a public constituency as defined in Annex 1;
"Public Governor"	means a member of the Council of Governors elected by the Members of the Public Constituency;
"Registered Dentist"	a registered dentist within the meaning of the Dentists Act 1984;
"Registered Medical Practitioner"	a fully registered person within the meaning of the ~~Medicines~~ Medical Act 1983 who holds a licence to practice under that Act;
"Secretary" or "Company Secretary"	means the Trust Company Secretary or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary;
"Senior Independent Director"	means the non-executive director ~~appointed by the Board as the senior independent director of the Trust;~~appointed as the senior independent director of the Trust in accordance with paragraph 25.10;
"Staff Class"	means a class of Membership within the Staff Constituency as provided for in Schedule 7 to the 2006 Act and as set out in Annex 2;
"Staff Constituency"	means the part of the Trust's Membership consisting of the staff of the Trust and which is divided into the classes as specified in Annex 2;
"Staff Governor"	means a member of the Council of Governors elected by a Staff Class in accordance with the provisions of this Constitution;
"the Trust"	means Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

1.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder

1.3 References to legislation include all regulations, statutory guidance and directions.

1.4 Headings are for ease of reference only and are not to affect interpretation.

1.5 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein or the law, then the provisions of this Constitution shall prevail unless the law requires otherwise.

1.6 All Annexes referred to in this Constitution form part of it.

1.7 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an Annex to this Constitution it shall be a reference to a paragraph in that Annex unless the contrary is expressly stated, or the context otherwise so requires.

2. NAME

2.1 The name of the foundation trust is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust).

3. PRINCIPAL PURPOSE

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also undertake activities other than those mentioned in section 3 for the purpose of making additional income available in order better to carry on the Trust's principal purpose.

3.5 Notwithstanding the provisions of 3.1 above, the purpose of the Trust is to provide goods, and services, including education, training and research and other facilities for the provision of healthcare, in accordance with its statutory duties.

3.6 The Trust may carry out research in connection with the provision of healthcare and make facilities and staff available for the purposes of education, training or research carried on by others.

4. POWERS

4.1 The powers of the Trust are set out in the 2006 Act and amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Subject to any restriction contained in this Constitution or in legislation, any of these powers may be delegated to a committee of directors or to an executive director.

5. MEMBERSHIP AND CONSTITUENCIES

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a Public Constituency; or

5.1.2 a Staff Constituency.

6. APPLICATION FOR MEMBERSHIP

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

6.2 Applications for membership will be handled by the Trust in accordance with the provisions set out in Annex 6.

7. PUBLIC CONSTITUENCY

7.1 The Public Constituency comprises three areas as set out in Annex 1. Each area of the Public Constituency is to be known by the name listed in Annex 1.

7.2 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust provided that:

7.2.1 they have made an application for membership to the Trust; and

7.2.2 they are not eligible to become a member of the Staff Constituency; and

7.2.3 they are not otherwise disqualified from membership under paragraph 4 or paragraph 12 of Annex 6.

7.3 Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

7.4 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. STAFF CONSTITUENCY

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve (12) months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

8.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.3 The Staff Constituency shall be divided into four (4) classes of individuals who are eligible for membership of the Staff Constituency, each class of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION - STAFF

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate Staff Class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate Staff Class within the Staff Constituency without an application being made, unless they inform the Trust they do not wish to do so.

9.2 The process by which an individual shall be invited or shall apply to become a member of the Staff Constituency shall be in accordance with the provisions of Annex 6.

10. ~~SECTION 10~~ PATIENTS CONSTITUENCY

Not Used

11. ~~SECTION 11~~ AUTOMATIC MEMBERSHIP BY DEFAULT - PATIENTS

Not Used

12. RESTRICTION ON MEMBERSHIP

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual shall not be eligible for membership of the trust if they:

12.3.1 are under sixteen (16) years old at the date of their application or invitation to become a member (as the case may be)

12.3.2 fail or cease to fulfil the criteria for membership of any Public or Staff Constituency

12.3.3 ~~has~~ have been placed on the sex offenders Register or is the subject of a Sex Offenders Order;

12.3.4 demonstrate~~s~~ aggression, violent or abusive behaviour at any hospital or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust and following such behaviour they have been asked to leave.

12.3.5 has have been confirmed as a "vexatious complainant" in accordance with the Trusts policy for handling complaints;

12.3.6 has have been removed as a member of the Trust of another NHS Foundation Trust

12.3.7 is are deemed to have acted in a manner contrary to the interests of the Trust.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 6.

13. ANNUAL MEMBERS' MEETING

13.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public. The Annual Members' Meeting shall be held no later than 30 September in each year, save as otherwise permitted by legislation.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 - Annual Members' Meeting.

14. COUNCIL OF GOVERNORS - COMPOSITION

14.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors and the Chair of the Trust.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

14.4 The Council of Governors may co-opt individuals who have reached the end of their elected term of office to remain as members of the Council of Governors but only for a time period until the next elections and will not exceed the usual term of office of an elected governor.

14.5 The agreement and removal of a co-opted governor will be subject to the approval of the Council of Governors by a majority of the Council of Governors present and voting.

14.6 Co-opted Governors shall not have voting rights at a general meeting nor be counted in the quorum but will have free access to contribute to discussions therein.

15. COUNCIL OF GOVERNORS - ELECTION OF GOVERNORS

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014.

15.2 The Model Election Rules as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

15.3 A subsequent variation of the Model Election Rules by the Department of Health & Social Care 2014 shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 47 of the constitution (amendment of the constitution).

15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

16.1 An elected governor may hold office for a period of up to three (3) years.

16.2 An elected Governor shall cease to hold office if they cease to be a Member of the Constituency or class by which they were elected.

16.3 An elected Governor shall be eligible for re-election at the end of their term, but no elected Governor may hold office for more than nine (9) years. An elected Governor may not stand for election again on completion of the maximum nine years. An elected Governor who does not complete the maximum nine-year term may stand for re-election but only for the remaining years to achieve nine (9) years in total.

16.4 An appointed governor may hold office for a period of three (3) years.

16.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

16.6 An appointed governor shall be eligible for re-appointment at the end of their term, but no appointed governor may hold office for more than nine (9) years as an appointed governor.

17. COUNCIL OF GOVERNORS - DISQUALIFICATION AND REMOVAL

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, ~~his~~ their creditors and has not been discharged in respect of it;

17.1.3 a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

17.1.4 a governor, whose term of office is terminated in line with Annex 5 section 3.

17.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

17.4 Provisions for the removal of governors are set out in Annex 5.

18. COUNCIL OF GOVERNORS - DUTIES OF GOVERNORS

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

18.1.3 as a result of the Health and Care Act 2022 governors are required to factor into their decision making a balance between serving the public interest of their constituents (i.e. the Trust and local community which elects them) with a wider (regional) public interest across the Integrated Care Systems the Trust is linked with.

18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

18.3 Governors must take up the opportunities that the Trust offers to provide them with these skills and knowledge. In the event that a Governor is deemed to not be fulfilling these roles and responsibilities, then the Trust Secretary will carry out a review with that Governor and identify any programme of support required to address the situation. In the absence of any improvement, then a Council of Governors decision could be made to remove the Governor from their role.

19. COUNCIL OF GOVERNORS - MEETINGS OF GOVERNORS

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 below) or, in their absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 30 below), shall preside at meetings of the Council of Governors save that if the Chair and Deputy Chair are unable to preside whether for reasons of absence, conflict of interest or otherwise the Senior Independent Director or Lead Governor shall preside.

19.2 Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution.

19.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, and to be able to hold the non-executive directors to account for the performance of the Board, the Council of Governors may require one or more of the non-executive directors to attend a meeting.

19.4 Details on the standing orders for the procedure and practice of the Council of Governors is given in Annex 7.

20. COUNCIL OF GOVERNORS - STANDING ORDERS

20.1 The Council of Governors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure and practice at meetings and are attached at Annex 7.

21. COUNCIL OF GOVERNORS - REFERRAL TO THE PANEL

21.1 In this paragraph, the "Panel" means a panel of persons appointed by the Regulator to which a member of the Council of Governors may refer a question as to whether the Trust has failed or is failing:

21.1.1 to act in accordance with this constitution, or

21.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

21.2 A member of the Council of Governors may refer a question to the Panel only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the referral.

22. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

22.1 Governors are required to declare any pecuniary, personal or family interest on nomination and on appointment as a governor, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

22.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed. The Chair of the meeting decides on exclusion on the facts.

23. COUNCIL OF GOVERNORS - TRAVEL EXPENSES

23.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. For the avoidance of doubt, members of the Council of Governors are not to receive remuneration but can receive expenses incurred as part of their role as governors.

24. COUNCIL OF GOVERNORS - FURTHER PROVISIONS

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. BOARD OF DIRECTORS - COMPOSITION

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and non-executive directors.

25.2 All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.

25.3 The Board of Directors is to comprise:

25.3.1 a non-executive Chair (who shall have a casting vote)

25.3.2 other non-executive directors (i.e. not including the Chair)

25.3.3 executive directors (but not exceeding the combined number of non-executive directors and the Non-Executive Chair)

25.4 One of the executive directors shall be the Chief Executive.

25.5 The Chief Executive shall be the Accounting Officer.

25.6 One of the executive directors shall be the Chief Finance Officer.

25.7 One of the executive directors is to be a registered medical practitioner or a registered dentist with a licence to practice (within the meaning of the Dentists Act 1984).

25.8 One of the executive directors is to be a registered nurse or a registered midwife.

25.9 For the avoidance of doubt, the Deputy Chair shall have the casting vote in the event that the Chair is not participating at the meeting where voting takes place.

25.10 The Senior Independent Director will be nominated by the Chair and approved by the Council of Governors and shall perform the role set out in the Code of Governance for NHS Provider Trusts.

25.11 At least half of the Board of Directors, excluding the Chair, shall be non-executive directors whom the Board considers to be independent in accordance with the Code of Governance. The Board shall publish its reasoning where it considers a non-executive director to be independent despite circumstances that may appear to affect independence.

26. BOARD OF DIRECTORS - GENERAL DUTY

26.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

27. BOARD OF DIRECTORS - QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

27.1 A person may be appointed as a non-executive director only if:

27.1.1 they are a member of the Public Constituency; and

27.1.2 they are not disqualified by virtue of paragraph 32 below.

28. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

28.1 The Chair and non-executive directors shall normally be ~~are~~ appointed for ~~a~~ terms of up to three years. This may be extended by a further term of up to three years if the needs of the organisation so determine. ~~The Chair and non-executive directors may not usually serve for more than six years, unless it considers such an extension is in the best interests of the Trust.~~The Chair and non-executive directors shall not serve for more than six years in total

unless the Council of Governors, following a rigorous review and the agreement of NHS England where required by the Code of Governance, determines that an extension is in the best interests of the Trust. In no circumstances shall the Chair or any non-executive director remain in post beyond nine years in total from the date of their first appointment to the Board of Directors.

28.2 For the avoidance of doubt:

28.2.1 the nine-year maximum is a single cumulative limit that runs from the date of first appointment to the Board of Directors in any non-executive capacity;

28.2.2 time served as a non-executive director counts towards the limit if that person is later appointed as Chair (and a non-executive director who becomes Chair after a three-year term as a non-executive director is not required to have a further review until the Chair has served three years);

28.2.3 a new term of office as Chair does not restart the nine-year period; and (d) any extension beyond six years must be reviewed on an individual basis, recorded in the minutes of the Council of Governors and reported in the Annual Report.

28.3 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other non-executive directors.

28.4 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

28.5 The provisions of paragraph 5 of Annex 5 and paragraph 6 of Annex 6 shall also apply.

28.5 If any resolution to remove a non-executive director (including the Chair) is not approved at a meeting of the Council of Governors in accordance with paragraph 28.~~2~~3 above, no further resolution can be put forward to remove such non-executive director, or the Chair which is based on the same reasons within 12 calendar months of the meeting of the Council of Governors at which the resolution mentioned in paragraph 28.~~2~~ 3 above was considered.

28.6 Subject to the provisions of paragraphs 28.1 to 28.5, new non-executive directors and the Chair will be appointed using the procedures set out below:

28.6.1 only a member of a Public Constituency may be appointed as the Chair or other non-executive director; and

28.6.2 the Chair and other non-executive directors shall be appointed in accordance with paragraphs 28.7 to ~~28.13~~ 28.11 below.

28.7 The Council of Governors shall establish a committee of its members to be called the Nominations and Remuneration Committee to discharge those functions in relation to the appointment of the Chair and non-executive directors described in paragraphs 28.8 - 28.11 below.

28.8 The Nominations and Remuneration Committee shall consist of no more than seven members which shall comprise of at least:

28.8.1 3 Public Governors;

28.8.2 1 Staff Governor; and

28.8.3 The Chair of the Trust, except where their performance or remuneration is being considered at which point the Senior Independent Director should assume this position.

28.8.4 The members of ~~each~~ the Nominations and Renumeration Committee shall be appointed by the Council Governors. ~~are not fixed and will be selected via email ballot for each required meeting.~~ In the event that a meeting of the Committee would otherwise be inquorate, the Council of Governors may nominate another Governor to attend that meeting. Any Governor attending in these circumstances shall count towards the quorum for that meeting.

28.9 The functions of the Nominations and Remuneration Committee shall be as follows:

28.9.1 to determine the criteria and process for the selection of candidates for office as Chair or other non-executive director of the Trust having first consulted with the Board of Directors as to those matters and having regard to such views as may be expressed by the Board of Directors;

28.9.2 where the Nominations and Remuneration Committee considers that either the Chair or the non-executive director coming to the end of their term of office should be reappointed for a further term, the Nominations and Remuneration Committee shall make a recommendation to the Council of Governors to that effect. ~~save that the Nominations and Remuneration Committee may not make any such recommendation other than for a first re-appointment of the Chair or the non-executive director in question;~~

28.9.3 Where:

(a) the Nominations and Remuneration Committee does not make a recommendation that the Chair or a non-executive director should be reappointed in accordance with paragraph 28.9.2 above; or

(b) the Chair or (as the case may be) the non-executive director in question does not want to be reappointed; or

(c) the Council of Governors rejects a recommendation that the Chair or (as the case may be) a non-executive director should be reappointed in accordance with paragraph 28.9.2 above,

(d) the Nominations and Remuneration Committee shall initiate a process of open competition for the appointment of the Chair or (as the case may be) the non-executive director, and the post will be advertised. Further, the Nominations and Remuneration Committee shall assess and select for interview such candidates as are considered appropriate and in doing so the Nominations and Remuneration Committee shall be at liberty to seek advice and assistance from persons other than members of the Nominations and Remuneration Committee or the Council of Governors;

28.9.4 on a regular and systematic basis monitor the performance of the Chair and other Non-executive directors and make reports thereon to the Council of Governors from time to time when requested to do so or when in the opinion of the Nominations and Remuneration Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors; and

28.9.5 to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair and other non-executive directors.

28.10 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the Board of Directors and of the Nominations and Remuneration Committee as to the suitability of the available candidates.

28.11 The Council of Governors will not consider nominations for membership of the Board of Directors other than those made by the appropriate Nominations and Remuneration Committee.

29. INITIAL FOUNDATION TRUSTS'S

Not used

30. BOARD OF DIRECTORS - APPOINTMENT OF DEPUTY CHAIR

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chair. The Deputy Chair will be the Deputy Chair of the Council of Governors.

30.2 The Deputy Chair shall be appointed for a term of 3 years and shall be eligible for re-appointment at the end of that term but may not serve as Deputy Chair for more than a total of 6 years, unless ~~it~~ the Council of Governors considers~~s~~ such an extension is in the best interests of the Trust. Service as Deputy Chair does not extend, or restart, the nine-year maximum applicable to all non-executive directors under paragraph 28.1.

31. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER ~~NS~~ EXECUTIVE DIRECTORS

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other Executive directors.

~~32. Section 32 (Initial Foundation Trusts's)~~

~~Not used~~

32. Board of Directors - disqualification

32.1 The following may not become or continue as a member of the Board of Directors:

32.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

32.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and who has not been discharged in respect of it;

32.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

32.1.4 a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

32.1.5 The Regulator has exercised its powers to remove them as a director of the Trust or has suspended them from office or has disqualified them from holding office as a director of the Trust for a specified period or the Regulator has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS foundation trust or

32.1.6 a person who falls within the further grounds for disqualification set out in Annex 6.

33. BOARD OF DIRECTORS - MEETINGS

33.1 Meetings of the Board of Directors shall be open to members of the public as observers. Members of the public may be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

33.2 Before holding a meeting, the Board of Directors must make available the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must make available the approved minutes of the meeting to the Council of Governors.

34. BOARD OF DIRECTORS - STANDING ORDERS

34.1 The Board of Directors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, and are given in Annex 8.

35. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

35.1 The duties that a director of the Trust has by virtue of being a director include in particular:

35.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

35.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

35.2 The duty referred to in sub-paragraph 35.1.1 is not infringed if:

35.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

35.2.2 The matter has been authorised in accordance with the constitution.

35.3 The duty referred to in sub-paragraph 35.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

35.4 In sub-paragraph 35.1.2, "third party" means a person other than –

35.4.1 The Trust, or

35.4.2 A person acting on its behalf.

35.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or, arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

35.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

35.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

35.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

35.9 A director need not declare an interest –

35.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

35.9.2 if, or to the extent that, the directors are already aware of it;

35.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) By a meeting of the Board of Directors, or

(b) By a committee of the directors appointed for the purpose under the constitution.

35.10 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

36. BOARD OF DIRECTORS - REMUNERATION AND TERMS OF OFFICE

36.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

36.2 A committee of non-executive directors shall be established to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive directors.

37. REGISTERS

37.1 The Trust shall have:

37.1.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

37.1.2 a register of members of the Council of Governors;

37.1.3 a register of interests of governors;

37.1.4 a register of directors; and

37.1.5 a register of interests of the directors.

38. ADMISSION TO AND REMOVAL FROM THE REGISTERS

38.1 The process of admission to and removal from the registers shall be as set out in Annex 6.

39. REGISTERS - INSPECTION AND COPIES

39.1 The Trust shall make the registers specified in paragraph 37 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

39.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

39.3 So far as the registers are required to be made available:

39.3.1 they are to be available for inspection free of charge at all reasonable times; and

39.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

39.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

40. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

40.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

40.1.1 a copy of the current constitution;

40.1.2 a copy of the latest annual accounts and of any report of the auditor on them;

40.1.3 a copy of the latest annual report;

40.1.4 a copy of the latest annual quality report.

40.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

40.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

40.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

40.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

40.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

40.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

40.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England), 65KB (Secretary of State's response to NHS England decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

40.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

40.2.8 a copy of any final report published under section 65I (administrator's final report),

40.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

40.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

40.3 Any person who requests a copy of or extract from any of the above documents is to be provided with access to a copy.

40.4 If the person requesting access to a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. AUDITOR

41.1 The Trust shall have an external auditor.

41.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

42. AUDIT AND RISK COMMITTEE

42.1 The Trust shall establish a committee of non-executive directors as an audit and risk committee to perform such monitoring, reviewing and other functions as are appropriate.

42.2 In line with the Code of Governance, the Audit and Risk Committee shall comprise a minimum of three independent non-executive directors; the Chair of the Trust shall not be a member; the Deputy Chair and the Senior Independent Director shall not chair the committee; and the Board of Directors shall satisfy itself that at least one member has recent and relevant financial experience.

43. ACCOUNTS

43.1 The Trust must keep proper accounts and proper records in relation to the accounts.

43.2 The Regulator may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

43.3 The accounts are to be audited by the Trust's external auditor.

43.4 The Trust shall prepare in respect of each financial year annual accounts in such form as the Regulator may with the approval of the Secretary of State direct.

43.5 The functions of the Trust with respect to the preparation of the annual accounts as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

44. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

44.1 The Trust shall prepare an Annual Report and send it to the Regulator.

44.2 The Trust shall give information as to its forward planning in respect of each financial year to the Regulator.

44.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

44.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

44.5 Each forward plan must include information about:

44.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

44.5.2 the income it expects to receive from doing so.

44.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 44.5.1 the Council of Governors must:

44.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

44.6.2 notify the directors of the Trust and its determination.

44.7 Where the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

45. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

45.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

45.1.1 the annual accounts;

45.1.2 any report of the external auditor on them; and

45.1.3 the annual report.

45.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

45.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 45.1 with the Annual Members' Meeting.

46. INSTRUMENTS

46.1 The Trust shall have a seal.

46.2 The seal shall not be affixed except under the authority of the Board of Directors.

47. AMENDMENT OF THE CONSTITUTION

47.1 The Trust may make amendments to its Constitution only if:

47.1.1 more than half of the members of the Council of Governors voting at a meeting approve the amendments; and

47.1.2 more than half of the members of the Board of Directors voting at a meeting approve the amendments.

47.2 Amendments made under paragraph 47.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

47.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

47.3.1 At least one member of the Council of Governors most likely the Lead Governor must attend the next Annual Members' Meeting and present the amendment, and

47.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

47.4 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect, and the Trust must take such steps as are necessary as a result.

47.5 Amendments by the trust of its constitution are to be notified to the Regulator. For the avoidance of doubt, the Regulator's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

48. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

48.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors voting at a general meeting.

48.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting at a general meeting approve entering into the transaction.

48.3 For the purpose of paragraph 48.2, "significant transaction" means a transaction which meets any one of the following criteria:

48.3.1 where the *gross assets subject to the transaction are greater than or equal to 25% of the gross assets of the Trust;

48.3.2 where the income attributable to the assets or the contract associated with the transaction is greater than or equal to 25% of the income of the Trust;

48.3.3 where the **gross capital of the company or business being acquired or divested, or the effects on the ***total capital of the Trust resulting from a transaction, is greater than or equal to 25% of the total capital of the Trust following completion of the transaction.

* Gross assets are the total of fixed assets and current assets.

** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets.

*** Total capital of the Trust equals taxpayers' equity.

ANNEX 1 - THE PUBLIC CONSTITUENCY

Table 1

1	2	3	4
Name of the Public Constituency	**Area of the Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**	**Number of Governors to be Elected**
Bassetlaw	Bassetlaw District Council (or any successor organisation)	20	3
Doncaster	City of Doncaster (or any successor organisation)	20	8
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	20	1
Total	**Public Governors**		**12**

ANNEX 2 - THE STAFF CONSTITUENCY

Table 1

Staff Class	Minimum Number of Members	Number of Governors to be elected
Medical and Dental Practitioners Staff Class	20	1
Nurses and Midwives Staff Class	20	21
Other Healthcare Professionals Staff Class	20	1
Non-Clinical Staff Class	20	21
TOTAL	120 80	6 4

1. CLASSES OF THE STAFF CONSTITUENCY

1.1 The Staff Constituency shall be divided into four classes as follows:

1.1.1 Medical and Dental Practitioners Staff Class;

1.1.2 Nurses and Midwives Staff Class;

1.1.3 Other Healthcare Professionals Staff Class; and

1.1.4 Non-Clinical Staff Class.

1.2 Medical and Dental Practitioners Staff Class

1.2.1 The Members of the Medical and Dental Staff Class are individuals who are Members of Staff Constituency who:

(a) are fully registered persons within the meaning of the Medicines Act 1956 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 89 of the Constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.3 Nurses and Midwives Staff Class

1.3.1 The Members of the Nurses and Midwives Staff Class are individuals who:

(a) are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be members of the Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph ~~8~~9 of the constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.4 Other Healthcare Professionals Staff Class

1.4.1 Members of the Other Healthcare Professionals Staff Class are clinical staff who do not fall within paragraphs 1.2 or 1.3 of this Annex 2, including clinical therapists, scientists and technical staff, who are employed by the Trust in that capacity at the date of their invitation or application under paragraph ~~8~~9 of the constitution to become a member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.5 Non-Clinical Staff Class

1.5.1 Members of the Non-Clinical Staff Class are Members of the Staff Constituency who do not come within paragraphs 1.2, 1.3 or 1.4 of this Annex 2.

2. MINIMUM NUMBERS AND NUMBERS OF GOVERNORS

2.1 The minimum number of members in each staff class and the number of governors to be elected by each such staff class are given in Table 1.

3. CONTINUOUS EMPLOYMENT

3.1 For the purposes of paragraph ~~7.1.2~~ 8.1.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

ANNEX 3 - COMPOSITION OF COUNCIL OF GOVERNORS

1. INTRODUCTION

1.1 The Council of Governors shall comprise:

1.1.1 The Chair of the Trust

1.1.2 Governors who are:

(a) elected by the respective constituencies in accordance with the provisions of this constitution; or

(b) appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of governors who are elected by members of the Public Constituency.

2. BODIES ENTITLED TO APPOINT A MEMBER TO THE COUNCIL OF GOVERNORS

2.1 The Trust may appoint partnering governor or governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Local Authority Governors

2.2.1 City of Doncaster Council (or its successor organisation) shall be entitled to appoint one governor in accordance with a process of appointment agreed by it with the Trust.

2.2.2 Bassetlaw District Council (or its successor organisation) shall be entitled to appoint one governor in accordance with a process of appointment agreed by each of them with the Trust.

2.3 Partner Governors

2.3.1 In addition to the organisations listed in ~~2.1 and~~ 2.2, the following organisations have also been nominated by the Trust as Partnership Organisations for the purposes of this constitution:

(a) University of Sheffield;

(b) Sheffield Hallam University;

2.3.2 In addition to the organisations listed above (2.2 and 2.3), the Trust may nominate 2 further organisations to appoint governors (1 per organisation).

2.3.3 Each of the partnering organisations shall be entitled to appoint a governor in accordance with a process of appointment agreed by it with the Trust.

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

	Electing / Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		**12**
	1.1 Bassetlaw District	3	
	1.2 City of Doncaster	8	
	1.3 Rest of England and Wales	1	
2.	**Staff Constituency**		64
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	21	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	21	
3.	**Appointed Governors**		up to 6
	3.1 City of Doncaster Council	1	
	3.2 Bassetlaw District Council (or its successor organisation) 3.3	1	
	3.34 University of Sheffield	1	
	3.45 Sheffield Hallam University	1	
	Provision available for further two (2) appointed governors from partnership organisations appointed by the Trust	2	
	Total Elected Governors		**165**
	Total Maximum Appointed Governors		**6**
	Total Number of Governors including appointed		**221**

4. FURTHER PROVISIONS

4.1 Further provisions relating to the composition of the Council of Governors are at Annex 6.

ANNEX 4 - THE MODEL ELECTION RULES

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this Constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"the Regulator" means the Independent Regulator for NHS Foundation Trusts

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor elected by the Council of Governors to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTION

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) Saturday or Sunday.
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of their functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that they are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,
(b) for a member of the public constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after ~~he or she~~ they have received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these

rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer may order a new election to fill any vacancy which remains unfilled, on a day appointed by him/her in consultation with the corporation unless the Council of Governors at a meeting agrees to co-option.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted, and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts ~~his or her~~ their vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts ~~his or her~~ their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts ~~his or her~~ their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (including a voter who casts his or her their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituency)

21.1 The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(a) that they have not marked or returned any other voting information in the election, and

(b) the particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held, ("declaration of identity") and

(c) the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the

constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer,

("e-voting information").

24.2 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:
(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.3 The corporation may determine that any member of the corporation shall:
(a) only be sent e-voting information; or
(b) only be sent postal voting information; or
(c) be sent both postal voting information (only if no e-mail) and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter their voter ID number; and
  (ii) where the election is for a public constituency, make a declaration of identity;
  in order to be able to cast their vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter's voter ID number;
  (ii) the voter's declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:
(a) require a voter to
  (i) enter their voter ID number in order to be able to cast ~~his or her~~ their vote; and
  (ii) where the election is for a public constituency, make a declaration of identity;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
  (iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:
(a) require a voter to:
(i) provide their voter ID number; and
(ii) where the election is for a public constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) prevent a voter from voting for more candidates than they are entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(i) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with ~~his or her~~ their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

(a) are satisfied as to the voter's identity; and

(b) have ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter on a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter on a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(d) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless they:

(a) are satisfied as to the voter's identity,

(b) have no reason to doubt that the voter did not receive the original voting information,

(c) have ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter on a list ("the list of lost ballot documents"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they have also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter on a list ("the list of tendered voting information"):
(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public constituency)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter ~~his or her~~ their voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted

to vote in the election.

34.4 When prompted to do so the voter may then cast their vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper on a list of disqualified documents (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled they are to:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(a) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(b) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election ~~he or she~~they shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper on the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the Board of Directors and the Council of Governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
(i) ballot papers that have been returned; and
(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:
(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him/her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such

votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
  (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value ~~he or she~~ they shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until ~~he has~~ they have dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes, or
  (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:
  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest

candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which ~~he~~ they obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

Council of Governors

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning

officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~ they have declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who ~~he or she has~~ they have declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~ they have declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting record, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:
(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:
(a) the inspection of, or the opening of any sealed packet containing –
(i) any rejected ballot papers, including ballot papers rejected in part,
(i) any rejected text voting records, including text voting records rejected in part,
(ii) any disqualified documents, or the list of disqualified documents,
(iii) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(iv) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that their vote was given, and
(ii) that the Regulator has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
  (i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
  (ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement/England under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings, whether online or face-to-face, to enable the candidates to speak and respond to questions, or to themselves gain further information.

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting (face-to-face or online) to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, in their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor or successor body (NHS England) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor or successor body (NHS England) by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by the Regulator.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 The Regulator shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

ANNEX 5: ADDITIONAL PROVISIONS - COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section 14 16)

a Governor shall:

1.1 be elected or appointed for a term of three years;

1.2 be eligible for re-election or re-appointment at the end of that term; but may not serve as a governor for more than a total of 3 terms;

1.3 shall cease to hold office if:

1.3.1 in the case of an elected governor, they cease to be a member of the constituency they represent or where relevant, the class of the constituency they represent and in the case of an appointed governor, the sponsoring organisation withdraws its sponsorship of them.

1.3.2 their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or are otherwise ineligible to hold office as a governor; or

1.3.3 they resign by notice in writing to the Trust.

1.4 A governor shall cease to hold office on death.

2. Council of Governors: **Eligibility to be on the Council of Governors**

2.1 A person shall not be eligible to become or continue in office as a Governor if:

2.1.1 In the case of an elected governor, they cease to be eligible to be a Member of the constituency or class within the constituency which they represent

2.1.2 in the case of an appointed governor, the appointing organisation withdraws its sponsorship of them;

2.1.3 any of the grounds contained in paragraph 17 of the Constitution apply to them;

2.1.4 they have within the preceding two years been lawfully dismissed otherwise than by reason of redundancy, by the coming to the end of a fixed term contract, by retirement or through ill health from any paid employment with a Health Service Body;

2.1.5 they are a person whose term of office as the Chair or as a member or director of a Health Service Body has been terminated on the grounds that their continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

2.1.6 they are a person who by reference to information revealed by a Disclosure and Baring Service (DBS) check is considered by the Trust to be inappropriate on the grounds that their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

2.1.7 they have failed to make, or have falsely made, any declaration as required to be made under Section 60 of the 2006 Act or have spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and they are judged to have acted so by a majority of the Council of Governors voting at a meeting;

2.1.8 they are subject to a direction made under section 142 (prohibition from teaching) of the Education Act 2002 (as amended);

2.1.9 They are a person who is the subject of a disqualification order made under the company Directors Disqualification Act 1986;

2.1.10 The Regulator has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or the Regulator has exercised any of those powers in relation to them on any other occasion whether in relation to DBTH or some other NHS Foundation Trust;

2.1.11 they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff in the preceding 10 years;

2.1.12 they have at any time been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended);

2.1.13 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

2.1.14 their term of office is terminated pursuant to paragraph 3 below;

2.1.15 they are a Member of a Staff Class and any professional registration relevant to their eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six 6 months;

2.1.16 they are a person incapable by reason of mental disorder, illness or injury in managing and administering their property and/or affairs;

2.1.17 They area a person who is an immediate family member of a Director or Governor

2.1.18 they are a person who has refused without reasonable cause to undertake training which the trust and /or the Council of Governors requires Governors to undertake;

2.1.19 They are a person who has failed to sign and deliver to the Company Secretary a statement form required by the Trust confirming acceptance of the Governors' Code of Conduct

2.1.20 the relevant organisation which they represent ceases to exist;

2.2 Where a person has been elected or appointed to be a Governor and they become disqualified from that appointment they shall notify the Company Secretary in writing

of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered them disqualified or removed.

2.3 If it comes to the notice of the Company Secretary that a Governor is disqualified, the Company Secretary shall immediately declare the Governor disqualified and shall give them notice in writing to that effect as soon as practicable.

2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Governor and their name shall be removed from the Register of Governors.

2.5 If a complaint is received against a member of the governing body, it shall follow the same process as members of the Trust;
2.5.1

3. Council of Governors: Termination of Tenure

3.1 A Governor's term of office shall be terminated:

3.1.1 by the Governor giving notice in writing to the Company Secretary of their resignation from office at any time during that term of office;

3.1.2 by the Trust if it becomes aware of the Governors ineligibility to continue in office for any of the previously stated reasons;

3.1.3 by the Council of Governors if they have failed to attend two consecutive meetings of the Council of Governors unless within one month of the second meeting, the Council of Governors is satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

3.1.4 if the Council of Governors resolves to terminate their term of office for reasonable cause on the grounds that in the reasonable opinion of the majority of Governors present and voting at a meeting of the Council of Governors that their continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(f) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and their continuance in office would not be in the best interests of the Trust; or

(g) They have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor by a date six months from the date of their election or appointment; or from a date when they have been asked to undertake additional training or development for any reason;

(h) Their conduct as a Governor has failed to comply and support in a material way with the values and principles of the National Health Service or the Trust, and the Constitution; or

(i) They have committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors Standing Orders;

3.2 Upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

3.3 A Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of 3 years from the date of their resignation or removal from office. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.

3.4 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out above, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below.

4. Council of Governors Vacancies

Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the following provisions apply:

4.1 In the case of an Elected Governor, where a vacancy arises within 12 months of the election then the candidate who secured the next highest number of votes for that Constituency will be appointed. In the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4.2 If the vacancy arises during the last 11 months of office, the office will remain vacant until it is filled at the next scheduled election.

4.3 If a vacancy arises at any other time, it will be filled at the next scheduled election, in accordance with the Election Scheme.

4.4 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

5. Council of Governors: Role and Responsibilities of Governors

5.1 The general duties of the Council of Governors are:

5.1.1 At a general meeting:

(a) To appoint or remove the Chair and the other non-executive directors. The removal of a non-executive director requires the approval of three quarters of the members of the Council of Governors.

(b) To decide the remuneration and allowances, and the other terms and conditions of office of the Chair and the non-executive directors;

(c) To appoint or remove the Auditors

(d) To be presented the annual accounts, any report of the Auditor on them and the Annual Report;

(e) To consider resolutions to remove a governor or a member pursuant to paragraph 17 of this constitution.

(f) To consider and give/withhold approval for applications for a merger, acquisition, separation or dissolution. Approval requires approval; of more than half the Council of Governors.

(g) To consider and give/withhold approval for the Trust to enter a significant Transaction. Approval requires the approval of more than half of the members of the Council of Governors of the Trust present and voting at a meeting of the Council of Governors.

5.1.2 At a general meeting or otherwise

(a) Approve an appointment of the Chief Executive. Approval requires the approval of more than half of the Council of Governors present and voting at the meeting.

(b) Give the views of the Council of Governors to the Directors for the purpose of the preparation (by the Directors) of the Forward Plan in respect of each Financial Year to be given to the Regulator.

5.2 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

5.3 Subject to the requirements specified above, each Governor shall exercise their own skill and judgement in their conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring an appropriate perspective of the constituency or organisation by which they were was elected or appointed.

5.4 The general duties of the Council of Governors are;

5.4.1 to hold the non-executive directors to individually and collectively to account for the performance of the Board of Directors;

5.4.2 to represent the interests of the Trust as a whole and the interests of the public.

6. Council of Governors: Meetings

6.1 The Council of Governors shall hold not less than 3 general meetings each financial year.

6.2 The Council of Governors may appoint sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

7. Council of Governors: Declarations

7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of their qualification to vote as a Member and that they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme.

8. Council of Governors: Lead Governor

8.1 No person may serve as the Lead Governor for more than a total of nine years.

8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if they cease to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

9. Council of Governors: Appointment of Senior Independent Director

9.1 A majority of the Governors shall at a general meeting of the Council of Governors agree the appointment of one of the non-executive directors as recommended by the Board of Directors to be the Senior Independent Director for a term of three years. The Senior Independent Director shall be eligible for re-appointment at the end of that term but may not serve as Senior Independent Director for more than a total of six years.

9.2 The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of the Chair or Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate.

9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if they cease to be a non-executive director and the Senior Independent Director's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors on the recommendation of the Chair.

ANNEX 6: FURTHER PROVISIONS

1. Eligibility for Membership

It is the responsibility of members to ensure their eligibility and not the Trust, but if the Trust is on notice that a member may be disqualified from membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

2. Public Constituency

2.1 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

2.1.1 their name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

2.1.2 the Trust is otherwise satisfied that the individual lives in the said area.

2.2 An individual who is a member of the Public Constituency shall cease to be eligible to continue as a member if they cease to live in the area of the Public Constituency of which they are a member save as may otherwise be provided in this paragraph 2.

2.3 Where a member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which they are a member they shall forthwith advise the Trust that they are no longer eligible to continue as a member and the Trust shall forthwith remove their name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter, treat that individual as a member of that other Public Constituency and amend the register of members accordingly provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

2.4 Where a member ceases to live temporarily in the area of the Public Constituency of which they are a member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the member will either return to live in the area of that Public Constituency of which they are a member or will live in some other part of the area of the Trust in which case the provisions of paragraph 2.1 shall apply as appropriate.

3. Staff Constituency

3.1 A member of a Staff Class will cease to be eligible to be a member of that Staff Class if they no longer meet the eligibility requirements of paragraph 8 of the constitution and of Annex 2.

3.2 Where an individual is a member by virtue of their eligibility to be a member of a Staff Class and they cease to be eligible for membership of that Staff Class but are eligible for membership of some other Staff Class then the Trust may give notice to that member of its intention to transfer them to that other Staff Class on the expiration of

a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

4. Membership Termination of Tenure

4.1 A member may be expelled from membership of the Trust by a resolution approved by the majority of Governors voting at a meeting of the Council of Governors. The following procedure is to be adopted:

4.1.1 any member may complain to the Company Secretary that another member has acted in a way detrimental to or contrary to the interests of the Trust, or is otherwise disqualified as set out in section 12 ~~above~~ of the Constitution; and

4.1.2 subject to paragraphs ~~12.2 to 12.6~~ 4.1.3 to 4.1.6 below, if a complaint is made, the Council of Governors will consider the complaint, having taken such steps as it considers appropriate, to ensure that each member's point of view is heard and may either:

(a) dismiss the complaint and take no further action;

(b) arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors; or

(c) determine that the complaint should be investigated by an agreed investigating body. For the avoidance of doubt, not every complaint received should result in investigation.

4.1.3 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4.1.4 At the meeting, the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

4.1.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

4.1.6 A person expelled from membership will cease to be a member upon the declaration by the person chairing the meeting in question that the resolution to expel them is carried.

4.1.7 No person who has been expelled from membership pursuant to the provisions of paragraph 4.1 above is to be re-admitted as a member except by a resolution of the Council of Governors carried by the majority of governor votes ~~present and voting~~ at a meeting of the Council of Governors.

4.2 A member shall cease to be a member if:-

4.2.1 they cease to be entitled under this constitution to be a member of any of the public constituencies or one of the classes of the Staff Constituency;

4.2.2 they resign by notice in writing to the Company Secretary;

4.2.3 they die;

4.2.4 they are expelled under this constitution;

4.2.5 if it appears to the Company Secretary that they no longer wish to be involved in the affairs of the Trust as a member, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a member.

4.3 All members of the Trust shall be under a duty to notify the Company Secretary of any change in their particulars which may affect their entitlement as a member.

5. Board of Directors: Disqualification

5.1 In addition to the grounds of disqualification set out in Sections 28 31 27 and 32 of the Constitution, a person may also not be or continue as a director of the Trust if:

5.1.1 in the case of a Non-executive director, s/he they no longer satisfyies the relevant requirements for appointment;

5.1.2 s/he they are is a person whose tenure of office as a chair or as a director of a Health Service Body has been terminated on the grounds that their his or her appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

5.1.3 s/he has they have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body;

5.1.4 information revealed by a DBS check is such that it would be inappropriate for him or her them to become or continue as a director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

5.1.5 in the case of an executive director, s/he is they are no longer employed by the Trust;

5.1.6 s/he is they are a person who has have had their name removed by a Direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and have not subsequently had their name included on such a list;

5.1.7 s/he is they are the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

5.1.8 s/he has they have failed to sign and deliver to the Company Secretary in the form required by the Board of Directors confirmation that s/he they accepts the Trust's Standards of Business Conduct Policy;

5.1.9 s/he has they have failed or refused to undertake any training which the Board of Directors requires all Directors to undertake.

5.1.10 s/he is they are a partner or spouse of an existing director.

6. Governors and Directors: Communication and Conflict

6.1 Summary

This paragraph describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

6.2 Informal Communications

6.2.1 Informal and frequent communication between the Lead Governor, governors and the directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

6.2.2 The Chair shall use their reasonable endeavours to encourage effective informal methods of communication including:

(a) participation of the Board of Directors in the induction, orientation and training of governors;

(b) development of special interest relationships between Non-executive directors and governors;

(c) discussions between governors and the Chair and/or the Chief Executive and/or directors through the office of the Chief Executive or their nominated officer; and

(d) involvement in membership recruitment and briefing at public events organised by the Trust.

6.3 Formal Communication

6.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

6.3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

(a) specific requests by the Council of Governors will be made through the Company Secretary to the Chair to the Board of Directors;

(b) any governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair. Such issues should be raised with the Chair (or, if it involves the Chair then the Deputy Chair) no less than 10 working days before the meeting in order to be included in the agenda. In the event of disagreement, two thirds of the Governors present must approve the request. The Chair will raise the matter with the Board of Directors and provide the response to the Council of Governors;

(c) joint meetings will take place as and when, as, appropriate between the Council of Governors and the Board of Directors.

6.3.3 The Board of Directors may request the Chair to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

6.3.4 Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:

(a) the Board of Directors' proposals for the strategic direction the annual report and forward plan;

(b) the Board of Directors' proposals for developments;

(c) Trust Performance;

(d) involvement in service reviews and evaluation relating to the Trusts services; and proposed changes, plans and developments for the Trust other than those covered above.

6.3.5 The Board of Directors shall also present to the Council of Governors the Annual Accounts, Annual Report and any report of the auditors in accordance with the terms of this constitution and of the 2006 Act and any subsequent legislation or regulation.

6.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:

(a) attendance by the Board of Directors at a meeting of the Council of Governors; or

(b) provision of formal reports or presentations by executive and/or non-executive directors to a meeting of the Council of Governors;

(c) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

(d) reporting the views of the Council of Governors to the Board of Directors through the Chair, the Deputy Chair or the Senior Independent Director;

6.4 Resolving Conflict between the Council of Governor and the Board of Directors

6.4.1 The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

6.4.2 If the Chair cannot achieve resolution of a disagreement or dispute between the Council of Governors and the Board of Directors through informal efforts the Chair will follow the dispute resolution process described below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

(a) the Chair will call a joint meeting (Resolution Meeting) of equal numbers of governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. The resolution meeting will be held in private. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b) if the Resolution Meeting fails to resolve the conflict, the dispute will be deferred back to the Board of Directors who shall make the final decision;

7. Resolving Disputes about the Entitlement to Membership of the Trust and Eligibility for Membership of the Council of Governors

7.1 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other director of the Trust as the Chief Executive may, in their absolute discretion, nominate) as soon as reasonably practicable thereafter, and in any case, within 14 days of the Trust's decision.

7.2 The Chief Executive (or their nominated representative) shall:

7.2.1 view the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

7.2.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which they have considered; and

7.2.3 communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

7.2.4 Where a governor is declared ineligible or disqualified from office or their term of office as a governor has been terminated (for any reason other than expiry of their term of officer or as a consequence of their own resignation) and that person disputes the decision, they shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive, who shall use their reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

8. Indemnity

8.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any reasonable costs arising in this way will be met by the Trust.

8.2 The Trust may purchase and maintain insurance against the liability for its own benefit of members of the Council of Governors, the Board of Directors and the Company Secretary.

8.3 The Trust may take out insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority (NHS Resolution) or successor body, in respect of directors' and officers' liability, including liability arising by reason of the Trust acting as corporate trustee of an NHS Chairty or director of a wholly owned subsidiary.

9. Validity of Actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any action taken by them.

10. Registers

10.1 The Company Secretary shall be responsible for compiling and maintaining the Registers. Removal from any register shall be in accordance with the provisions of this constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days.

10.2 Register of Members

10.2.1 Members must complete and sign an application in the form prescribed by the Company Secretary; and

10.2.2 the Company Secretary shall maintain the register of members will be in two parts. Part 1 shall include the name of each Member Registers (see sections ~~32 and 33~~ 37 and 39) and the Constituency or class to which they belong and shall be open to inspection by the public in accordance with paragraph ~~33~~ 39 of this Constitution. Part 2 shall contain all the information from the individual's application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Trust is representative of those eligible for Membership.

10.3 Register of Members of the Council of Governors

The register shall list the names of members of the Council of Governors, their category of membership (public, staff or organisation represented) and an address through which they may be contacted which may be the Company Secretary.

10.4 Register of Interests of the Members of the Council of Governors

Each member of the Council of Governors shall complete and sign a form as prescribed by the Company Secretary setting out interests to be declared in accordance with the Standing Orders and the register shall contain the names of all members of the Council of Governors and any interests declared including no interests.

10.5 Register of Interests of Directors

The register shall list the names of members of the Board of Directors, their capacity on the Board and an address through which they may be contacted which may be the Company Secretary.

Each member of the Board of Directors shall complete and sign a form as prescribed by the Company Secretary setting out any interests to be declared in accordance with

the Standing Orders for the Board of Directors and the register shall contain the names of all members of the Board of Directors and any interests declared including no interests.

11. Auditor

11.1 A person may only be appointed auditor if they (or in the case of a firm each of its members) is a member of one or more of the following bodies:

11.1.1 the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

11.1.2 any other body of accountants established in the United Kingdom and approved by the Regulator.

12. Accounts

12.1 The following documents will be made available to the Comptroller and Auditor General for examination at their request:

12.1.1 the accounts;

12.1.2 any records relating to them; and

12.1.3 any report of the auditor on them.

12.2 In preparing its annual accounts, the Trust is to comply with any directions given by the Regulator with the approval of the Treasury as to:

12.2.1 the methods and principles according to which the accounts are to be prepared; and

12.2.2 the information to be given in the accounts.

12.3 The Trust must:

12.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

12.3.2 once it has done so, send copies of those documents to the Regulator.

12.4 Annual reports and forward plans

12.4.1 The annual report submitted by the Trust to the regulator in accordance with paragraph ~~39.1~~ 44.1 of the Constitution is to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies is representative of those eligible for such membership; and

(b) any other information the regulator requires.

12.4.2 The Trust is to comply with any decision the regulator makes as to:

12.4.3 the form of the reports;

12.4.4 when the reports are to be sent to it; and

12.4.5 the periods to which the reports are to relate.

ANNEX 7: STANDING ORDERS FOR THE PRACTICE AND THE PROCEDURE OF THE COUNCIL OF GOVERNORS

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10. MISCELLANEOUS

1. Introduction

1.1 Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire, DN2 5LT.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Council of Governors of the Trust to adopt Standing Orders for the regulation of its proceedings and business and to adhere at all times to the Code of Conduct for Governors.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

2. Definitions

In these Standing orders the definitions outlined in the constitution paragraph 1.

3. Meetings of the Council of Governors

3.1 Admission of the Public

3.1.1 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from a meeting on the grounds that:

a) any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

b) for other reasons stated in the resolution and arising from the nature of the business or the proceedings, that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the constitution.

c) Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.2 Calling Meetings

3.2.1 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 3 meetings in any year including:

a) an annual meeting no later than the 30 September in each year apart from the first year, when the Council of Governors are to receive and consider the annual accounts, any report by the auditor and the annual report; and

b) any other meetings required of the governors in order to fulfil their functions in accordance with the constitution.

3.2.2 The Company Secretary may call a meeting of the Council of Governors at any time. If the Company Secretary refuses to call a meeting after a requisition for that purpose, signed by at least three quarters of the members of the Council of Governors and specifying the business to be transacted at the meeting, has been presented to the Company Secretary, or if, without so refusing, the Company Secretary does not call a meeting within 5 clear days after such requisition has been presented to the Company Secretary at the Trust's Headquarters, such three-quarters or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

3.2.3 The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

3.2.4 The Council of Governors may agree that its governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 23.17 (Quorum).

3.3 Notice of Meetings

3.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf, shall be delivered to or sent by post to the usual place of residence every governor, so as to be available to them at least 7 days before the meeting, save in the case of emergencies.

3.3.2 Before each meeting of the Council of Governors, a public notice of the time and place of the meeting, and if possible, the public part of the agenda, shall be advertised on the Trust's website at least 7 days before the meeting, save in the case of emergencies.

3.3.3 Want of service of the notice on any one governor shall not affect the validity of a meeting but failure to serve such a notice on more than three governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of emailing.

3.3.4 In the case of a meeting called by governors in default of the Chair, the notice shall be signed by those governors, and no business shall be transacted at the meeting other than that specified in the requisition.

3.3.5 Agendas will be sent to governors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than 5 Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chair to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

3.3.6 In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SO 3.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 Annual Meeting of the Council of Governors

3.4.1 The Council of Governors shall hold an annual meeting of the Council of Governors in every calendar year so that there is no more than fifteen calendar months between one meeting and the next and no more than 6 months from the end of the previous financial year (30 September) and shall present to that meeting:

a) A report on the proceedings of its meetings held since the last annual meeting;

b) A report on the progress since the last annual meeting in developing the membership strategy including the steps taken to ensure that the actual membership of its Public Constituency and Service Users' and Carers' Constituency is fully representative of the persons who are eligible to be members under the constitution;

c) A report on any change to the governors which has taken place since the last annual meeting; and

d) A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding financial year and the future service development plans of the Trust.

3.5 Setting the Agenda

3.5.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A member of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make ~~his~~ their request in writing to the Chair or the Company Secretary at least 21 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 21 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

3.7 Chair of Meeting

3.7.1 At any Council of Governors meeting, the Chair, if present, shall preside. If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair shall preside.

3.7.2 If the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another non-executive director or the Lead Governor as shall be appointed by the Council of Governors shall preside.

3.8 Agenda

3.8.1 Where a governor has requested inclusion of a matter on the agenda in accordance with SO 3.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 3.8 shall apply in respect of the proposition:

3.8.2 The mover of the proposition shall have a right of reply at the close of any discussion on the proposition or any amendment thereto.

3.8.3 When a proposition is under discussion or immediately prior to discussion it shall be open to a governor to move: an amendment to the proposition;

a) the adjournment of the discussion or the meeting;

b) that the meeting proceeds to the next business;

c) the appointment of an ad hoc committee to deal with a specific item of business;

d) that the motion be now put;

e) that the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 3.1.

3.8.4 In the case of sub-paragraphs SO 3.8.3.c and SO ~~2.8.3.e~~ 3.8.3.e above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

3.8.5 No amendment to the proposition shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the proposition.

3.8.6 The mover of a proposition shall have a maximum of five minutes to move and five minutes to reply. Once a proposition has been moved, no Governor shall speak more than once or for more than five minutes.

3.9 Report from the Board of Directors

3.9.1 Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Chief executive or nominated representative shall present a report on the Trust's progress and forward planning.

3.10 Chair's Ruling

3.10.1 Statements of governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.11 Voting

The Council of Governors will endeavour to ensure that decisions taken are by consensus and without recourse to voting, except where a vote is formally required under the constitution. Where however consensus is not achieved, the following process of voting will be applied.

3.11.1 A governor may not vote at a meeting of the Council of Governors unless, within 7 clear days prior to the commencement of the meeting they have made a declaration in the form specified within Schedule A of these Standing Orders, that they are a member of the constituency which elected them and are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

3.11.2 Subject to SO 3.11.4 below, matters requiring the conduct of a vote shall be determined by a majority of the votes of the governors present and voting on the question.

3.11.3 Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal, have a casting vote.

3.11.4 A resolution for the removal of the Chair or a non-executive director shall be passed only in accordance with the provisions of 28.2 28.3 to 28.5 of the constitution.

3.11.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

3.11.6 If at least one-third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained.

3.11.7 If a governor requests, his their vote shall be recorded by name upon any vote (other than by paper ballot).

3.11.8 A governor may only vote if present at the time of the vote on which the question is to be decided; no governor may vote by proxy, but a governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.

3.12 Special Provisions relating to Termination of Governor's Tenure:

3.12.1 Where a person has been elected or appointed to be a governor and they become disqualified from office under paragraph 16 or paragraph 17 of the constitution, they shall notify the Company Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of the first becoming aware of those matters which render them disqualified. The Company Secretary shall forthwith remove them from the Register of Governors.

3.12.2 If it comes to the notice of the Company Secretary that the governor is disqualified pursuant to SO 23.12.1, whether at the time of the governor's appointment or later, the Company Secretary shall immediately declare that the individual in question is disqualified and give them notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the governor disputes that they are disqualified, the governor may refer the matter to the dispute resolution procedure set out in paragraph 7 of Annex 6 within 28 days of the date upon which the notice was given to the governor.

3.13 Minutes

3.13.1 The minutes of the proceedings of a meeting shall be drawn up by the Company Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the Chair presiding at it.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.13.2 Minutes of meetings will be taken and circulated in accordance with governors' wishes.

3.14 Suspension of Standing Orders

3.14.1 Except where this would contravene any statutory provision or any direction made by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the governors are present, and that a majority of those present vote in favour of suspension.

3.14.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and governors.

3.14.4 No formal business may be transacted while Standing Orders are suspended.

3.14.5 Record of Attendance; the names of the Chair and governors present at the meeting shall be recorded in the minutes.

3.15 Variation and Amendment of Standing Orders

3.15.1 Subject always to paragraph 3.14 of Annex 7 of the constitution, these Standing Orders shall be amended only if:

a) a notice of proposal under Standing Order 3.5 has been given; and

b) at least two thirds of the total number of governors is present; and

c) the majority of governors present vote in favour of amendment; and

d) the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision, guidance issued by the Regulator or the Constitution.

3.16 Record of Attendance

3.16.1 The names of the Chair and governors present at the meeting shall be recorded in the minutes.

3.17 Quorum

3.17.1 No business shall be transacted at a meeting unless at least one third of the total number of governors are present with the majority of those present being Public Governors.

3.17.2 If at any meeting there is no quorum present within 15 minutes of the time scheduled for its commencement, the meeting shall stand automatically adjourned for a period of seven days and the Chair shall give or procure the giving of notice to all governors of the date, time and place of that adjourned meeting. Upon reconvening, those present shall constitute a quorum.

3.17.3 If a governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on

any matter that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.18 Urgent Decisions

3.18.1 Where such a decision is required to be taken by the Council of Governors and which cannot await the next scheduled formal meeting of the Council of Governors, a section of the next Council of Governors development session be formally designated a formal general meeting for this specific purpose.

3.18.2 For decisions required to be taken in situations where the approach above does not result in a quorate meeting it is proposed that:

a) A decision to be taken, where justified, by the Lead Governor and Chair following consultation with the Deputy Lead Governor where elected.

b) Where the decision to be taken is one which would ordinarily be required under the constitution to be subject to a vote by the Council of Governors, that such a vote be conducted electronically outside of the meeting and overseen by the Company Secretary ~~(for those Governors who do not have access to or preference would be not to utilise IT, a paper vote would be enabled).~~

3.18.3 Any decision taken under such an approach would be reported to the next meeting of the Council of Governors.

3.18.4 The use of the above approach will only be utilised in exceptional circumstances, with the expectation that all business will be conducted at the formal Council of Governor meetings.

4 Lead Governor and Deputy Lead Governor

4.1 In accordance with the code of governance for NHS provider trusts the Council of Governors shall elect a Lead Governor and if required a Deputy Lead Governor who must be a governor. The Lead Governor (or in their absence a Deputy Lead Governor) has a role in facilitating direct communication between NHS England (or its successor) and the Council of Governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Company Secretary.

4.2 Without prejudice to the rights of any governor to communicate directly with the Chair, the Lead Governor shall be responsible for receiving from governors and communicating to the Chair any comments, observations and concerns expressed to the Chair by governors other than at meetings of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

4.3 The Deputy Lead Governor (where elected) shall be responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor whenever they are known to be unavailable.

4.4 Each governor shall communicate any comment, observation or concern which they may have to the Lead Governor in the first instance and only to the Deputy Lead Governor if the Lead Governor is known to be unavailable.

4.5 These appointments shall be made from those governors who have been elected as governors from the Public Constituency or appointed by a Partner Organisation.

4.6 The Lead Governor and the Deputy Lead Governor so elected shall hold office for a period of three years provided that they continue to hold the governor seat to which they were duly elected or appointed. They may subsequently seek re-election for one more three-year period of office, provided that they continue to hold the governor seat to which they were duly elected or appointed.

4.7 Nominations for appointment as Lead Governor and Deputy Lead Governor shall be sent out with the papers for the first meeting or annual meeting of the Council of Governors as the case may be. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the principal place of business of the Trust addressed to the Company Secretary to arrive by a stipulated date.

4.8 There shall be separate forms of nomination for appointment to the position of Lead Governor and the position of Deputy Lead Governor and eligible governors may be nominated for both positions. In the event of there being two or more nominations for either appointment a secret postal ballot shall be held of all the governors with each governor having one vote for each contested appointment. The governor whose nomination receives the largest number of votes for each position shall be appointed.

4.9 In the event of the number of votes in any election being equal, a draw will take place overseen by the Company Secretary. The nomination whose name is drawn will be elected to the role.

4.10 The result of the ballot shall be announced at the meeting.

5 Committees

5.1 Subject to such guidance as may be issued by the Regulator, the Council of Governors may appoint committees of the Council of Governors to assist it in the proper performance of its functions under the constitution and the Regulatory Framework, consisting wholly or partly of the Chair and governors.

5.2 All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the governors attending the meeting.

5.3 A committee appointed under SO 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.4 These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chair” to be read as a reference to the Chair of the committee, and the term “governor” to be read as a reference to a member of the committee as the context permits.

5.5 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Regulator, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Where committees are authorised to establish sub-committees, they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.7 Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, provided that the financial and other implications of seeking outside advisors have been discussed and agreed by the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out at paragraph 6.4 of Annex 6.

5.8 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.9 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, such appointments are to operate in accordance with applicable statute and regulations and with guidance issued by the Regulator.

5.10 Where the Council of Governors determines that persons who are neither governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

6 Declarations of Interests and Register of Interests

6.1 Declaration of Interests

6.1.1 The Regulatory Framework and the constitution require each governor to declare to the Secretary:

a) any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

b) any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust which is under consideration or is to be considered by the Council of Governors, as described in SOs 6.2.2 and 6.2.3; and

c) any actual or potential family interest, direct or indirect, of which the governor is aware, as described in SO 6.2.5.

6.1.2 Such a declaration shall be made either at the time of the governor's election or appointment or within 28 days thereof, or otherwise as soon as they become aware of

the existence of that interest, and in a form prescribed by the Company Secretary from time to time.

6.1.3 In addition, if a governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4 Subject to SO 6.2, if a governor has declared a pecuniary interest (as described in SOs 6.2.2 to 6.2.5) they shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the Council of Governor's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.5 This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a governor).

6.1.6 The interests of governors in companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.2 Nature of Interests

6.2.1 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

a) directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; or

c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS; or

d) a position of authority in a charity or voluntary organisation in the field of health and social care; or

e) any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

f) any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks; or

g) research/funding grants that may be received by an individual or their department; or

h) interests in pooled funds that are under separate management.

6.2.2 A governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) they, or a nominee of theirs, are a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, or which has a direct pecuniary interest in the other matter under consideration; or

b) they are a partner of or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.3 A governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

b) of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

c) of any travelling or other expenses or allowances payable to a governor in accordance with the constitution.

6.2.4 Where a governor:

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

d) the governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however it is their duty to disclose the interest.

6.2.5 A family interest is an interest of the spouse or partner or any parent, child, brother or sister of a governor which if it were the interest of that governor would be a personal interest or a pecuniary interest of theirs.

6.2.6 If governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Company Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including General Practitioners should also be considered.

7 Standards of Business Conduct

7.1 Members of the Council of Governors shall comply with the Trust's Code of Conduct for Governors and any guidance or best practice advice issued by the Regulator.

8 Appointments and Recommendations

8.1 A governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a governor from giving written testimonial of a candidate's appointment.

8.2 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4 The Chair and every governor shall disclose to the Trust Secretary any relationship between themself and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Company Secretary to report to the Council of Governors any such disclosure made.

8.5 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

8.6 Where the relationship to a member of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9 Remuneration and Expenses

9.1 Governors are not to receive remuneration.

9.2 The Trust will pay travelling expenses to governors in accordance with the relevant Trust policies for attendance at the Council of Governors, or any other business authorised by the Company Secretary as being under the auspices of the Council of Governors.

9.3 Expenses will be authorised and reimbursed through the Company Secretary's office on receipt of a completed and signed expenses form provided by the Company Secretary.

9.4 A summary of expenses paid to governors will be published in the Annual Report.

10 Miscellaneous

10.1 The Company Secretary shall provide a copy of these Standing Orders to each governor and endeavor to ensure that each governor understands their responsibilities within these Standing Orders.

10.2 These Standing Orders including all documents having effect as if incorporated in them shall be reviewed regularly by the Board of Directors and the Council of Governors.

10.3 Any written notice required by these SOs shall be deemed to have been given on the day the notice was sent to the recipient.

10.4 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All governors have a duty to disclose any non-compliance with these SOs to the Chair as soon as possible.

10.5 A governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

Schedule A: Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

I hereby declare that I am at the date of this declaration a member of the Public/Staff/Constituency (delete as necessary), and I am not prevented from being a member of the Council of Governors by reason of any provision of the Constitution.

Signed:

Print name:

Date:

Schedule B: Prescribed Form of Declaration of Interests

Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

Date

To the Secretary **of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust**

Dear

In fulfilment of the obligations imposed on me by paragraph 22 of the Constitution of the Foundation Trust and the provisions of Standing Order 6 of the Standing Orders for the Council of Governors generally, and in particular Standing Order 6.1.2, I hereby give notice to the Trust of my interest in:

[insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non-pecuniary, direct, indirect, actual, potential, etc.)**]**

as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's Register of Interests of the Members of the Council of Governors.

Yours faithfully
[name]

ANNEX 8: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. INTRODUCTION
2. THE BOARD OF DIRECTORS
3. MEETINGS OF THE TRUST
4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
5. COMMITTEES
6. INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS
~~6~~ 7. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS
~~7~~ 8. STANDARDS OF BUSINESS CONDUCT
~~8~~ 9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS
~~9~~ 10. SIGNATURE OF DOCUMENTS
~~10~~ 11. MISCELLANEOUS

1. Introduction

Statutory Framework

1.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular ~~paragraph 35~~paragraph 34 of the Constitution requires the Board of Directors to adopt Standing Orders for the regulation of its proceedings and business.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

1.5 The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1.6 The Trust shall deal with the Regulator in an open and co-operative manner and shall promptly notify the Regulator of anything relating to the Trust of which the Regulator would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its authorisation or any financial or performance thresholds which the Regulator may specify from time to time.

1.7 The Chair, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Nolan Committee, now the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for

Public Service. They will also ensure that they follow the best practice advice set out in the Code of Governance for NHS Provider Trusts.

1.8 Delegation of Powers – Scheme of Delegation

Under the Standing Orders relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

1.9 In these Standing orders the definitions outlined in the constitution paragraph 1 shall apply.

2. The Board of Directors

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to be made to the Charity Commission.

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided for in SO 3.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

3. Meetings of the Trust

3.1 Admission of the Public and the Press

3.1.1 Subject to SO 3.1.2, meetings of the Board of Directors shall be held in public, unless the Board of Directors in their absolute discretion determine that any part of a meeting of the Board of Directors shall be held in private.

3.1.2 Where the Board of Directors determines that meetings of the Board of Directors will be held in public, the public and representatives of the press may, at the absolute discretion of the Chair, be afforded facilities to attend a meeting of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" (Section1(2) Public Bodies (Admission to Meeting) Act 1960).

3.1.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

3.1.4 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.2. Calling Meetings

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of Directors, and this has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's Headquarters, such one third or more members of the Board of Directors may forthwith call a meeting.

3.2.3 The Trust will publicise and hold an Annual Public Meeting, which shall be on or before 30 September every year.

3.3. Notice of Meetings

3.3.1 Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an Officer of the Trust authorised by the Chair to sign on ~~his~~ their behalf, shall be delivered to every Director, by email so as to be available to ~~him~~ them at least 7 days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

3.3.3 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those directors, and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite 7 days' notice provided that every effort is made to make personal contact with every

Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4. Agendas

3.4.1 Agendas will be accessible to members of the Board of Directors six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be accessible no later than three days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.4.2 A public notice of the time and place of the meeting, and the agenda (excluding any part of the agenda for which members of the public may be excluded from for special reasons), shall be displayed on the Trusts website at least three days before the meeting

3.5. Setting the Agenda

3.5.1 The Chair, or in their absence the Deputy Chair, shall determine the agenda for each meeting of the Board of Directors, being advised in this regard by the Chief Executive and the Company Secretary.

3.5.2 A Director desiring a matter to be included on an agenda shall make ~~his~~ their request to the Chair at least ten clear days before the meeting, subject to SO 3.3. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Chair. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6. Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

3.7. Chair of Meeting

3.7.1 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if there is one who is present, shall preside. If the Chair and Deputy Chair are absent, such non-executive director (and who is not also an Officer of the Trust) as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the members of the Board of Directors present shall choose, shall preside.

3.8. Chair's Ruling

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9. Notices of Motion

3.9.1 Subject to the provisions of SO 3.11 and SO 3.12, a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chair.

3.9.2 The notice shall be delivered at least 10 clear days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these SOs and the appropriate Regulations. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10. Emergency Motions

3.10.1 Subject to the agreement of the Chair, and subject also to the provision of SO 3.11, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.11. Motions: Procedure at and during a meeting

3.11.1 Who may propose

i) A motion may be proposed by the Chair of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 Contents of motions

i) The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

a) the reception of a report;

b) consideration of any item of business before the Board of Directors;

c) the accuracy of minutes;

d) that the Board of Directors proceed to next business

e) that the Board of Directors adjourn; or

f) that the question be put now.

3.11.3 Amendments to motions

i) A motion for amendment shall not be discussed unless it has been proposed and seconded.

ii) Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors

iii) If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.4 Rights of reply to motions

i) Amendments

a) The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

ii) Substantive/original motion

a) The member of the Board of Directors who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 Withdrawing a motion

i) A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11.6 Motions once under debate

i) When a motion is under debate, no motion may be moved other than:

a) an amendment to the motion;

b) the adjournment of the discussion, or the meeting;

c) that the meeting proceeds to the next business;

d) that the question should be now put;

e) the appointment of an 'ad hoc' committee to deal with a specific item of business;

f) a motion under SO 3.1.2 resolving to exclude the public (including the press); and

g) that a member be not further heard.

ii) In the cases of a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d), in the interests of objectivity, such a motion should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

iii) If a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

iv) The mover of a motion shall have a maximum of five minutes to move and five minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak for more than five minutes.

3.12. Motion to Rescind a Resolution

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate. This provision shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13. Voting

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

~~13.3.2~~3.13.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

~~13.3.3~~3.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each director present voted or abstained.

~~13.3.4~~3.13.4 If a director so requests, ~~his~~ their vote shall be recorded by name upon any vote (other than by paper ballot).

~~13.3.5~~3.13.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

~~13.3.6~~3.13.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An Officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14. Minutes

3.14.1 The minutes of the proceedings of a meeting shall be drawn up by the Company Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained via electronic form and archive.

3.14.3 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.15. Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chair and the directors.

3.15.4 No formal business may be transacted while SOs are suspended.

3.15.5 The Audit and Risk Committee shall review every decision to suspend SOs.

3.16. Variation to Standing Orders

3.16.1 Subject always to paragraph 3.15 of Annex 8 of the constitution, these SOs shall be amended only if:

(i) relevant notice of a meeting has been served in accordance with SO 3.3;

(ii) a notice of motion under SO 3.9 has been given;

(iii) no fewer than half the total of the Trust's non-executive directors vote in favour of amendment;

(iv) at least two-thirds of the Board of Directors are present; and

(v) the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by the Regulator.

3.17. Record of Attendance

3.17.1 The names of the Chair and the directors present at the meeting shall be recorded in the minutes.

3.18. Quorum

3.18.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director and the Chair.

3.18.2 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.18.3 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the ~~Appointment and Terms of Service Committee~~ Nominations and Remuneration Committee).

3.19. Meetings: Electronic Communication

3.19.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.19.2 A director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Board of Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the directors attends by way of electronic communication is deemed to be held at such a place as the directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present ***and maintained*** throughout the meeting.

3.19.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the directors were all able to hear each other and were present throughout the meeting.

4 Arrangements for the Exercise of Functions by Delegation

4.1 Subject to SO 2.6 and such guidance as may be given by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.4 below, or by a director or an officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2~~Notwithstanding the provisions of SO 4.1, the provisions of paragraphs 4.2 to 4.3 of the Constitution apply~~ Notwithstanding the provisions of SO 4.1, the powers reserved to the Board of Directors in the Scheme of Reservation and Delegation, and the emergency provisions at SO 4.3, apply.

4.3 Emergency Powers

4.3.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.4 Delegation to Committees

4.4.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.5 Delegation to Officers

4.5.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

4.5.2 The Chief Executive shall prepare a Scheme of Delegation identifying ~~his~~ their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.5.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer or other Executive director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

4.5.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.6 Duty to Report Non-Compliance with Standing Orders

4.6.1 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these SOs to the Company Secretary as soon as possible.

5. Committees

5.1 Appointment of Committees

5.1.1 Subject to SO 2.6 and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator, shall appoint committees of the Trust consisting wholly or partly of directors of the Trust or other Health Service Bodies or wholly of persons who are not directors of the Trust or other health service bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to such guidance as may be given by the Regulator, the Board of Directors or the other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of Directors (whether or not they are Directors of the Trust in question) or wholly of persons who are not directors of the Trust or the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any relevant legislation and/or regulations, and such guidance or best practice advice issued by the Regulator. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees, they may not delegate Executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 The committees and sub-committees established by the Board of Directors are:

i) Audit and Risk Committee;

ii) Nominations and Remunerations Committee;

ii) Finance and Performance Committee;

iv) Quality Committee; and

v) People Committee.

vi) as Trustees on behalf of DBTH of the Trust Charity - The Charitable Funds Board

5.1.8 The terms of reference of those Committees in paragraph 5.1.7 above shall be agreed by the Board of Directors.

5.1.9 The Board of Directors may also operate as a committee in accordance with SO 5.1.2. Any decisions taken by the Board of Directors in committee (i.e. Seminar meeting of the Board of Directors) must be brought to the next meeting of the Board of Directors.

5.2 Confidentiality

5.2.1 A member of a committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.2.2 A director or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. Interface between the Board of Directors and the Council of Governors

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the constitution.

6.2 The directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to the regulator.

6.3 The directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the auditor on them, and the annual report.

6.4 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 47 and 48 ~~and 49~~ of the constitution is included on the agenda for a meeting of the Board of Directors.

6.5 If the Council of Governors so desires, such a matter as described within SO 6.4 to be included on an agenda item, they shall make their request in writing to the Chair at least 14 clear days before the meeting of the Board of Directors, subject to SO 3.3. The Chair shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 14 clear days before a meeting may be included on the agenda at the discretion of the Chair.

7. Declarations of Interests and Register of Interests

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Company Secretary:

7.1.1 any pecuniary interest in any contract, proposed contract or other matter which is under consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust irrespective of whether those interests are direct or indirect, actual or potential.

7.2 All existing members of the Board of Directors should declare such an interest as soon as the director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Company Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within seven clear days of becoming aware of the existence of a relevant and material interest.

7.4 In addition, if a director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.5 If a director has declared a pecuniary interest in accordance with SO 7, they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Board of Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.6 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

7.6.1 Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.6.2 ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.6.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

7.6.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.6.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.6.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks;

7.6.7 any other commercial interest in the decision before the meeting.

7.7 Any travelling or other expenses or allowances payable to a director in accordance with the constitution shall not be treated as a pecuniary interest.

7.8 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.9 A director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.9.1 they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, or which has a direct pecuniary interest in the other matter under consideration; or

7.9.2 they are a partner of or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.10 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.10.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.10.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.11. Where a director:

7.11.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.11.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.11.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.12 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of the constitution and the SOs to be also an interest of the other.

7.13. If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Company Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships should also be considered.

7.14. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.15. SO7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a director).

7.16 Register of Interests

7.16.1 The Register of Interests shall contain the names of each director, whether they have declared any interests and, if so, the interests declared in accordance with the constitution or these SOs.

7.16.2 It is the obligation of the Director to inform the Company Secretary in writing within seven clear days of becoming aware of the existence of a relevant or material interest. The Company Secretary must amend the appropriate Register of Interests upon receipt of new or amended information as soon as is practical and, in any event, within fourteen clear days.

7.16.3 The Register of Interests will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register of Interests to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register of Interests must be provided to members free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests

7.16.4 The details of directors' interests recorded in the Register of Interests will be kept up to date by means of a regular review as necessary of the Register of Interests by the Company Secretary during which any changes of interests recently declared will be incorporated.

8. Standards of Business Conduct Policy

8.1 Policy

8.1.1 Directors and officers should comply with the Code of Governance for NHS Provider Trusts, the Trust Code of Conduct and any guidance and/or best practice advice issued by the Regulator. This section of SOs should be read in conjunction with these documents.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Company Secretary of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A director or officer must also declare to the Chief Executive or Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with

the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the Register of Directors interests.

8.3. Canvassing of, and Recommendations by, Directors in Relation to Appointments

8.3.1 Canvassing of directors or members of any committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4. Relatives of Directors or Officers

8.4.1 Candidates for any staff appointment shall when making an application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The directors and every member and officer of the Trust shall disclose to the Chief Executive any relationship between ~~him~~themself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an officer or another director of the Trust is disclosed, SO 8 shall apply.

8.5. External Consultants

8.5.1 SO 7 and SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Trust's Scheme of Delegation should be adhered to at all times.

9. Custody of Seal and Sealing of Documents

9.1 Custody of Seal

9.1.1 The common seal of the Trust shall be kept by the Company Secretary in a safe at Trust Headquarters. The seal shall only be released from the safe to enable it to be affixed to a document in accordance with these Standing Orders.

9.2 Sealing of Documents

9.2.1 The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

9.2.2 Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of two directors or a director and the Secretary duly authorised by the Chief Executive and not also from the originating department and shall be attested by them.

9.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an Officer nominated by ~~him/her~~ them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them ~~him/her~~ who shall not be within the originating Directorate).

9.3 Register of Sealing

9.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least annually (The report shall contain details of the seal number, the description of the document and date of sealing).

9.3.2 Every contract for building and engineering works, which exceeds the sum of £250,000 shall be executed under the common seal of the Trust.

9.3.3 The officer responsible for the register of the opening of tender/quotation envelopes shall retain this under secure custody and will make it readily available to external and internal audit for inspection as required.

9.3.4 Trust officers issuing and receiving the tender/quotation documents shall retain those documents and envelopes under secure custody, for the following periods:

i) for documents under seal, 12 years; and

ii) for documents under hand, 6 years.

10. Signature of Documents

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11. Miscellaneous

11.1 Standing Orders to be given to members and officers

11.1.1 It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to Officers designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies, where appropriate, of SOs.

11.2 Documents having the standing of Standing Orders, Standing Financial Instructions and the Scheme of Delegation shall have the effect as if incorporated into SOs.

11.3 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

ANNEX 9: ANNUAL MEMBERS' MEETING

1. ANNUAL MEMBERS' MEETING

1.1 The Trust shall publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year (unless the circumstances of para 16.5 apply)(unless exceptional circumstances apply, in which case the Chair shall decide in consultation with the Lead Governor).

1.2 The following documents are to be presented to the members and governors of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

1.2.1 the annual accounts;

1.2.2 any report of the external auditor on them; and

1.2.3 the annual report.

1.3 There may be times and reasons that the Annual Members' Meeting may be held "virtually online" and not face to face. The Chair will decide these times in consultation with the Lead Governor and Board of Directors.

2. ADMISSION OF THE PUBLIC AND PRESS

2.1 Members, the public and representatives of the press shall be afforded facilities to attend the Annual Members' Meeting.

2.2 The Chair (or Deputy Chair) shall give such directions as s/he they thinks fit in regard to the arrangements for meetings and accommodation of members, the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption.

2.3 Members, the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography, or use of social media.

3 CHAIR

3.1 The Chair, if present, shall preside at the annual members meeting. If the Chair is absent from the meeting the Deputy Chair shall preside.

3.2 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

4 NOTICE OF MEETING

4.1 The Company Secretary shall give at least fourteen days' notice of the date and place of the Annual Members' Meeting to all governors. Notice will also be published in communications to Trust members and on the Trust's website.

4.2 The notice of the meeting will specify the business proposed to be transacted at it

4.3 Lack of service of the notice on any governor shall not affect the validity of a meeting.

4.4 Before the Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, shall be placed on the Trust's website and shall be delivered to every governor by e-mail, by e-mail or sent by post to the usual place of residence of such Governor if e-mail facility not available, so as to be available to them him/her at least three clear days before the meeting.

Where the AMM is held virtually, members will have opportunities to ask questions on the business transacted before and after the meeting presentations by submitting directly to the AMM website and/or via the Trust Board Office.

5 PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS

5.1 The following documents are to be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

5.1.1 the annual accounts;

5.1.2 any report of the auditor on them; and

5.1.3 the annual report.

6 AMENDMENT OF THE CONSTITUTION

6.1 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

6.1.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment(s), and

6.1.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

6.2 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect, and the trust must take such steps as are necessary as a result.

7 QUORUM

7.1 There may be times and reasons why the AMM is held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor and quoracy arrangements dependant on the nature of the business transacted.

7.1.1 In extremis *(see para 16.5)*(for example, where the meeting is held virtually), the Chair may decide to review the terms of the meeting.

7.2 Where the Annual Members' Meeting is combined with a Council of Governors meeting for the purpose of receiving the annual accounts and reports, the quorum of the Council of Governors shall apply.

8 VOTING

8.1 Every question for decision at a meeting will be determined by a majority of the votes of the members present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

8.2 As members, governors may vote at the Annual Members' Meeting except where the matter under consideration is a constitution amendment regarding the powers or duties of the Council of Governors, (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

8.3 With the exception of the Chair, directors may not vote at the Annual Members' Meeting.

8.4 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands.

8.5 If a majority of the members present so request, the voting on any question may be recorded to show how each member present voted or abstained.

8.6 If a member so requests, ~~his/her~~ their vote shall be recorded by name upon any vote

8.7 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

9 MINUTES

9.1 The names of governors, directors and members present at the meeting shall be recorded. However, if meeting is held virtually then monitoring of "virtual views" will be performed by a member of the Communications team and information given to both Chair and Company Secretary.

9.2 The minutes of the proceedings of a meeting shall be drawn up and maintained as a public record and submitted for final agreement at the next ensuing meeting where they will be signed by the person presiding at it.

9.3 They may be circulated for information prior to the next year's meeting and interim agreement of accuracy acknowledged by the Council of Governors.

9.4 Minutes shall be made available to the public in draft (interim Council of Governors accuracy approved) format and then once finally approved at the next AMM, unless AMM was held virtually where agreement of accuracy will be acknowledged by the Council of Governors.

9.5 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

10 AGENDA

10.1 A governor or member desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting is notified to governors and members. Requests made less than ten days before a meeting is notified to governors may be included on the agenda at the discretion of the Chair.

11 MOTIONS

11.1 A governor or member of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting is notified to governors to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being

permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved without notice during the meeting, on any business mentioned on the agenda.

11.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

11.3 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

11.4 When a motion is under discussion or immediately prior to discussion it shall be open to a governor or member to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceeds to the next business. *

(v) That the motion be now put to a vote. *

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a governor who has not previously taken part in the debate.

11.5 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

12 CHAIR'S RULING

12.1 Statements of governors and members shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Scheme of Reservation and Delegation of Powers to the Board

~~April 2025~~ October 2026



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Name and title of author/reviewer:	Brenda Thomas - Interim Company Secretary Rebecca Allen - Company Secretary Sam Wilde Chief Finance Officer
Date written/revised:	~~March 2025~~June 2026 and October 2026
Approved by (Committee/Group):	The Board of Directors
Date of approval:	~~May 2025~~~~August Board of Directors 2026~~ [Date to be inserted - Board approval deferred pending further review]
Date issued:	
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Target audience:	Trust-wide

Scheme of Reservation and Delegation of Powers of the Board

Amendment Form

Please record brief details of the changes made alongside the next version number.
If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
Version 15	[Date to be inserted]	• Redrafted following Board review: aligned to the revised Constitution and Standing Orders (paragraph and SO cross-references corrected); added reserved matters and Council of Governors responsibilities; clarified designations and abbreviations; corrected typographical errors and the contents page. • Updated on SO and SFI references. Updated on executive designations,	Brenda Thomas Rebecca Allen
Version 14	April 2025	• Updated on authors • Expanded introduction • Removed duplicated clauses	Rebecca Allen Sam Wilde Matthew Bancroft Richard Somerset
Version 13	September 2024	• Updated minor typographical and formatting errors • Included reference to Grip and Control meetings • Updated Procurement terminology from EU to UK law • Clarity on losses and compensation decisions and above delegated limits • Replacing gender referenced language	Matthew Bancroft Richard Somerset Rebecca Allen
Version 12	July 2023	• Resetting Director of Finance and Deputy Chief Executive limits to pre-interim arrangements in 2022 • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 11	July 2022	• Introduction of the Deputy Chief Executive role within the delegation limits • Updated job titles • Removed reference to NHS Improvement • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft

Version 10	July 2021	• Replaced DoN with Chief Nurse • Updated references to NHS Improvement/NHS England • Reference to e-signing of contracts • Ensure Directors sign-off levels are consistent	Matthew Bancroft
Version 9	July 2020	Renaming names of structures/meetings	Matthew Bancroft
Version 8	November 2018	Renaming names of structures/meetings	Jon Sargeant
Version 7	September 2017	Various	Jon Sargeant and Matthew Kane
Version 6	September 2016	• Update to ensure consistency with the SFIs • Update for consistency with new committee structure • Various changes	Maria Dixon / Andrew Thomas
Version 5	March 2015	• Updated to reflect changes to Standing Orders relating to e-tendering and Working Together Group thresholds	Andrea Smith
Version 4	November 2013	• References throughout to Director of Finance, Information and Procurement / DoFIP amended to Director of Finance and Infrastructure / DoFI; • References throughout to Director of Human Resources amended to Director of People and Organisational Development; • Updated references and amendments for consistency to revised Standing Orders section 11 and tendering annex; • Clarification added to the posts included in role of 'Senior Officer'.	Robert Paskell

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1. Introduction

1. Arrangements for the Exercise of Functions by the Trust and its Officers

1.1 The Code of Governance for NHS providers requires the Board of Directors to draw up a schedule of decisions reserved to the Board of Directors only, and to ensure that management arrangements are in place to enable the clear delegation of other responsibilities. This document sets out the powers reserved to the Board of Directors, and the powers which may be delegated, and it should be referred to as the "Scheme of Reservation and Delegation".

1.2 Within the Licence Conditions issued by the Regulator, the Trust is required to demonstrate the existence of comprehensive governance arrangements which may be delegated in accordance with Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. These arrangements are to be read in conjunction with and subject to the Constitution, the Standing Orders and Standing Financial Instructions adopted by the Trust.

1.3 This document, sets out the powers reserved to the Board, the powers delegated to committees of the Board and to specific officers of the Trust. The document sets out the delegation derived from the code of conduct and accountability and from the Standing Orders for the Board of Directors. The document does not duplicate the extensive delegated powers and responsibilities set out within the Standing Financial Instructions. Therefore, the Scheme of Delegation must be read in conjunction with the Standing Financial Instructions.

1.4 In the absence of a named officer or committee, decisions may only be exercised by the Board of Directors in formal session.

1.5 The Board remains accountable for all of its functions; even those delegated to the Chair, individual Chiefs, or Officers, and would therefore expect to receive information about the exercise of those delegated functions to enable it to maintain a monitoring role.

2. Key Points

2.1 Role of the Chief Executive

2.1.1 All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated.

2.1.2 The Chief Executive will establish appropriate management arrangements to ensure that senior Officers pursue the Trust's policies in a corporate manner. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

2.1.3 The Chief Executive is the Accounting Officer of the Trust (Paragraph 16(1) of Schedule 7 to the 2006 Act) and is responsible and accountable for discharging the functions specified in the NHS Foundation Trust Accounting Officer Memorandum.

2.2 Caution over the Use of Delegated Powers

Powers are delegated to Chiefs and Officers on the understanding that they would not exercise delegated powers in a matter which, in their judgement, was likely to be a cause for public concern.

2.3 Chiefs and Officers Ability to Delegate their own Delegated Powers

2.3.1 The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.3.2 To assist the Chief Executive in their duties, and in accordance with the principle of holding individual Officers accountable for specific duties, they will delegate such functions as they consider appropriate, and in turn adjust such delegations as they deem~~s~~ necessary.

2.3.3 Individual Officers will have the opportunity to delegate such functions to their subordinates with the agreement of the Chief Executive, but such further delegation, if agreed, does not remove the accountability for the correct discharge of the function from the Senior Officer.

2.4. Absence of Chiefs or Officers to Whom Powers have been Delegated

In the absence of a director to whom powers have been delegated those powers shall be exercised by that ~~Chiefs~~ director's or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive

3. Reservation of Powers to the Board

3.1 **The Code of Accountability** which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 3.2 to 3.9 below:

3.2 General Enabling Provision

The Board may determine any matter it wishes for which it has delegated or statutory authority in full session within its statutory powers.

3.3 Regulations and Control

3.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

3.3.2 Approval of a scheme of delegation of powers from the Board to officers or other bodies.

3.3.3 Suspension of Standing Orders in accordance with SO ~~5.36~~3.15.

3.3.4 Variation or amendment of Standing Orders in accordance with SO ~~17~~3.16.

3.3.5 Requiring and receiving the declaration of Executive and non-executive directors' and governor interests which may conflict with those of the Trust and determining the extent to which that director/governor may remain involved with the matter under consideration.

3.3.6 Requiring and receiving the declaration of officers' interests which may conflict with those of the Trust.

3.3.7 Disciplining members of the Board of Directors who are in breach of statutory requirements or the SOs.

3.3.8 Approval of the disciplinary procedure for officers of the Trust.

3.3.9 Approval of arrangements for dealing with complaints.

3.3.10 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to. For Clarity this would comprise details of the structure of the Board of Directors and its committees, plus the directorate structure of the Trust only.

3.3.11 To receive reports from committees including those which the Trust is required by the Secretary of State, independent regulator or other regulation to establish and to take appropriate action on.

3.3.12 To confirm the recommendations of the Trust's committees where the committees do not have executive powers and to establish terms of reference and reporting arrangements of all committees established by the Board of Directors.

3.3.13 Ratification of any urgent decisions taken in accordance with ~~SO 6.10~~ SO 4.3 (emergency powers) and reported to the next formal meeting of the Board.

3.3.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

3.3.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

3.3.16 Authorise Use of the Seal in accordance with SO ~~14~~9.

3.3.17 Approval of the Trusts Resilience Plan.

3.3.18 Specification of its financial and performance reporting requirements.

3.3.19 Approval of amendments to the Constitution (Constitution section 47), which also require the approval of the Council of Governors and, where they affect the powers or duties of the Council of Governors, the Annual Members' Meeting.

3.3.20 Approval of the Board's arrangements for the appointment of the Senior Independent Director and the Deputy Chair, and for the review of Chair and non-executive director tenure against the nine-year maximum (Constitution paragraphs 25.10, 28.1 and section 30).

3.4 Appointments

3.4.1 The appointment and dismiss committees (and individual members) that are directly accountable to the Board of Directors.

3.4.2 The appointment, discipline and dismissal of Chiefs. ~~(subject to SO 3.).~~

3.4.3 The appointment of members to committees of the Board of Directors and as representatives of the Trust on any outside bodies.

3.4.4 Appointment, discipline and dismissal of the Company Secretary.

3.5 Policy Determination

3.5.1 To approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so received shall be listed.

3.6 Strategy, Plans and Budgets

3.6.1 Definition of the strategic aims and objectives of the Trust.

3.6.2 Approval of budgets, the Trusts Annual Plan, and Cost Improvement Plans submitted by the Chief Executive at least annually.

3.6.3 Approval of the capital programmes and determine guidelines within which the Chief Executive Officer may approve variations to the programme.

3.6.4 Approval in principle to the content and cost of individual capital schemes or single items of equipment over the expenditure limit of £1 million and to accept tenders for such, including tenders for any management consultancy.

3.6.5 Approval of proposals for ensuring quality and the developing clinical governance in services provided by the Trust, having regard for guidance issued by the Secretary of State or Independent Regulator.

3.6.6 To i~~I~~dentify k~~K~~ey strategic risks, evaluate them and ensure adequate r~~R~~isk management responses are in place and monitored through the Board of Directors and its committees

3.6.7 To consider advice from any other advisory committees as the Board of Directors may establish or recognise.

3.6.8 To approve written evidence on behalf of the Trust to be submitted to statutory or other official bodies. Where urgent action is required, the Chief Executive Officer should act on behalf of the Trust and consult with the Chair of the Trust (or Deputy Chair in their absence) and report action taken at the next meeting of the Board of Directors.

3.6.9 Approval of the workforce plans set out within the Annual Plan.

3.7 Direct Operational Decisions

3.7.1 Acquisition, disposal or change of use of land and/or buildings.

3.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000.

3.7.3 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1 million over the period of the contract

3.7.4 Approval of individual compensation payments made outside any legal/statutory or mandatory requirements after treasury approval received.

3.7.5 Approval of proposals for action on litigation against or on behalf of the Trust.

3.7.6 Approval of proposals in individual cases for the write off of losses or making special payments above the delegation limits (for losses and special payments)

3.7.7 Approval of business cases requiring additional revenue resources of over £1 million per annum

3.8 Financial and Performance Reporting Arrangements

3.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Chiefs, committees, and officers of the Trust as set out in management policy statements and delegated powers. All monitoring returns required by NHS England and the Charity Commission shall be reported, to the Board of Directors.

3.8.2 Approval of the opening or closing of any bank or investment accounts and insurance brokers.

3.8.3 Receipt and approval of a schedule of NHS contracts to be signed in accordance with arrangements approved by the Chief Executive.

3.8.4 Consideration and approval of the Trust's Annual Report including the annual accounts.

3.8.5 Receipt and approval of the Annual Report(s) for funds held on trust.

3.8.6 Receipt of reports from the Chief Finance Officer on financial performance against plan.

3.8.7 To authorise payments which due to their value require prior approval from the Board of Directors under the SOs and SFIs.

3.9 Audit Arrangements

3.9.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit and Risk Committee meetings and take appropriate action.

3.9.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

3.9.3 The receipt of the annual report received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

4. Delegation of Powers to Committees of the Board

4.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements

of NHS England and or the Charity Commissioners (including the need to appoint an Audit Committee and a Nomination and Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO ~~7.5~~5.1.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

5. Scheme of Authorisation to Officers

5.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Chief Finance Officer (CFO) and other Chiefs and Officers. These responsibilities are summarised below.

> [**NOTE** It should be noted that the SFIs generally specify officers responsible for various matters whereas SOs only do this occasionally].

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Chief Finance Officer - with operational responsibility delegated to the Chief Information Officer
Health and Safety Arrangements	Chief Finance Officer - with operational responsibility delegated to the Director of Infrastructure

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each Chief Officer is responsible for the delegation within their area of responsibility. They should produce a scheme of authorisation for matters. In particular, the scheme of authorisation should include how budget management and procedures for approval of expenditure are delegated.

A more detailed scheme of delegation including financial limits is given in Section ~~5~~ 8.

As part of the scheme of delegation, senior officers are accountable back to the Board of Directors. To enable the Directors to assist with this delegation, ~~Grip and Control~~financial oversight meetings ~~have been put~~are in place at a Divisional level. This helps Directors have oversight on the day to day powers that are delegated to senior offices, but also allows for both challenge and support, to help senior officers make decisions that are consistent across the Trust, ~~but also help~~supporting the Trust to function in a manner that is as efficient as possible.

6 - SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SCHEME OF DELEGATION DERIVED FROM THE BOARD OF DIRECTORS STANDING ORDERS ANNEX 8

SO REF	DELEGATED TO	DUTIES DELEGATED
2.1 3.8	CHAIR	Final authority in interpretation of Standing Orders (SOs).
4.1 3.7	CHAIR	Chair all board meetings and associated responsibilities.
5.6 CHECK3.2	CHAIR/DEPUTY CHAIR OR 1/3RD OF THE BOARD OF DIRECTORS	Calling meetings of the Board of Directors.
CHECK3.8	CHAIR	Give final ruling in questions of order, relevancy and regularity (including procedure on handling motions) of meetings and the interpretation of any SO or SFI. 'Chairs ruling'.
3.4 (a)3.13.1	CHAIR	Have a second or casting vote.
CHECK3.15	BOARD OF DIRECTORS	Suspension of the Standing Orders.
CHECK3.16	BOARD OF DIRECTORS	Review variation or amendment of the Standing Orders.
CHECK4	BOARD OF DIRECTORS	Formal delegation of powers to committees, sub-committees or joint committees, and approval of their constitution, specific executive powers and terms of reference of such committees.
CHECK7	BOARD OF DIRECTORS	Declare relevant and material interests including any pecuniary interest in any contract, proposed contract or other matter under consideration by the Board of Directors.
CHECK5.1.54.4.1	BOARD OF DIRECTORS	The Board of Directors shall agree from time to time the delegation of executive powers.
8.87.16	COMPANY SECRETARY	Register(s) of interests.
CHECK4.5	CE	Prepare a scheme of delegation which shall be considered and approved by the Board of Directors
CHECK 15.1 & 15.2	CHIEF EXECUTIVE	Approve and sign all documents which will be necessary in legal proceedings. Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
CHECK3.15.33.15.5	AUDIT AND RISK COMMITTEE	Review every decision to suspend the SOs (power to suspend the SOs is reserved to the Board of Directors). and report as appropriate to the Council of Governors and/or regulators.

SCHEME OF DELEGATION DERIVED FROM THE BOARD OF DIRECTORS STANDING ORDERS ANNEX 8

SO REF	DELEGATED TO	DUTIES DELEGATED
check11.1.1	CHIEF EXECUTIVE	Ensuring that existing Chiefs and Officers and all new appointees are notified of and understand their responsibilities within the SOs and the SFIs.
11.18	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
11.20	CE	Best value for money is demonstrated for all services provided under contract or in-house.
11.20	CE	Nominate an officer to oversee and manage the contract on behalf of the Trust.
11.21	CE	Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.
11.23	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
12.1(a)	CE OR NOMINATED OFFICER	Determining any items to be sold by sale or negotiation.
14.19	COMPANY SECRETARY	Keep seal in safe place and maintain a register of sealing.
14.46.3.2-9.2.3 and 9.3.2	CE/CFO OR NOMINATED OFFICERS	Approve and sign under seal all building, engineering, property or capital documents exceeding the sum of £250,000.
15.110.1	CE	Approve and sign all documents which will be necessary in legal proceedings
15.210.2	CE OR THEIR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
16.1	CHAIR	Existing Directors, Governors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs.
Annex s2	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex s3	SENIOR OFFICERS	Open tenders.
Annex s4	CFO	Decide whether any late tenders should be considered.
Annex s5	CE OR CFO	Keep lists of approved firms for tenders.

7 - SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	CHIEF FINANCE OFFICER (CFO)	Responsible for implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	CFO	Form and adequacy of financial records of all departments.
2.1.1	AUDIT AND RISK COMMITTEE	Provide independent and objective view on internal control and ~~probity~~risk management.
2.2	CFO	Monitor and ensure compliance with directions on fraud and corruption.
2.5	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.6	COUNCIL OF GOVERNORS	Appoint external auditors.
3	CFO	~~Ensuring compliance with NHS England's requirements, ensure loans drawn are for approved expenditure only at time of need, and ensuring adequate system of monitoring.~~Prudential Borrowing Requirement Control – Not used
~~4~~4.1.3	CFO ~~CFO~~ ~~CE~~	Submit budgets. ~~Monitor performance against budget; submit to Board financial estimates and forecasts.~~ ~~Delegate budget to budget holders and submit monitoring returns.~~
4.1.4	CFO	Monitor performance against budget; submit to Board financial estimates and forecasts.
4.2	CE	Delegate budget to budget holders and submit monitoring returns.
4.3	CFO	Devise and maintain systems of budgetary control.
5	CFO	Annual accounts and reports.
6	CFO	Banking arrangements.

7 - SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
7	CFO	Income systems, fees charges, security of case, cheques and other negotiable instruments.~~.~~
8.1	CE	Negotiating contracts for provision of patient services.
	~~CFO~~	~~Regular reports of actual and forecast contract expenditure.~~
8.3	CFO	Regular reports of actual and forecast contract expenditure.
9.1	NOMINATION & REMUNERATION COMMITTEE	Remuneration & Terms of Service of ~~VSM~~directors and those employees not on Agenda for Change or Medial and dental contracts.
9.2	CE	Variation to funded establishment of any department.
9.3	CE	Renumeration of workforce~~Staff~~, including agency staff, appointments.
9.4	CHIEF PEOPLE OFFICER	Processing of all aspects of Payroll
10.1	CE ~~/ CFO~~	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.2	CFO	Be responsible for the Prompt payment of accounts.
10.2.3	CFO	Systems and process in place to ensure the Choice, requestioning , ordering and procurement of goods and services is in line with legislative requirements and best value for the Trust
10.2.5	CE	Authorise officers for the use of official orders.
10.2.7	CFO	Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance.
10.3	CFO	Legally binding agreements
10.3	~~CE~~CFO	Grants for provision of patient services.
11	CFO	Advise Board on borrowing and investment needs and prepare procedural instructions.

7 - SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12	CE	Capital investment programme
12.3	CE	Maintenance of asset registers.
12.3.8	CFO	Calculate and pay capital charges in accordance with NHS England requirements.
12.4.1	CE	Overall responsibility for fixed assets.
12.4.4	DIRECTORS	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
13	CFO	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supply Chain Warehouses.
14.1	CFO	Responsible for systems and controls for the disposal of assets
14.2	CFO	Prepare procedures for recording and accounting for losses and special payments and informing NHS Counter Fraud Authority and the External Auditor of all frauds and informing police in cases of suspected arson or theft.
15	CFO	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' liability for their own money and property and any procedures on admission.
17	CFO	Shall ensure each fund held on trust is managed appropriately ~~(subject to the discretion and approval of DBTH Charitable Funds)~~and maintain such records and accounts necessary and in line with audit requirements and legislation~~.~~
18	CE	Retention of document procedures
19.1	CE ~~CFO~~	Has systems and processes in place for an effective Risk management programme ~~Insurance arrangements~~

7 - SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
19.1.2	THE BOARD OF DIRECTORS	Insurance arrangements: Risk Pooling schemes administered by NHS Resolution
20	THE COMPANY SECRETARY	Acceptance of Gifts

8 - DETAILED SCHEME OF DELEGATION AND AUTHORISATION

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. The delegation and authorisation shown below is the lowest level to which authority is given. Delegation and authorisation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising, consult with other Directors as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

Key: CE - Chief Executive, DCEO Deputy Chief Executive Officer, ~~MD - Medical Director~~CMO- Chief Medical Officer, CN - Chief Nurse, CFO - Chief Finance Officer,
CPO – Chief People Officer, COO - Chief Operating Officer,
DoCM Director of Communications and Engagement
CoSec – The ~~individual in the role of~~ Company Secretary

Directors for the purpose of SO/SFI and Scheme of Delegation are Executive Directors.
For the avoidance of doubt: In the absence of the Chief Executive – the Deputy Chief Executive will be authorised to the same level of the Chief Executive within this document.
Senior officers are staff employed in the post of Divisional Director, General Manager, Deputy Director or Head of a department.

Delegated Matter	Authority Delegated To	Reference Document
1. Management of Budgets		SFIs Section 4
Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Budget Holder	
b) At service level	Divisional Director or Executive Director	
c) For the totality of services covered by Functional Director	Executive Director or CE	
d) For all other areas:	CFO or Appropriate Delegated Manager	
Budgetary or virement limits ~~– and not part of agreed plan~~		
a) Up to £250,000 per request	Executive Director	
b) Up to £500,000 per request	CFO	
c) Over £500,000 per request	Executive Team ~~Committee~~	
Approval for the carry forward of funds into a different budgetary period~~, after discussion with the CFO~~	CFO~~E~~	
Approval of revenue business cases ~~and not part of agreed plan~~		
a) Cases up to £~~250~~500,000	Corporate Investment Group	
b) Cases over £~~250~~500,000 and below £1,~~5~~000,000	~~Board of Directors~~Finance and Performance Committee	
C) Cases over £~~5~~1,000,000	Board of Directors	

Delegated Matter	Authority Delegated To	Reference Document
2. Maintenance / Operation of Bank Accounts Maintenance / Operation of Bank Accounts	 CFO	SFIs Section 6 & Appendix 1
3. Quotation, Tendering & Contract Procedures **Authority to obtain at least:** a) To obtain best value for goods/services between £10,000 and £35,000 – three informal quotes b) 3 written quotations via e-tendering portal for goods/services from £35,000 to UK threshold (Find a Tender Service) currently £~~111,750),~~£112,515 excluding VAT~~40,596~~ with one quote where possible from a local supplier. c) Competitive tenders via e-tendering portal for works goods/services for tenders above UK threshold (Find a Tender Service) d) Single quotation approval between £10,000 to UK Threshold (Find a Tender Service) (single quotation above UK threshold (Find a Tender Service)~~-~~ is not permitted)	 Buyers & Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) or Executive Director Head of Procurement	SFIs Section 10 ~~&~~ ~~SOs Section 11 &~~ ~~Annex~~ Appendix 4
4. Non Pay Expenditure/Requisitioning/Ordering/ Payment of Goods & Services Authorisation of requisitions/non pay expenditure: a) Requisitions to £2,000 b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £500,000 e) Requisitions between £500,000 to £1,000,000 ~~e~~f) Requisitions over £1,000,000 Authorisation of contracts for goods & services and subsequent variations to contracts a) Contracts up to £250~~500~~,000 b) Contracts over £250,000~~500,000~~ to £~~1,000,000~~500,000 c) Contracts between £500,000 to £1,000,000 c) Contracts over £1,000,000 (this includes electronic signing of contracts) * These figures are the maximum allowed, but can be lower for staff as agreed within the Financial system	 Authorised Signatory for Budget* Head of Dept. General Manager or Divisional Director* Executive Director* CFO CE CE CFO ~~& CE~~ CE~~CE – Finance and Performance Committee~~ Finance & Performance Committee ~~CE after approval by the Board~~Board of Directors	SFIs Section 10 & ~~SOs Section 11& Annex~~ Appendix 4

Delegated Matter	Authority Delegated To	Reference Document
5. Capital Schemes		
Business Cases ~~- not part of agreed plan~~		SFIs Section 12
a) Production of case of need for every capital expenditure proposal	CFO	~~& SOs Section 11~~
b) Certification of costs and revenue consequences	CFO	
c) Approval of business cases to £1,000,000 ~~and not linked to new service development~~	Corporate Investment Group	
d) Approval of business cases over £1,000,000 ~~or linked to new service development~~	Board of Directors	
Capital Programme		
a) Production of draft capital programme	CFO	
b) Confirmation of capital funds available	CFO	
c) Approval of capital programme	Board of Directors	
Capital Expenditure		
a) Issue authority to commit expenditure and proceed to tender up to budget approved in capital programme	CFO	
b) Responsibility of keeping expenditure within scheme budget	Scheme Manager	
c) Responsibility of keeping expenditure within total capital budget	CFO	
d) Approval of variations to scheme budgets from plan:		
i) To 10% of original scheme budget, a maximum of £50,000	CFO	
ii) To 20% of original scheme budget, a maximum of £250,000	CE	
iii) Above £250,000 or 20% of original scheme budget	Board of Directors	
e) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within UK regulations	CFO	
f) Financial reporting on all capital scheme expenditure	CFO	
g) Financial monitoring of all capital scheme expenditure	CFO	
h) Granting and termination of leases with annual rent <£100k	CFO	
i) Granting and termination of leases of annual rent >£100k	CE	
6. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	CFO	SFIs Section 7
b) Price of all NHS Contracts	CFO	SFIs Section 8

Delegated Matter	Authority Delegated To	Reference Document
7. Engagement of Staff Not On the Establishment (Within NHS England price caps) a) Management Consultancy b) Engagement of Trust's Solicitors c) Booking of Bank or Agency Staff i) Medical Locums ii) Nursing iii) Clerical Outside NHSE price caps	 CFO Relevant Executive lead General Manager or Divisional Director Divisional Nurse Divisional General Manager for Divisions / Relevant Executive Director for corporate areas Executive Director	SFIs Section 9
8. Expenditure on Charitable and Endowment Funds Up to £25,000 per request Over £25,000 per request	 CFO CEO or CFO after authorisation from the Charitable Funds Board	SFIs Section 17
9. Agreements/Licences a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff b) Extensions to existing leases c) Letting of premises to outside organisations d) Approval of rent based on professional assessment	 CFO and CPO CFO CFO CFO	SFIs Section 10
10. Condemning & Disposal a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively b) disposal of x-ray films c) disposal of controlled drugs	 Divisional ~~Director of Operations (GM)/~~General Manager, Department Manager and Condemning Officer Superintendent Radiographer Chief Pharmacist	SFIs Section 14
11. Losses, Write-off & Compensation a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000 b) Fruitless Payments (including abandoned Capital Schemes) Up to £100,000 c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	 Two Executive Directors Two Executive Directors Cash ~~Committee~~ Group	SFIs Section 14

Delegated Matter	Authority Delegated To	Reference Document
Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000	 Two Executive Directors	
e) Compensation payments made under legal obligation	Two Executive Directors	
f) Extra Contractual payments to contractors Up to £50,000	 Two Executive Directors	
<u>Ex-Gratia Payments</u> g) Patients and staff for loss of personal effects Up to £50,000	 Two Executive Directors	
h) For clinical negligence up to £1,000,000 (negotiated settlements) i) Negotiate settlement up to £50,000 ii) £50,000 to £100,000 iii) Over £100,000 iv) Authorise payment (up to £1,000,000)	 ~~MD~~ CMO CE Board of Directors CE or Nominated Director and CFO	
i) For personal injury claims involving negligence where legal advice has been obtained and guidance applied i) Negotiate settlement up to £25,000 ii) £25,000 to £100,000 iii) over £100,000 iv) Authorise payment (up to £1,000,000)	 CPO CE Board of Directors CE or Nominated Director and CFO	
j) Other, except cases of maladministration where there was no financial loss by claimant £50,000	 CE or Nominated Director and CFO	
Losses, Write-Off & Compensation above delegated limits	Audit & Risk Committee	
<u>12. Reporting of Incidents to the Police</u> a) Where a criminal offence is suspected (other than theft or fraud) b) Where a theft is involved c) Where a fraud is involved	 Director with managerial responsibility for the area CFO or CPO CFO	SFIs Sections 2 & 14
<u>13. Petty Cash Disbursements</u> a) Not permitted ordinarily, and no cash office in place currently. Disbursements to be processed through payroll expenses system only.	 Budget holder	SFIs Section 10

Delegated Matter	Authority Delegated To	Reference Document
14. Receiving Hospitality Applies to both individual and collective items of hospitality (Including transport and accommodation costs, nominal fees etc) received **or offered and declined**, in excess of £50.	Declaration required by the individual in Trust's Hospitality Register	SFIs Section 20
15. Implementation of Internal and External Audit Recommendations	CFO	SFIs Section 2
16. Maintenance & Update on Trust Financial Procedures	CFO	SFIs Section 1
17. Investment of Funds (including Charitable & Endowment Funds)	CFO	SFIs Section 17
18. Personnel & Pay		
a) Authority to fill funded post on the establishment with permanent staff.	Budget holder (after vacancy control approval)	SFIs Section 9
b) Authority to appoint staff to post not on the formal establishment.	CE and CFO	
c) Additional Increments		
The granting of additional increments to staff within budget	CPO	
d) Upgrading & Regrading		
All requests for upgrading/regrading shall be dealt with in accordance with Trust procedure	CPO	
e) Establishments		
i) Additional staff to the agreed establishment with specifically allocated finance	Budget holder (after vacancy control approval)	
ii) Additional staff to the agreed establishment without specifically allocated finance	CE and CFO	
f) Pay		
i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Senior Officer or relevant Executive Director	
ii) Authority to authorise overtime	Senior Officer or relevant Executive Director	
iii) Authority to complete and authorise positive reporting forms	Senior Officer or relevant Executive Director	
iv) Authority to authorise travel & subsistence expenses	Senior Officer or relevant Executive Director	
v) Approval of Performance Related Pay Assessment	Nomination and Remuneration Committee/CE	
g) Leave		
i) Approval of annual leave	Senior Officer or relevant Executive Director	
ii) Annual leave - approval of carry forward (up to maximum of 5 days).	Senior Officer or relevant Executive Director	
iii) Annual leave - approval of carry over in excess of 5 days.	relevant Executive Director	
iv) Compassionate leave up to 3 days	Senior Officer or relevant Executive Director	
v) Compassionate leave over 3 days	R~~r~~elevant Executive Director	
vi) Special leave arrangements	R~~r~~elevant Executive Director	
paternity leave	Senior Officer or relevant Executive Director	
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence	~~MD~~ CMO and CE	
paid and unpaid	General Manager or Divisional Director	

Delegated Matter	Authority Delegated To	Reference Document
ix) Time off in lieu	Automatic approval with guidance	
x) Maternity Leave - paid and unpaid	Automatic approval with guidance	
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with CPO	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with CPO	
iii) Extension of sick leave on full pay	CPO or CE	
i) Study Leave		
i) Study leave outside the UK	CPO or CMO ~~MD~~	
ii) Medical staff study leave (UK)	~~Medical Director~~Divisional Director / ~~Executive Medical Director~~Chief Medical Officer	
iii) All other study leave (UK)	Senior Officer or Executive Director	
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by Directors taking up new appointments (providing consideration was promised at interview)	CPO	
k) Grievance Procedure	CPO	
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of ~~a the~~the Chief People Officer must be sought when the grievance reaches the level of Associate/Dept. Manager		
l) Authorised Car & Mobile Phone Users		
Requests for new posts to be authorised as car users	CPO	
Requests for new posts to be authorised as mobile telephone users	CPO	
m) Renewal of Fixed Term Contract	Senior Officer or Executive Director	
n) Redundancy	CPO	
o) Ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health	CPO	
p) Dismissal	Appointing Officers	
q) Development of personnel, industrial relations & training strategies and procedures	Executive Directors	
r) Authorisation of expenditure on recruitment advertising	CPO	
s) Day to day management of Consultants' contracts	~~MD~~ CMO / Divisional Directors	
t) Excellence Awards to Medical staff.	CE	
19. Authorisation of New Drugs		SFIs Section 10
Estimated total yearly cost up to £25,000	Medicines Management Group	
Estimated total yearly cost above £25,000	CE (Subject to consultation with the above)	
20. Authorisation of Sponsorship deals	CE	

Delegated Matter	Authority Delegated To	Reference Document
21. Authorisation of Research Projects	CE or ~~MD~~ CMO or Chief Nurse	
22. Authorisation of Clinical Trials	CE and ~~MD~~CMO	
23. Insurance Policies and Risk Management	CFO ~~MD~~CMO	SFIs Section 19
24. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively under regulations. b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico - Legal Complaints Co-ordination of their management.	CE Senior Officer and PALS Rep. ~~MD~~CMO	
25. Relationships with Press a) Non-Urgent General Enquiries Within Hours Outside Hours b) Urgent Within Hours Outside Hours	 DoCM Executive Director on call DoCM Executive Director on call	
26. Infectious Diseases & Notifiable Outbreaks	CN~~O~~ or Consultant Microbiologist or Control of Infection Nurse	
27. Extended Role Activities Approval of any professions to undertake duties / procedures which can properly be described as beyond the normal scope of practice.	~~Clinical Governance~~ Quality Committee	
28. Patient Services a) Variation of operating and clinic sessions within existing numbers Outpatients Theatres Other b) All proposed changes in bed allocation and use (excluding critical care)	 COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director	

Delegated Matter	Authority Delegated To	Reference Document
Temporary Change **Permanent Change** Contract monitoring & reporting c) Critical Care	In hours COO with Head of Patient Flow advice. Out of hours Executive on call with Clinical Site Manager advice CE with advice from COO & Chief Nurse CFO CE or Executive Director on call	
29. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience students	CPO	
30. Review of fire precautions	CE	SFIs Section 19
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	CE	SFIs Section 19
32. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	-CE	
34. Review of Trust's compliance with the Data Protection Act, including GDPR	~~CE~~CFO	SFIs section 15
35. Monitor proposals for contractual arrangements between the Trust and outside bodies a) Monitor proposals for contractual arrangements between the Trust and other healthcare bodies b) Monitor proposals for contractual arrangements between the Trust and non-healthcare bodies	 CFO CFO	
36. Review the Trust's compliance with the Access to Records Act	~~MD~~CMO	
37. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	~~MD~~CMO	
38. The keeping of a Declaration of Interests Register	Company Secretary	SFIs Section 20

Delegated Matter	Authority Delegated To	Reference Document
39. Attestation of sealings in accordance with Standing Orders	CE and CFO	Constitution Paragraph ~~47~~46
40. The keeping of a register of Sealings	Company Secretary	Constitution Annex 8, ~~para 8~~ SO 9.3
41. The keeping of the Hospitality Register	Company Secretary	~~Constitution Para 7~~ SFIs Section 20; Constitution Annex 8, SO 8
42. Retention of Records	~~COO~~CE	Section 18
43. Clinical Audit	~~MD~~CMO	
44. Nominated Fire Director Within Hours Outside Hours	 CE Executive Director on call	
45. Agreement of Policies a) To recommend the adoption of new policies to the Board of Directors b) To approve policies where authorised to do so by the Board of Directors	The appropriate sub-committee of the Board e.g. Finance and Performance for finance related policies	
46. Working Together Partnership Committee in Common All functions agreed to be delegated by the Board and listed in the DBTH Committee in Common terms of reference.	Committee in common consisting of CEO and Chair or nominated deputies	DBTH CiC TORs
47. Intellectual Property The disposal of intellectual property rights	Executive Team~~Committee~~	

9. ROLES AND RESPONSIBILITIES OF GOVERNORS

The Constitution states that at general meetings, the Council of Governors shall discharge the following responsibilities:

9.1 The appointment or removal of the Chair and the other Non-Executive Directors (Trust Constitution; section 28, paragraph 28.3 and Annex 5, paragraph 5).

9.2 Approve an appointment (made by the Non-Executive Directors) of the Chief Executive (Trust Constitution; section 31, paragraph 31.2 ~~An~~ and Annex 5; paragraph 5).

9.3 The appointment or removal of the Trust's auditors (Trust Constitution; Annex 5; paragraph 5.1.1(c)).

9.4 Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors (Trust Constitution; Annex 5; paragraph 5.1.1(b)).

9.5 Approve any significant transaction, as defined in the constitution (Trust Constitution; Annex 5; paragraph 5).

9.6 Approve any merger, acquisition, separation or dissolution proposed (Trust Constitution; Annex 5; paragraph 5).

9.7 Appoint or remove the Deputy Chair and agree the appointment of the Senior Independent Director (Trust Constitution; section 30 and Annex 5, paragraph 9).

9.8 Approve or reject any extension of a term of office of the Chair or a non-executive director beyond six years, following rigorous review and with the agreement of NHS England where required; no Chair or non-executive director may serve beyond nine years in total from first appointment to the Board, including time served as a non-executive director before becoming Chair (Trust Constitution; paragraph 28.1).

9.9 Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors and represent the interests of the members and the public (Trust Constitution; section 18 and Annex 5, paragraph 5).

9.10 Approve any increase of 5% or more in the proportion of total income from non-NHS activities and determine whether non-NHS activities interfere with the principal purpose of the Trust (Trust Constitution; section 44).

9.11 Approve amendments to the Constitution, alongside the Board of Directors (Trust Constitution; section 47).

9.12 Decide whether to refer a question to the Panel (more than half of governors present and voting) (Trust Constitution; section 21).

9.13 Elect the Lead Governor and, where required, the Deputy Lead Governor (Annex 7, SO 4).

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Scheme of Reservation Delegation CORP/FIN 1 (C) 14	CE/Finance	Rebecca Allen	Existing Policy	February 2025

1) Who is responsible for this policy? Name of CSU/Directorate – Chief Executive Office

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards of business conduct

4) What factors contribute or detract from achieving intended outcomes? Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] - N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: February 2026

Checked by: Rebecca Allen Date: February 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Standing Financial Instructions

~~April 2025~~~~June~~October 2026



Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Matthew Bancroft – Head of Financial Control
Date written/revised:	~~April 2025~~June 2026 and October 2026
Approved by (Committee/Group):	Board of Directors
Date of approval:	November~~August~~ 2026 ~~(BDS)~~
Date issued:	
Next review date:	~~April 2026~~January 2027 (governance timetable)
Target audience:	Trust-wide

Standing Financial Instructions

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 14	November 2026	• Minor formatting changes • Reflect changes to the SORD and Standing Orders	Rebecca Allen Matthew Bancroft
Version 13	April 2025	• Amending limits for invoice approval so they mirror those in the Standing Orders/SoD • Amending responsibility for notification for staff who leave employment without giving notice • Clarified wording confirming that Deputies have the same invoice sign-off levels as the substantive postholder, when the substantive post holder is on leave.	Matthew Bancroft
Version 12	September 2024	• Minor typographical/layout changes • Updated guidance with regards to petty cash not being used within the Trust • Updated Procurement guidelines	Matthew Bancroft
Version 11	July 2023	• Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 10	July 2022	• Removed references to NHS Improvement • Updated job titles • Introduction of IFRS 16 within capital section • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 9	July 2021	• "Chairman" replaced by "Chair" • Updated reference to NHS Improvement/NHS England. • Clarified Procurement process for £25k-£50k	Matthew Bancroft
Version 8	July 2020	• Updated job titles throughout • Updated the NHS Logistics provider details • Updated references to NHSI/NHSE throughout. • Updated references to procurement legislation and the impact of leaving the EU • Updated references to "Estate code"	Matthew Bancroft

		• Updated references to "NHSLA"	
Version 7	March 2019	• Updated names of structures/meetings • Updated sections relating to PBL, Data Protection, Health & Safety and budget virements.	Jon Sargeant
Version 6	30 January 2018	• Updated sections on Audit, Budgets, funded/ budgeted establishment, Banking, Payment of Directors and Employees, Non Pay Expenditure, Funds Held on Trust • Procurement and Tendering Appendix added	Winston Weir

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FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1. INTRODUCTION

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of ~~Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust~~Reservation and Delegation. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2. These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer subject to review by the Finance and Performance Committee.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4. **Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.**

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

“the Board”	means the board of directors as constituted in accordance with the Trust Constitution;
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
"Budget Holder"	means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;
“Chair”	means the Chair of the Trust appointed in accordance with the Trust Constitution;
“Chief Executive”	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Constitution"	means the Trust Constitution and all annexes to it;

"Director"	means a director on the Board of Directors;
"Chief Finance Officer"	means the Chief Finance Officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"NHS England"	means the body corporate known as NHS England;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Officer"	means an employee of the Trust;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

1.2.2. Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the ~~'Reservation of Powers to the Board'~~'Scheme of Reservation and Delegation' document.

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as ~~Accountable~~ Accounting Officer to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

And, without prejudice to any other functions of directors and employees to the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to the Trust and its directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8. All directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook.

The Board has established the Audit and Risk Committee to perform the role of the Audit Committee along with additional responsibilities in relation to risk management and assurance. The sub-committee will provide an independent and objective view of internal controls and risk management by:

(a) overseeing Internal and External Audit services;

(b) reviewing all internal audit reports;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) ensuring that there are adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work;

(f) assessing and providing assurance to the Board on the validity of the control environment within the Trust

(g) reviewing schedules of losses and compensations and making recommendations to the Board;

(a) reviewing controls assurance systems, including disseminating relevant information to governors; and

(b) reviewing risk management arrangements.

The Board shall satisfy itself that at least one member of the committee has recent and relevant financial experience.

2.1.2 Where the committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chair of the committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England. (To the Chief Finance Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 Fraud and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with directions on fraud and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS).

2.2.3 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist will provide a written report to the Audit and Risk Committee, at least annually, on counter fraud work within the Trust and national context.

2.3 Security Management

2.3.1 The Chief Executive will monitor and ensure compliance with directions on NHS security management.

2.3.2 The Board shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).

2.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated by the Chief Executive to the Director responsible for Security Management (SMD) and the appointed Local Security Management Specialist (LSMS).

2.3.4 The LSMS shall work with the staff in NHS Counter Fraud Authority.

2.3.5 The LSMS will provide a written report, at least annually, to the ~~Audit and Risk Committee~~Finance and Performance Committee on security management work within the Trust.

2.4 Chief Finance Officer

2.4.1 The Chief Finance Officer is responsible for;

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the mandatory audit standards;

(c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:

(i) a clear statement on the effectiveness of internal control,
(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

2.4.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.5 Role of Internal Audit

2.5.1 Internal audit will provide an independent and objective opinion on risk management, control and governance arrangements by measuring and evaluating their effectiveness. The Head of Internal Audit will provide an annual opinion on the whole system of internal control.

2.5.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the integrity, reliability and suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.5.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

2.5.4 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all committee members, the Chair and Chief Executive of the Trust.

2.5.5 The Head of Internal Audit shall be accountable to the Audit and Risk Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit and Risk ~~Sub-~~Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.6 External Audit

2.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust, in accordance with paragraph ~~35~~ 42 of the constitution. The auditor must be a member of one or more of the bodies referred to in ~~paragraph 11,~~ Annex 6, paragraph 11 of the constitution.

2.6.2 The Council of Governors must ensure that the auditor meets the criteria included by the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General at the date of appointment and on an ongoing basis throughout the term of their appointment.

3. PRUDENTIAL BORROWING REQUIREMENT CONTROL

No longer required

4. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 In addition the Chief Finance Officer will annually compile, and submit to the Board, such financial plans as required by NHS England.

4.1.3 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the annual business plan;
- accord with workload and staffing plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks; and
- comply with NHS England requirements and other regulations

4.1.4 The Chief Finance Officer shall monitor financial performance against budget and business plan monthly and report to the Board and Financial Oversight Committee appropriately.

4.1.5 All budget holders must provide information in a timely manner as required by the Chief Finance Officer to enable budgets to be compiled.

4.1.6 All Budget Holders will sign up to their allocated Budgets at the commencement of each financial year.

4.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer. In defining what is either non-recurring or recurring the Chief Finance Officer will have the final decision.

4.3 Budgetary Control and Reporting

4.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

- income and expenditure to date showing trends, forecast year-end position, and variances against budget;
- balance sheet;
- cashflow;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- movements in reserves;
- details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and staffing budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers or virements.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

4.3.3 Detailed rules relating to budgetary virement are set out in Appendix 3.

4.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and other parties as required and in line with G1 (1-4) of the NHS provider licence.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the Trust's accounting policies, Government Accounting Manual and international financial reporting standards (IFRS);

(b) prepare and submit annual financial reports in accordance with current guidelines; and

(c) submit financial returns for each financial year in accordance with the guidance and timetable prescribed by NHS England.

5.2 The Trust's audited annual accounts and auditor's report and Quality Accounts must be presented to the Board of Directors for approval or to Audit and Risk Committee by delegation from the Board and to a general meeting of the Council of Governors.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at the Annual Members' Meeting. The document will comply with NHS England's Annual Reporting Manual (ARM).

6. BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

6.1 General

6.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by NHS England.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and Government Banking Service Accounts

6.2.1 The Chief Finance Officer is responsible for:

(a) Setting arrangements in place that NHS Shared Business Service compiles with its contract with the organisation for bank and banking services

(b) Commercial bank accounts and accounts operated through the Government Banking Service (GBS);

(c) establishing separate bank accounts for the Trust's non-exchequer funds;

(d) ensuring payments made from commercial banks or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

(e) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Procedures

6.3.1 The Chief Finance Officer will prepare detailed instructions (agreed with NHS Shared Business Services) on the operation of commercial bank and GBS accounts which must include:

(a) the conditions under which each commercial bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 Payments over £10,000 shall be supported by more than one authorised signature on the cheque or authority to pay as appropriate.

6.3.4 The Chief Finance Officer shall nominate members of ~~his~~ their staff who are authorised to

act as signatories in respect of commercial bank and GBS accounts.

6.4 Tendering and Review

6.4.1 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.2 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.3 The Chief Finance Officer shall be responsible for implementing any such guidance issued by NHS England in relation to the costing and pricing of services, and in particular services provided to NHS Commissioning bodies.

7.3 Debt Recovery

7.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. Where receipt of such indemnities is problematic or unclear no such items shall be held in Trust safes.

7.4.5 A cheque and payable order register shall be kept in which all cheque and payable order stocks ordered, received and issued shall be recorded and signed for by nominated officers.

8. CONTRACTING FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

8.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

8.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income (linked to contract activity) with a detailed assessment of the impact of the variable elements of income and an assessment of any significant risks faced.

8.4 This also includes both partnership and provision of facilities arrangements to private

healthcare providers in their provision of health care and diagnostic services to patients.

9. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 Nomination, Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders, the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

(i) Identify and appoint candidates to fill Executive Director positions when they arise.

(ii) Identify and nominate a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

(iii) Decide any matter relating to the disciplining or the continuation in office of any Executive Director and the company secretary at any time including the suspension or termination of service of an individual as an employee of the Trust.

(iv) Monitor and evaluate the performance of individual Executive Directors on an annual basis.

(v) Decide and review the terms and conditions of office of Executive Directors and senior managers on locally-determined pay in accordance with relevant Trust policies, including:

a. Salary, including any performance-related pay or bonus;
b. Provisions for other benefits, including pensions and cars; and
c. Other allowances.

(vi) Decide all contractual arrangements for Executive Directors, including, but not limited to, termination payments.

9.1.3 The Committee shall report to the Board regarding its recommendations.

9.1.4 The Trust will remunerate the Chair and Non-executive Directors in accordance with instructions issued by the Council of Governors.

9.2 Funded/Budgeted Establishment

9.2.1 The staffing plans incorporated within the annual budget will form the funded / budgeted establishment. The funded/ budgeted establishment will list out the grade, amount, whole time equivalent for the relevant department(s) and must be set out and agreed each financial year.

9.2.2 The funded/budgeted establishment of any department may be varied in line with Appendix 3 Budgetary Virement~~may not be varied without the approval of the Chief Executive, and Director of People & OD~~.

9.2.3 The funded/budgeted establishment of any clinical department will take account of the required safe levels of clinical staff as necessary for the running of those services.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief People Officer is responsible for:

(a) ensuring that arrangements in place so that the Trust receives an effective and efficient payroll service

(b) specifying timetables for submission of properly authorised time records and other notifications;

(c) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

9.4.2 The Chief People Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for pension, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payments to employees;

(i) procedures for the recall of bank credits

£ (j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Divisional General Manager must be informed immediately.

9.4.4 Where the Chief People Officer has contracted with another body to administer the Trust's payroll service responsibility for compliance with the above requirements remain with the Chief People Officer.

9.4.5 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.6 Directors and Staff Expenses

9.6.1 Claims for expenses should be submitted in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

9.6.2 All claims should be submitted for authorisation, along with any accompanying receipts, as

soon as possible after the end of the month concerned. However, all claims must be submitted within three months of the month in which the claim arose. Any claim periods in excess of this deadline will not usually be paid.

9.6.3 Once authorised, claims will be paid in accordance with current guidelines and regulations.

9.6.4 Claimants must not make duplicate claims for expenses from any other body in addition to that from the Trust.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Wherever appropriate, the supply of goods and services shall be covered by a contract following a competitive exercise.

10.2.2 The Trust's Head of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

10.2.3 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 4);

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(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) be responsible for ensuring that all payments made by the Trust fall within its powers.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV) and the intention is not to

circumvent cash limits;

(b) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet ~~his~~ their commitments;

(c) the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered, even where electronically generated;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with public procurement regulations);

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHS England/NHS Improvement;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered in advance on an official order as outlined in

the Procurement Policy. All invoices received where an order is not already in place will be returned;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. All such instances shall be reported to the Chief Finance Officer and followed up with an official purchase order;

(h) No orders shall be issued retrospectively of the items being received or the service being delivered;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are not permitted and any such expenditure should be performed on an exception basis, and reclaimed through the payroll expenses system.

10.2.7 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Legally Binding Agreements (e.g. leases)

10.3.1 Any leases or rental agreements must be vetted by the Chief Finance Officer prior to final agreement, to enable insurance issues and technical accounting treatment to be determined. In addition, all leases entered into on behalf of the Trust should represent value for money.

10.3.2 All lease agreements must be signed on behalf of the Trust by the Chief Finance Officer (or ~~his~~ their deputy) in addition to being accompanied by the usual order and duly authorised in accordance with these SFIs.

10.4 Grants to Local Authorities and Voluntary Bodies

10.4.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

10.4.2 The financial limits for officers' approval of grants are set out in the Scheme of Delegation.

11. EXTERNAL BORROWING AND INVESTMENTS

11.1 External Borrowing

11.1.1 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS England for NHS Foundation Trusts. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning Public Dividend Capital debt and all loans and overdrafts.

11.1.2 Any application for PDC, a loan or overdraft will only be made by the Chief Finance Officer or by an employee so delegated by him. Also, such applications must however first be authorised by the Board.

11.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.

11.1.4 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan. Where there is a need to vary from this principle due to unforeseen in year events a revised business plan will be prepared and provided to the Board to support its deliberations when considering the need to borrow.

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board and within such government guidance as may be in place from time to time. The need to prudently manage public funds from unnecessary risk will be a key factor in any decision making regarding what bodies to deposit such funds with.

11.2.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

(d) shall ensure that processes and procedures are in place to monitor, record and report spend against each element of the Capital programme.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "The efficient management of healthcare estates and facilities" (previously "Estatecode") and other official guidance that may become available from time to time.

The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "The efficient management of healthcare estates and facilities" guidance and the Trust's Standing Orders.

12.1.5 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.1.6 Due to the introduction of IFRS 16, for the avoidance of doubt, leases of over 12 months in length should follow the process for capital projects.

12.2 Private Finance

12.2.1 Where appropriate the possibility of attracting private finance will be investigated for capital expenditure proposals.

12.2.2 The Chief Executive will consider such proposals along with all other bids received, in line with the Trust's priorities.

12.2.3 Where the proposal is approved the private sector will be invited to submit their bids based upon clear, high level, service based objectives.

12.2.4 Once the private sector bids have been received the Chief Finance Officer will provide or commission any specialist assistance to allow the bids to be appraised on a like for like basis.

12.2.5 The Chief Executive shall be responsible for deciding upon the preferred shape of the proposed contract and inviting the bidders to tender.

12.2.6 The Chief Finance Officer shall ensure that all privately financed proposals represent value for money and genuinely transfer risk to the private sector.

12.2.7 Proposals which include the lease of equipment and/or buildings will be tested for Value for Money and the Transfer of Risk by the Capital Accountant.

12.2.8 To allow this appraisal of the lease to take place the following financial details shall be obtained:

(a) Capital value of asset(s) supplied;
(b) Minimum lease period;
(c) Minimum lease payment;
(d) Frequency of lease payment, including details as to whether required in arrears or advance;
(e) Premium for payment by non-direct debit method if applicable;

(f) Interest rate implicit in the lease (if available).

12.2.9 Figures shall be requested for a number of different lease periods, to identify the option, which gives the best returns for the Trust, and be exclusive of VAT.

12.2.10 For comparative purposes the capital value of the asset supplied will be the value at the start of the contract plus the discounted value of any enhancements during the minimum lease term less the discounted value of any disposal proceeds at the end of the lease term.

12.2.11 The fundamental requirements of a PFI proposal with regards risk are that it is allocated to the party which is best able to manage it and that it is genuinely transferred to the private sector.

12.2.12 By achieving optimum risk transfer between the parties to the PFI proposal there is a greater likelihood that value for money will also be achieved.

12.2.13 The risks associated with a project typically fall under the following headings:

(a) Design and Construction Risks;

(b) Commissioning and Operating Risks;

(c) Demand, Volume or Usage Risks;

(d) Technology and Obsolescence Risks;

(e) Regulation and Other Risks;

(f) Project Financing Risks.

12.2.14 The Value for Money attributable to a project is tested by comparing the net present value (or cost) of the estimated annual cash flows over an appraisal period equivalent to the PFI contract term.

12.2.15 In addition the PFI proposal shall be assessed for its affordability. This will show whether the proposal is affordable to the Trust and that the impact on prices can be afforded by the Trust's main commissioner.

12.2.16 The Chief Finance Officer will be notified in advance of all lease and PFI agreements before any commitment is made.

12.2.17 The Chief Executive will ensure that all proposed agreements are scrutinised by either in-house experts or the Trust's Solicitors to ensure that the agreements are comprehensive and are not disadvantageous to the Trust.

12.2.18 The Board must specifically agree all PFI proposals before any contracts are signed.

12.2.19 When comparing the financials of the various options VAT shall be included within the calculation in so far as it is irrecoverable. The Chief Finance Officer shall engage professional

VAT advisers to facilitate this where it is felt necessary.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. Where systems are in place to monitor these on an ongoing basis a rolling programme of checks and/or sampling will be acceptable.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be based on good accounting practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with good accounting practice and NHS England guidelines. A periodic revaluation of land and buildings will be undertaken, by an independent professional valuer, as required by accounting guidelines.

12.3.7 The value of each asset shall be depreciated using methods and rates as specified in accounting standards.

12.3.8 The Chief Finance Officer or ~~his~~ their nominated representatives shall calculate capital charges.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines –to apply such appropriate routine security practices in relation to property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and similar items of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. Where stock control systems allow this may be undertaken on a rolling or sample basis as is felt best to ensure the accurate control and recording of stock.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain Coordination Limited (SCCL) central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy ~~himself~~ themself that the goods have been received before accepting the recharge.

13.9 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification.

13.10 The issue of stores shall be supported by an authorised requisition note and a receipt for the stores issued shall be returned to the Procurement Department, Issuing Department, or Chief Finance Officer.

13.11 Where a 'topping up' system is used a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variances.

13.12 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Chief Finance Officer.

13.13 Breakages and other losses of goods in stores shall be recorded as they occur and a summary shall be presented to the Chief Finance Officer at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain food stuffs and natural deterioration of certain goods.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

The Trust may not dispose of any protected property without the approval of NHS England in line with the provider licence CoS 2.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS, who will then inform NHS Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer must ensure that NHS Counter Fraud Authority and the External Auditor are notified of all frauds.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Finance Officer must immediately notify:

(a) the Board, and

(b) the External Auditor.

14.2.4 The Board shall approve the writing-off of losses. The level of delegation to Senior Officers of the Trust are set out in the Reservation of Powers to the Board and Delegation of Powers ~~section~~ Table ~~5~~8, ~~paragraph~~ section 11.

14.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

14.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 All losses and special payments must be reported to the Audit and Risk Committee at every meeting although the identities of individuals should not be reported unless requested.

15. INFORMATION TECHNOLOGY

15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

15.2 The Chief Finance Officer shall satisfy ~~himself~~ themself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 In the case of computer systems which are proposed General Applications, all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

15.6 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.7 The Chief People Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the verbal advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where it is a requirement for the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) or other statue, the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the duel accountabilities to the Charity Commission for charitable funds held on trust and to NHS England for all funds held on trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust. Any further guidance is set out in the Charitable Funds Policy (approved by Board of Directors on an annual basis).

17.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.5 The Chief Finance Officer shall maintain such accounts and records, including an investment register, as may be necessary to record and protect all transactions and funds of the Trust as trustees of funds held on trust.

17.2 Existing Trusts

17.2.1 The Chief Finance Officer shall make arrangements for the administration of all existing funds held on trust and shall produce instructions covering every aspect of the financial management of the funds.

17.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make

recommendations to the Board regarding the potential for rationalisation, within statutory guidelines.

17.3 New Trusts

17.3.1 The Chief Finance Officer shall arrange for the creation of a new trust where funds and/or other assets are received and cannot be adequately managed as part of an existing trust.

17.3.2 When making such as assessment as outlined in 17.3.1 above the needs for simplicity of administration and therefore downward pressure on costs shall also be considered.

17.4 Sources of New Funds

17.4.1 In respect of donations, the Chief Finance Officer shall:

(a) provide guidelines to officers of this Body as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 The Chief Finance Officer shall deal with all Legacies and Bequests.

17.4.3 In respect of Fundraising, the Chief Finance Officer shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of this Body and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Chief Finance Officer shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) for alerting the Board to any irregularities regarding the use of this Body's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

17.4.4 In respect of Trading Income, the Chief Finance Officer shall:

(a) be primarily responsible with other designated officers, for any trading undertaken by this Body as corporate trustee; and

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 Investment Management

17.5.1 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) the formulation of investment policy within the powers of this Body under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Chief Finance Officer shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to approve;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 Disposition Management

17.6.1 The exercise of this Body's dispositive discretion shall be managed by the Chief Finance Officer in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Body; and

(f) the definitions of "charitable purposes" as agreed by the Charity Commission.

17.7 Banking Services

17.7.1 The Chief Finance Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Body as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

17.8 Asset Management

17.8.1 Assets in the ownership of or used by this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Chief Finance Officer shall ensure:

(a) that appropriate records of all assets owned by this Body as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust are accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for;

(e) all share and stock certificates and property deeds shall be deposited either with the Trust's bankers or, where this is not practicable, held securely at trust premises.

17.9 Reporting

17.9.1 The Chief Finance Officer shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Chief Finance Officer shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board.

17.10 Accounting and Audit

17.10.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Chief Finance Officer on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

17.11 Administration Costs

17.11.1 The Chief Finance Officer shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

17.12 Taxation and Excise Duty

17.12.1 The Chief Finance Officer shall ensure that this Body's liability to taxation, duties and other such charges is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17.13 Authorisation Levels of Expenditure from Trust Funds

17.13.1 The Board has established levels of authorisation necessary for expenditure from the funds held on trust, these are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 8.

These will be reviewed on a regular basis to ensure that they remain at an appropriate financial level.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained following good practice under the direction contained in Department of Health guidelines.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 Programme of Risk Management

19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to complete the annual governance statement within the Annual Report and Accounts.

19.1.3 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

19.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (previously NHS Litigation Authority) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3 Insurance Arrangements with Commercial Insurers

19.3.1 The Board shall decide if the Trust will insure with commercial insurers to supplement or replace the cover available through the risk pooling schemes. If the Board decides to use commercial insurers this decision shall be reviewed annually.

19.4 Arrangements to be followed by The Board in Agreeing Insurance Cover

19.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

19.4.3 The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.4.4 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Board Company Secretary shall ensure that all staff are made aware of the Trust Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the department of health standards of business conduct for NHS staff set out in "Code of Conduct for Directors and employees".

APPENDIX 1 - INVESTMENTS

INVESTMENTS

1. The Chief Finance Officer shall ensure that all funds are invested in the name of the Trust. No officer other than the Chief Finance Officer shall open accounts to invest funds on behalf of the Trust.

2. The Chief Finance Officer shall advise bankers and other approved deposit facilities in writing of the conditions under which each account shall be operated.

3. Transfers of funds from bank and GBS accounts to investment accounts must be authorised by two signatories.

APPENDIX 2 – SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

1. All cash, cheques postal orders and other forms of payments received by an officer other than a cashier shall be entered immediately on an approved form. All cheques and postal orders shall be crossed immediately "Not negotiable -A/c Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust". The remittances shall be passed to the cashier from whom a signature shall be obtained.

2. The opening of coin operated machines and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Chief Finance Officer and the coin box keys shall be held by a nominated officer.

3. Where amounts of cash have to be transported, special arrangements shall be made by the Chief Finance Officer with a specialist security firm. Under no circumstances shall cash in excess of (£500) be transported by only one officer and the route travelled and times of collection shall be varied as far as practicable.

4. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in ~~his~~ their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

5. All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

6. Staff shall be informed on appointment, by the appropriate departmental or senior officers, of their responsibilities and duties for the collection, handling or disbursement or cash, cheques, etc, in line with appropriate financial procedures. This must be in writing, acknowledged, and acknowledgement retained.

7. Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned shall be reported immediately to the Chief Finance Officer

APPENDIX 3 – BUDGETARY VIREMENT

BUDGETARY VIREMENT

1. Virement is the term used to define the movement of funds from one budget heading to another.

2. Virement within Individual Budgets:

2.1 Where a budget holder is expected to be under spent at the year-end, the budget holder may be allowed to offset this under spending against overspendings elsewhere in his/her budget, subject to the criteria itemised below.

2.2 Budget holders are not allowed to use non-recurrent savings for recurrent commitments, for example, savings on equipment purchased cannot be used to appoint new permanent staff.

2.3 Subject to the overall financial position of the individual Division and the Trust, virement will be allowed using the following criteria:

(a) Efficiency/CIP targets are being achieved;
(b) The predicted year end expenditure will be within budget;
(c) The predicted year end income will at least achieve the target;
(d) The proposed expenditure is within overall policy, i.e. virement cannot be used to initiate a development of a new / existing service, which is not policy;
(e) All other targets are being achieved;
~~(f) Approval has been obtained from the Chief Finance Officer.~~

2.4 Virement between Divisions:

Expected underspend~~ing~~s can be transferred to another Division subject to the agreement of both budget holders and the same constraints as above.

2.5 Virement between Revenue and Capital:

This can only be done in exceptional circumstances when approved in advance by the Chief Finance Officer.

2.6 Budgetary and Virement Limits of the Chief Executive:

Budgetary or virement limits of the Chief Executive delegated by the Board are outlined in the Scheme of Delegation.

APPENDIX 4 - PROCUREMENT AND TENDERING

1 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to procurement and tendering.

1.3 The Chief Finance Officer (or Deputy in ~~his~~ their absence) must personally authorise any contract which commits the Trust to expenditure from £10,000 up to £250,000 as determined by the scheme of delegation. The Chief Executive (or Chief Finance Officer in ~~his~~ their absence) must authorise all expenditure from £250,000 to £1,000,000. Any contract over £1,000,000 requires Board approval before Chief Executive authorization.

1.4 Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases~~, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan~~ must be approved by the Trust's Corporate Investment Group (CIG). ~~Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to CIG for review and recommendation to the Board.~~ These costs are whole life costs. All expenditure in excess of £1.0~~.5~~m requires approval of the Board.

1.5 In addition to the Trust delegated tendering limits, attention must be paid to the UK procurement regulations and any subsequent procurement legislation that become statutes following the UKs exit from the European Union in all cases advice should be sought from the Head of Procurement Head of Procurement to ensure compliance with appropriate thresholds.

2 COMPETITIVE TENDERING (Over £35,000)

2.1 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price. The standard method of procurement will be by competitive tender for goods or services expected to cost in excess of £35,000; this may be waived under the following circumstances:

- Where the requirements are ordered under existing contracts or where in the opinion of the ~~Finance Director~~Chief Finance Officer:

- there is only one supplier and no reasonably satisfactory alternative product/service;

- competition would be impractical, impossible or not beneficial;
- the requirement is to be ordered under existing contracts;
- the work for practical reasons must be of the same manufacture, for instance repairs/spare parts for existing equipment;
- where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

2.2 In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (£35,000 and under)

3.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £35,000 but is above £10,000. For quotations over £35,000, these must be undertaken by the Procurement Department.

3.2 Non-competitive quotations in writing may be obtained for the following purposes:

(a) where the supply of goods (or related goods) is of a special character and does not exceed £10,000;

or where in the opinion of the ~~Finance Director~~Chief Finance Officer:

(b) there being only one supplier and no reasonably satisfactory alternative product/service available;

(c) competition would be impractical, ~~impossible~~ or ~~not Beneficial;~~have no benefit to the Trust in terms of cost or time

(d) the requirement ~~is~~ to be ordered ~~under existing contracts;~~with the current provider, albeit outside the normal contract terms, for continuity reasons.

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment or brand recognition;

(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

(g) where there is an urgent time constraint to procure a product or service, that in all reasonable circumstances, the Trust would not have been able to foresee.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3.3 Officers should involve the Head of Procurement in choice of supplier, price negotiation and in the procurement process for all goods and services.

3.4 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the Head of Procurement should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

3.5 No single supplier or single annual order should be used for a period in excess of 12 months. The advice of Head of Procurement should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

4 TENDERING PROCEDURES

4.1 The basic procedures to be followed in relation to competitive tenders are set out below.

4.2 In all cases the tender that provides the best value for money must be accepted using a defined combination of cost and quality. Any proposal to waive this rule would need the approval of:

- goods/services in excess of £10,000 and up to UK Threshold of £112,515 excluding VAT~~111,750~~	Chief Finance Officer

Anything over UK Threshold needs initial advice from the Head of Procurement before commencement.

4.3 Officers with any doubts concerning the appropriateness of competitive tendering in particular circumstances must seek formal clarification from the Chief Finance Officer. The Trust will not be responsible for officers committing costs other than in accordance with the above procedures.

4.4 Tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

4.5 Every tender for building and engineering works, except any tender for maintenance work only, where "The efficient management of healthcare estates and facilities" guidance should be followed, shall embody or be in the terms of the current Edition of the Standard Form of Building Contract Local Authorities Edition with (or, where appropriate, without) quantities or the Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate or (when the contents of the works is primarily engineering) the General Conditions of Contracts recommended by the Institute of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institution of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These base documents should be modified and amplified to accord with current Departmental guidance forms of contract may be used after prior consultation with the Department.

4.6 Tenders submitted via e-tendering will be electronically date and time stamped.

4.7 Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

4.8 Alterations to tenders submitted via e-tendering will be electronically marked.

4.9 Tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

4.10 Technically late tenders (i.e. those uploaded in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

4.11 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon ~~his~~ their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

4.12 Necessary discussion with a tenderer of the contents of ~~his~~ their tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

4.13 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tenders will remain electronically unopened.

4.14 Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

4.15 Every contract for building and engineering works, except measured term contracts where Estmancode guidance should be followed, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

4.16 No goods, services or works other than works and services, executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Chief Finance Officer.

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Financial instructions –April 2025 - CORP/FIN 1 (B) v.13	CE/Finance	Matthew Bancroft	Existing Policy	April 2025

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework within which the Trust can properly conduct its financial affairs and transactions.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: April 2026

Checked by: Matthew Bancroft Date: April 2025

2611 - G2 EMERGENCY PLANNING, RESILIENCE & RESPONSE COMPLIANCE AGAINST CORE STANDARDS

Information Item | Denise Smith, Chief Operating Officer | 12:30

5 minutes

REFERENCES

Only PDFs are attached

- G2 - Emergency Planning Resilience & Response Annual Assurance.pdf
- G2 - Appendix A - EPRR Annual Assurance Core Standards Process.pdf
- G2 - Appendix B - EPRR Core Standards Self Assessment.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

<table>
<tr><th colspan="6">Report Template</th></tr>
<tr><td>Meeting Title:</td><td colspan="2">Board of Directors</td><td>Meeting Date:</td><td colspan="2">3 November 2026</td></tr>
<tr><td>Report Title/ Ref:</td><td colspan="5">Emergency Planning Resilience & Response Annual Assurance</td></tr>
<tr><td>Sponsor:</td><td colspan="5">Denise Smith, Chief Operating Officer</td></tr>
<tr><td>Authors:</td><td colspan="5">Suzanne Stubbs, Deputy Chief Operating Officer</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendix A: NHSE Emergency preparedness, resilience and response (EPRR) annual assurance process for 2026 - 2027
Appendix B: DBTH Core Standards Self-Assessment</td></tr>
<tr><td>Purpose of the report</td><td>Assurance</td><td><s>Approval/decision</s></td><td><s>Information</s></td><td colspan="2"><s>Discussion</s></td></tr>
<tr><td>Proposed assurance Level (For assurance papers only)</td><td colspan="5">Significant Assurance</td></tr>
<tr><td>Assurance Rationale</td><td colspan="5">The Trust Board of Directors is asked to take Significant Assurance as the Trust has made significant progress compared to the 2025/26 self-assessment, in line with the three-year improvement plan. There is an annual work plan in place to continue this improvement through 2027/28 and there is clear accountability for delivery.</td></tr>
<tr><td>Impacts on Strategic Risks (BAF 1-7)</td><td colspan="5">BAF 1</td></tr>
<tr><td>For decision papers only:
Is this in line with Current risk appetite YES/NO</td><td colspan="5">Highlight only where this report is outside of the Board Risk Appetite and a decision is requested
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Quality</td><td>Finance</td><td>People</td><td></td></tr>
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Executive Summary – Key messages and Issues

This report sets out the emergency preparedness, resilience and response (EPRR) annual assurance process for 2026 - 2027 and the Trust's self-assessment against the EPRR Core Standards.

The Trust has completed the initial self-assessment; this is attached at Appendix B for information. The self-assessment shows the Trust as:

- fully compliant with 58 of the 62 core standards
- partially compliant with 4 core standards

This gives a 94% compliance rate and overall assessment of substantially compliant.

Recommendations

The Trust Board of Directors is asked to receive the report for ASSURANCE.

Healthier together – delivering exceptional care for all	
Patients	Strengthens patient safety and service continuity during emergencies through improved preparedness and response planning.
People	Supports staff training, resilience, and confidence through EPRR training.
Partnerships	Builds multi-agency collaboration, particularly through joint planning with partners, ICBs and emergency services.
Pounds	Reduces financial risk by mitigating disruption and ensuring efficient emergency response.
Health Inequalities	Ensures emergency planning considers and protects vulnerable patient groups.
Legal/ Regulation:	Demonstrates compliance with statutory duties under the Civil Contingencies Act and NHS Core Standards for EPRR.
Partner ICB strategies	Aligns with and supports the resilience priorities of both South Yorkshire and Nottinghamshire ICBs.
Assurance Route	
Previously considered by - including date:	Executive Team 14 October 2026 Audit and Risk Committee 15 October 2026
Any outcomes/next steps / time scales	By 31 October 2026: Self-assessment and submission of evidence to the ICB.

1. Introduction

This report sets out the:

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2026 - 2027.
- Trust self-assessment against the EPRR Core Standards,

2. Background

The Trust has a responsibility for developing and monitoring compliance with the mandatory obligations within the Civil Contingencies Act (2004), and ensuring compliance with the National Guidance set out in the NHS England Emergency Planning Resilience and Response (EPRR) Framework (2015).

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

3. Final Outcome of the Annual Assurance Process for 2025 - 2026

The Trust final self-assessment and Accountable Emergency Officer statement of compliance was submitted on 31 October 2025. This showed a final self-assessment of fully compliant with 51 of the 62 core standards, partially compliant with 10 of the 62 core standards, and non-compliant with one of the core standards, giving 82% compliance and overall assessment of partially compliant.

4. Annual Assurance Process for 2026 - 2027

The NHS England Emergency preparedness, resilience and response (EPRR) annual assurance process for 2026 - 2027 is set out at Appendix A.

The Trust is asked to undertake a self-assessment against the individual core standards and rate the compliance for each. The compliance level for each standard is defined as follows:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

There are no deep dive standards for 2026 - 2027.

5. Organisational assurance rating

The overall organisation assurance rating is based on the percentage of core standards the organisation assesses itself as being 'fully compliant' with, the criteria for each overall rating is as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89% - 99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77% - 88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

6. Trust self-assessment

The Trust has completed the initial self-assessment; this is attached at Appendix B for information and shows a comparison with the 2025 - 2026 outcome.

The initial self-assessment shows the Trust as fully compliant with 58 of the 62 core standards and partially compliant with 4 of the 62 core standards; this gives a 94% compliance and overall assessment of substantially compliant.

This is an improvement from 31% in 2023 - 2024, 55% in 2024 - 2025 and 82% in 2025 - 2026.

7. Summary and next steps

- 30 October 2026: Self-assessment and submission of evidence
- 2 November 2026: ICB submits evidence to NHSE Region for all organisations against the standards identified for sampling
- w/c 9 November: NHS review of dip sample submissions
- w/c 16 November: dip sample check and challenge window (if required)
- 26 November 2026: Regional sign off – ICB, Provider and Regional returns

8. Recommendations

The Trust Board of Directors is asked to receive the paper for ASSURANCE.

South Yorkshire ICB EPRR Annual Assurance Process Note 2026/27
July 2026

1 Purpose

This note sets out the proposed South Yorkshire ICB process for coordinating the NHS England Emergency Preparedness, Resilience and Response annual assurance process for 2026/27 with NHS Trusts and other relevant NHS-funded providers. It is intended to support a consistent, proportionate and evidence-informed approach across South Yorkshire, building on the reviews undertaken in the last two years.

(all dates given in this document are for 2026 unless indicated otherwise)

2 National context

NHS England has confirmed that the 2026/27 EPRR annual assurance process uses organisational self-assessment against the relevant NHS Core Standards for EPRR, with providers submitting assurance outcome reports to their ICB. ICBs are expected to lead local assurance across the Local Health Resilience Partnership (LHRP) and submit an assurance outcome report to NHS England regional EPRR teams. NHS England has also confirmed that no national deep dive will be undertaken for 2026/27. The national regional-to-national submission deadline is 17 December 2026.

3 Scope

The process applies to NHS Trusts and other NHS-funded providers within the South Yorkshire geography that are required to complete the relevant NHS EPRR Core Standards self-assessment. The process also informs the ICB's own organisational assurance and its system-level assurance report to NHS England regional EPRR colleagues.

Organisations who work in South Yorkshire but report to a different ICB for Core Standards (e.g. South West Yorkshire Partnerships NHS FT, Yorkshire Ambulance Service) do not need follow the South Yorkshire arrangements, though they are welcome to use any tools shared in SY which they feel would be helpful.

4 Domain 10 – CBRN / Hazmat

The Yorkshire Ambulance Service are still commissioned to undertake this review by NHS England, so compliance and evidence for these standards will remain a separate process undertaken by YAS with the Trusts. The ICB's proposed process below applies to the standards in Domains 1 – 9.

4 Proposed local process and key milestones

- **End of June 2026** ***(completed)*** –

- Sharepoint evidence repositories created for all SY NHS organisations to upload evidence into, including the ICB. Folders are accessible by all organisations and staff with existing access to the Teams/Sharepoint site - Core Standards 2026
- Compliance tracker spreadsheets uploaded into each Trust's repository for them to use in support of their process, and by the ICB in checking evidence submitted. **NB:** these will not be submitted as part of evidence submissions to NHS England, but only used by the ICB and each organisation to support internal checks and navigation of evidence submissions.
- This repository can be maintained as a 'live' position for future / rolling assurance processes (acknowledging some changes will be needed when the updated national standards are formally issued)

- **By 7th August** – Confirmation of this process with NHS providers in South Yorkshire
- **2nd September** – ICB presents assurance methodology to Regional Health Resilience Partnership
- **Ongoing up to close of play Friday 25th September** –
  - Trusts to notify the ICB via Syicb.eprr@nhs.net when evidence has been uploaded and is ready for review, along with accompanying explanatory text where needed on the tracker spreadsheet.
- **w/c 28th September** –
  - ICB to review evidence submitted and provide any feedback/confirmation via the tracker in the Teams channels; ongoing informal liaison with Trust EPRR teams during this period to check assumptions, evidence, any amendments etc.
  - Trusts can access each other's evidence this year so are welcome to submit observations to the ICB for follow up as part of the review process where appropriate, and/or to the ICB itself about its own submitted evidence.
- **Thursday 8th October to Friday 16th October** – Confirm & Challenge meetings for each Trust with the AEOs[1] and EPOs from the Trust and the ICB; to be arranged by the ICB – may be stood down if both parties are happy that there are no significant issues to discuss.
  - The LHRP currently scheduled for Tuesday 13th October will be repurposed for Core Standards Confirm & Challenge discussions and the November LHRP will become the 'business as usual' meeting instead.
- **w/c 19th October** – exact date yet to be confirmed by NHSE
  - NHS England Region confirm standards for their 'dip sampling' exercise to be undertaken in November.
  - It is expected that all evidence will already be in place from all organisations, however the ICB will re-check in case of any gaps (e.g. provisional documents awaiting sign-off by the end of the month)
- **30th October (close of play)** – all organisations confirm submission to the ICB via syicb.eprr@nhs.net of the core documents from those circulated in early July:
  - Completed NHS England national Core Standards self-assessment tool for the relevant organisation type.

[1] AEO attendance strongly recommended – however deputy AEOs may cover if they have delegated authority from the AEO to make changes to their compliance rating if required by the review.

- Overall organisational assurance rating and compliance statement signed off by the organisation's AEO on behalf of their Board, to be later ratified by their Boards following the review process

  These can be attached to the email, or links provided to the files uploaded to the directories already used for the evidence – either is fine.

- **2nd November** – ICB submits evidence to NHSE Region for all organisations against the standards identified for sampling.
- **w/c 9th November** – NHSE review of dip sample submissions
- **w/c 16th November** – dip sample check & challenge window (if required)
- **26th November** - Regional Sign off – ICB, Provider & Regional returns
- **4th December** - Assurance Regional Health Resilience Partnership

6 ICB review approach

The ICB review will be supportive and confirmatory, not a re-audit of every evidence item. It will focus on whether the return is complete, the scoring is consistent with the definitions set out by NHSE, areas of partial/non-compliance have credible action plans, and any system risks or mutual aid dependencies are visible. Where the ICB identifies a potential inconsistency, this will be discussed with the provider before the rating is finalised.

7 Ongoing review at LHRP meetings

For standards which remain Partial or Non-Compliant, organisations will be asked to give an update on progress to subsequent LHRP meetings. This is likely to be via a summary report to be part of the LHRP papers, so that the focus at the LHRP itself can be on the risks of non-compliance and support that can be offered,

8 References

- NHS England. Emergency preparedness, resilience and response annual assurance process for 2026/27. Published 1 July 2025. https://www.england.nhs.uk/long-read/emergency-preparedness-resilience-and-response-eprr-annual-assurance-process-for-2025-26/
- NHS England. EPRR annual assurance process for 2026/27: confirms self-assessment, local assurance, regional assurance, no deep dive, organisational ratings and national submission by 31 December 2025.

Ref	Standard name	Standard Detail	2025 - 2026 Submission	2026 - 2027 Self-assessment
Domai	Governance			
1	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Fully Compliant	Fully Compliant
2	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Fully Compliant	Fully Compliant
3	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Fully Compliant	Fully Compliant
4	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Fully Compliant	Fully Compliant
5	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Fully Compliant	Fully Compliant
6	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Fully Compliant	Fully Compliant
Domain 2 - Duty to risk assess				
7	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Fully Compliant	Fully Compliant
8	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Fully Compliant	Fully Compliant
Domain 3 - Duty to maintain Plans				
9	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Fully Compliant	Fully Compliant
10	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Fully Compliant	Fully Compliant
11	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Fully Compliant	Fully Compliant
12	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Fully Compliant	Fully Compliant
13	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Fully Compliant	Fully Compliant
14	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Fully Compliant	Fully Compliant

Ref	Standard name	Standard Detail	2025 - 2026 Submission	2026 - 2027 Self-assessment
15	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Partially Compliant	Fully Compliant
16	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Fully Compliant	Fully Compliant
17	Lockdown	Fully	Partially Compliant	Partially Compliant
18	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Fully Compliant	Fully Compliant
19	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Partially Compliant	Partially Compliant
Domain 4 - Command and control				
20	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Partially Compliant	Fully Compliant
21	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Partially Compliant	Fully Compliant
Domain 5 - Training and exercising				
22	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially Compliant	Fully Compliant
23	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Fully Compliant	Fully Compliant
24	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Fully Compliant	Fully Compliant
25	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Fully Compliant	Fully Compliant
Domain 6 - Response				
26	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Fully Compliant	Fully Compliant
27	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Fully Compliant	Fully Compliant
28	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Fully Compliant	Fully Compliant
29	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially Compliant	Partially Compliant
30	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Fully Compliant	Fully Compliant

Ref	Standard name	Standard Detail	2025 - 2026 Submission	2026 - 2027 Self-assessment
31	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Fully Compliant	Fully Compliant
32	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Fully Compliant	Fully Compliant
Domain 7 - Warning and informing				
33	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Fully Compliant	Fully Compliant
34	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Fully Compliant	Fully Compliant
35	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Fully Compliant	Fully Compliant
36	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Fully Compliant	Fully Compliant
Domain 8 - Cooperation				
37	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Fully Compliant	Fully Compliant
38	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Fully Compliant	Fully Compliant
39	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Fully Compliant	Fully Compliant
43	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Fully Compliant	Fully Compliant
Domain 9 - Business Continuity				
44	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Fully Compliant	Fully Compliant
45	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Fully Compliant	Fully Compliant
46	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Fully Compliant	Fully Compliant
47	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Fully Compliant	Fully Compliant
48	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Fully Compliant	Fully Compliant
49	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Fully Compliant	Fully Compliant
50	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Fully Compliant	Fully Compliant

Ref	Standard name	Standard Detail	2025 - 2026 Submission	2026 - 2027 Self-assessment
51	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Fully Compliant	Fully Compliant
52	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Fully Compliant	Fully Compliant
53	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Fully Compliant	Fully Compliant
Domain 10 - CBRN				
55	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Fully Compliant	Fully Compliant
56	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Fully Compliant	Fully Compliant
57	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Fully Compliant	Fully Compliant
58	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Fully Compliant	Fully Compliant
59	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Partially Compliant	Fully Compliant
60	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Partially Compliant	Fully Compliant

Ref	Standard name	Standard Detail	2025 - 2026 Submission	2026 - 2027 Self-assessment
61	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Fully Compliant	Fully Compliant
62	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Fully Compliant	Fully Compliant
63	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Fully Compliant	Fully Compliant
64	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Partially Compliant	Partially Compliant
65	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Partially Compliant	Fully Compliant
66	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Fully Compliant	Fully Compliant

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	12	11	1	0
Total	62	58	4	0
Check Total	62			
Percentage		94		

2611 - G3 USE OF TRUST SEAL ANNUAL REPORT

Information Item | Michael Wright, Interim Deputy Chief Executive | 12:40

Brenda Thomas, Interim Company Secretary

REFERENCES

Only PDFs are attached

G4 - Use of Trust Seal.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**03 November 2026**
Report Title/ Ref:	**Use of Trust Seal**			
Executive Sponsor:	Michael Wright, Interim Deputy Chief Executive Officer			
Author:	Brenda Thomas, Interim Company Secretary			
Appendices:	None			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 4 and BAF 5. The use of the Trust Seal is a primary control in relevant contract management and leases.			

Executive Summary - Key messages and Issues

Purpose of the report

This report provides the Board of Directors with details of significant transactions which have required the application of the Trust Seal.

Summary of key points

In accordance with the Standing Orders of the Board of Directors (paragraph 9, Annex 8 of the Trust's Constitution), the Trust Seal has been applied on four occasions since November 2025. These comprise one lease and three building contracts and are set out in Table 1 below.

In each case the transaction was between Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and the counterparty shown, and the sealing was attested by the Chief Executive Officer (or Acting Chief Executive Officer) and the Chief Finance Officer.

Table 1: Use of the Trust Seal since November 2025

No.	Date sealed	Type	Transaction	Counterparty	Signatories
1	4 March 2026	Lease	Renewal underlease for part of Sandringham Health Centre	Community Health Partnerships Limited	Zara Jones, Acting Chief Executive Officer Sam Wilde, Chief Finance Officer
2	3 June 2026	Contract	Demolition of the existing Carousel Building at Doncaster Royal Infirmary	Bermar Building Company Limited	Zara Jones, Acting Chief Executive Officer Sam Wilde, Chief Finance Officer
3	14 October 2026	Contract	Enabling works associated with the installation of a replacement MRI at Doncaster Royal Infirmary	Bermar Building Company Limited	Richard Jenkins, Chief Executive Officer Sam Wilde, Chief Finance Officer
4	14 October 2026	Contract	Fire Precautions Programme – W & C Ward, GS and LS Theatres	Bermar Building Company Limited	Richard Jenkins, Chief Executive Officer Sam Wilde, Chief Finance Officer

Recommendations

The Board is asked to note the use of the Trust Seal on four occasions since November 2025, as set out in Table 1.

<table>
<tr><th colspan="2">Healthier together - delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>The use of the Trust Seal has no direct impact on patients</td></tr>
<tr><td>People</td><td>The use of the Trust Seal has no direct impact on people</td></tr>
<tr><td>Partnerships</td><td>The use of the Trust Seal has no direct impact on partnerships</td></tr>
<tr><td>Pounds</td><td>The use of the Trust Seal is a control for ensuring the Trust is spending public money wisely</td></tr>
<tr><td>Health Inequalities</td><td>The use of the Trust Seal has no direct impact on health inequalities</td></tr>
<tr><td>Legal/ Regulation:</td><td>The Trust Seal is applied in accordance with the Standing Orders for the practice and procedure of the Board of Directors</td></tr>
<tr><td>Partner ICB strategies</td><td>The use of the Trust Seal has no direct impact on ICB Strategies.</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Not applicable</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Not applicable</td></tr>
<tr><td>Is this in line with Current risk appetite

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

2611 - H INFORMATION

12:40

2611 - H1 NHSE PROVIDER CAPABILITY SELF-ASSESSMENT 2026 - REPORT ON SUBMISSION

Information Item | Michael Wright, Interim Deputy Chief Executive | 12:40

REFERENCES

Only PDFs are attached

H1 - NHSE Provider Capability Self-Assessment 2026 - Report on Submission.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report				
Meeting Title:	**Board of Directors**		**Meeting Date:**	**03 November 2026**
Report Title/ Ref:	**NHS England Provider Capability Self-Assessment 2026: Report on Submission**			
Sponsor:	Michael Wright, Interim Deputy Chief Executive			
Author:	Brenda Thomas, Interim Company Secretary			
Appendices:	Appendix 1: 2026 Provider Capability Self-Assessment as submitted to NHS England on 2 October 2026			
Purpose of the report	**Assurance**	~~Approval/decision~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1-7: The self-assessment is the Board's assessment of the Trust's capability to deliver its strategic objectives and so relates to all seven strategic risks.			

Executive Summary – Key messages and Issues

NHS England requires every NHS trust and foundation trust to complete an annual Provider Capability Self-Assessment as part of the NHS Oversight Framework. The Board rates the Trust's capability across six domains (Green, Amber-Green, Amber-Red or Red), and NHS England's regional team then considers the return alongside its own views and third-party information to propose an overall capability rating, subject to national moderation.

The timetable did not allow a completed return to come to the Board before the 2 October 2026 deadline. In line with the authority delegated by the Board at its confidential meeting on 1 September 2026, the Executive Team finalised the self-assessment, which was signed off by the Chair and the Interim Chief Executive and submitted to the NHS England regional team on 2 October 2026. The submission is attached at Appendix 1. The Trust's self-assessed ratings are:

Domain	2025 assessment	2026 self-assessment
Strategy, Leadership and Planning	Confirmed	Amber-Red
Quality of Care	Partially Confirmed	Amber-Green
People and Culture	Partially Confirmed	Amber-Green
Access and Delivery of Services	Partially Confirmed	Red
Productivity and Value for Money	Confirmed	Amber-Red
Financial Performance and Oversight	Confirmed	Red

The 2025 assessment used a "confirmed / partially confirmed" scale, so the two years are not directly comparable. The 2026 submission is nevertheless a more critical assessment: no domain is rated Green, two are rated Red and two Amber-Red.

NHS England confirmed the Trust's overall capability rating as Amber-Red in February 2026. It will now consider the 2026 submission alongside its own intelligence and propose domain and overall ratings for national moderation. The Board will be updated when feedback is received from NHS England which is expected by November 2026.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board is asked to:
1. Note that the 2026 Provider Capability Self-Assessment was approved by the Chair and Chief Executive under the authority delegated by the Board and submitted to NHS England on 2 October 2026, in line with the national deadline.
2. Note the self-assessed domain ratings and the basis for each rating, as set out in the submission at Appendix 1.
3. Note the next steps in NHS England's assessment process, and that the Board will be informed of NHS England's feedback and proposed capability rating when received.
4. Note NHS England's expectation that trusts tell their oversight team promptly of any material in-year change affecting the self-assessment.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>Review and assessment of the Trust capability is a key factor in delivery of safe and effective services to patients.</td></tr>
<tr><td>People</td><td>Review and assessment of the Trust capability is a key factor in supporting our people to deliver safe and effective care.</td></tr>
<tr><td>Partnerships</td><td>Review and assessment of the Trust capability is a key factor in effective and positive partnerships.</td></tr>
<tr><td>Pounds</td><td>Review and assessment of the Trust capability is a key factor in delivery of financial sustainability.</td></tr>
<tr><td>Health Inequalities</td><td>Review and assessment of the Trust capability is a key factor in delivering positive outcomes for health inequalities.</td></tr>
<tr><td>Legal/ Regulation:</td><td>Completing and returning the NHS England Provider Capability Self-Assessment is a regulatory requirement. The Trust submitted its return on 2 October 2026, in line with the deadline.</td></tr>
<tr><td>Partner ICB strategies</td><td>These documents have no positive or negative impact on ICB Strategies.</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Board of Directors, 1 September 2026 (delegation of authority to the Chair and Chief Executive to approve and submit the return). Executive Team, prior to sign-off on 2 October 2026.</td></tr>
<tr><td>Any outcomes/next steps / timescales</td><td>NHS England regional review and national moderation of the ratings. The Board will be updated on NHS England's feedback and the Trust's proposed capability rating when received.</td></tr>
<tr><td>In line with Current risk appetite: Yes</td><td>Risk Appetite levels: - highlight only if this report is outside of Board Assessment
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
</table>

NHS England Provider Capability Self-Assessment 2026: Report on Submission

Background

The NHS England Provider Capability Self-Assessment is part of the NHS Oversight Framework. It asks the Board to assess the Trust's capability against 18 capability statements across six domains: strategy, leadership and planning; quality of care; people and culture; access and delivery of services; productivity and value for money; and financial performance and oversight. Each domain is rated Green, Amber-Green, Amber-Red or Red.

Where the Board cannot make a positive self-assessment, NHS England expects it to explain why, how long the issue has persisted, how far it is outside the Trust's control, the mitigating actions in train, and the plan, timescale and measures of progress. NHS England's guidance also makes clear that having processes in place is not sufficient unless the Trust can show that they deliver improvement.

NHS England's regional team uses the self-assessment, together with its own view of the Trust, its track record and third-party information, to propose an overall capability rating. Proposed ratings are moderated nationally and ratified by NHS England's executive board. Capability is assessed separately for each trust, even where trusts share a leadership team.

2025 submission and outcome

The Trust completed its first self-assessment in autumn 2025. The Board confirmed three domains (Strategy, Leadership and Planning; Productivity and Value for Money; Financial Performance and Oversight) and partially confirmed three (Quality of Care; People and Culture; Access and Delivery of Services). The areas identified for further development were quality governance and use of insight from data; people and culture, including cultural improvement and Freedom to Speak Up; and access and delivery, particularly elective recovery and health inequalities.
NHS England's February 2026 response confirmed an overall organisational capability rating of Amber-Red following triangulation of the Trust's self-assessment against wider evidence and intelligence.

2026 assessment process and sign-off

The self-assessment was not developed enough for formal Board consideration at the Board Development Session on 14 August 2026. The Board meeting on 1 September 2026 also fell too early for a complete and validated return, therefore, the Board delegated authority to the Chair and Interim Chief Executive to review, approve and submit the final return on its behalf.

The Executive Team led the assessment, drawing on:

- Board and committee assurance reports, including the Integrated Performance Report and the Board Assurance Framework;
- performance and quality reporting, including CQC findings and action plans;
- workforce and culture indicators, including the staff survey and Freedom to Speak Up reviews;
- financial and productivity evidence, including the month 5 financial position and Model Health System benchmarking;
- progress against the areas identified in the 2025 assessment; and
- external reviews and internal audit reports.

The Executive Team discussed and finalised the assessment, which was signed off by the Chair and the Interim Chief Executive on 2 October 2026 and submitted to the NHS England regional team by the 5pm deadline on the same day. In line with NHS England's guidance, each domain rating is accompanied by a basis for rating that sets out the strengths, the issues preventing a Green rating and the actions being taken.

The Board was presented with the completed self-assessment after it was submitted to NHS England at the Board development session on 6 October.

Reporting is being done to the formal Board for completeness, since the report to the 1 September Board stated that reporting will be done to the 3 November Board.

The self-assessment submitted to NHS England is attached at Appendix 1.

Next steps

NHS England's regional team has confirmed receipt of the submission and will review the return alongside its own views of the Trust, its track record and third-party information, and propose domain and overall ratings. NHS England's guidance indicates around five to six weeks for the regional review and a further two to three weeks for moderation. Last year's response was received in February 2026, so the Board should expect feedback after its 3 November 2026 meeting.

The regional team may form a different view from the Trust on individual domains.

NHS England expects trusts to tell their oversight team promptly of any material in-year change that affects the self-assessment. Examples in its guidance include director resignations, adverse internal audit reports and emerging issues affecting delivery of the plan.

There have been no material changes since the 2 October 2026 submission date.

Appendix 1 (as submitted to the NHS England Regional Team on 2 October 2026)

Provider capability self-assessment template 2026

Provider name:	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to england.neyoversightregulation@nhs.net by **5pm Friday 2 October 2026**.

I. Strategy, leadership and planning

Capability statements	**Proposed domain rating**
	Amber-Red
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	**Basis for rating:** *Even though the Trust is not in breach of its licence and has a refreshed strategy, effective cyber and digital governance and active system partnerships, the primary reasons for Amber-Red include: (i) strategic direction has not yet translated into delivery of access standards and the financial plan (domains IV and VI); (ii) interim and changing leadership at Chair, Chief Executive, Deputy Chief Executive and Chief People Officer level. Actions are described under statements 3 to 4.* The Trust's refreshed strategy, *Healthier Together - Delivering Exceptional Care for All*, sets out clear priorities for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) while reflecting the wider objectives of system partners across South Yorkshire, Bassetlaw and North Nottinghamshire. It has been informed by national and system priorities and by engagement with partners, and it builds on the Trust's role as an acute provider, a teaching hospital and a key partner in the communities it serves. **Turning strategy into delivery** During 2026 the Trust has strengthened the link between its longer-term ambitions and the operational, financial and transformation priorities needed to secure sustainable services. The three-year plan and the Reset programme are the main vehicles for this, organised around five pillars: workforce and organisational development; the future shape of DBTH's sites and services; access and flow; productivity and financial sustainability; and culture and leadership. Executive oversight of delivery and transformation supports Board and committee oversight, and the Reset programme has given the Board greater visibility of delivery against strategic, operational and financial priorities. **Board oversight and risk** The Board oversees the strategy and associated plans through the Board and its committees. Strategic planning is also informed by the Trust's participation in system and provider collaborative arrangements, recognising that a number of the Trust's priorities require delivery with partners rather than by DBTH alone.

	The Digital Enabling Plan 2025-2029 was approved by the Board in November 2025 and supports delivery of the Trust strategy, including progress towards an electronic patient record and wider digital convergence with partners. The Finance and Performance Committee reviewed updates of progress in delivering the strategy in both July 2026 and September 2026 noting the expected progress in year one of the enabling plan, an improved Digital Maturity Assessment score (up to 2.6 from 2.4 and now in line with expectations for a Trust without an electronic patient record system), an improved risk profile and a Data Security and Protection Toolkit internal audit with a low risk, high confidence rating across all 5 Cyber Assurance Framework objectives. The Board Assurance Framework (BAF) records the principal strategic risks to delivery of the Trust's objectives, and these risks, with their controls and assurances, are reviewed by the Board and its committees. There are currently seven risks on the BAF, linked to people, patients and pounds. **Alignment with partners** A number of the Trust's priorities can only be delivered with partners, and strategic planning is informed by the Trust's participation in system and provider collaborative arrangements (statement 4). The Digital Enabling Plan 2025–2029, approved by the Board in November 2025, supports delivery of the strategy (statement 5). **Challenge** The Board recognises that its principal challenge is translating strategic direction into demonstrable, sustainable delivery in the context of significant operational and financial pressure and wider system change. The three-year plan and Reset programme are the main mechanisms for doing so, alongside continued work with system partners on the future configuration and sustainability of services. The Trust's current position on access standards and on its financial plan (domains IV and VI) shows that this translation is not yet complete.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE.	The Trust is not in breach of its licence and continues to meet all licence conditions, as set out in its self-assessment of compliance with the conditions of the licence, including Continuity of Services (Section 7). The Trust is not subject to any imposed licence conditions or to a formal performance improvement plan (PIP), and NHS England enforcement action is therefore not applicable to this submission. The Trust does remain subject to national oversight and recovery arrangements and participates in them. It is in Tier 2 for elective waits and meets NHS England fortnightly to review the position (statement 12), and it is subject to NHS England Integrated Quality Improvement Group (IQIG) oversight of performance and recovery.
3. The board has the skills and expertise to deliver its strategy in the	The Board has individuals in place with the skills and experience required for their roles, and there are no unfilled Board roles, although some roles are filled on an interim basis. The Board keeps its collective skills, experience and capacity under review so that it remains equipped to deliver the Trust's strategy and respond to the changing requirements of the NHS, including the 10-Year Health Plan.

context of the 10-Year Health Plan.	**Interim arrangements** Three Board roles are currently filled on an interim basis. Mark Bailey was appointed as interim Chair effective 1 January 2026. Mark has 6 years Board level NHS experience serving as a non-executive in this Trust and with the Derbyshire Community Health Services NHS Foundation Trust. Prior commercial and operations experience in senior executive director positions at Rolls-Royce plc. The recruitment process for a substantive Trust Chair is underway. Dr Richard Jenkins took up the post of interim Chief Executive Officer in August 2026, in consultation with NHS England, as part of an interim shared leadership arrangement for an initial period of 12 months; he is also Chief Executive of Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. A Memorandum of Understanding (MoU) with the other trusts sets out governance, accountability and review arrangements and supports timely consideration of the future leadership position. Richard has 14 years experience as an executive director including 5 as Medical Director and 9 as CEO. The Deputy Chief Executive Officer left the trust at the end of September 2026. Recruitment is under way in line with the Trust's constitutional documents, with interim arrangements in place to maintain continuity, executive capacity and clear accountability. Michael Wright is currently serving as the Interim Deputy Chief Executive Officer. Michael has been an executive director across a number of trusts for over 10 years holding roles including Director of Finance, Turnaround Director, Deputy CEO and Managing Director. The Chief People Officer leaves in December 2026, and recruitment is also under way to allow an appropriate handover and continuity of leadership for the people portfolio. **Skills, succession and accountability** A Board skills audit was carried out in 2025 to assess collective skills and experience and identify areas for strengthening. Since then, the Board has been strengthened through appointments and changes in membership, and non-executive director appointments are made with regard to identified needs and skills gaps. Succession planning, Board development and individual objectives are in place and are reviewed as the Board's composition changes. Diversity of the Board in terms of ethnicity, breath of experience and lived experience is being strengthened through competitive and open recruitment. Responsibilities and accountabilities across the Executive Team are set out in role descriptions and portfolio arrangements, amended where responsibilities change, and provide clear accountability for quality and safety, operational delivery and access standards, planning, workforce and finance. Executive objectives are aligned to organisational priorities and are the basis for individual performance review. Fit and proper persons test (FPPT) checks are carried out on appointment of board members and yearly, and an annual report is presented to the Board to confirm the Trust's compliance to the fit and proper persons framework. The last report was presented to the Board in January 2026.

	The Board is engaging with an independent board development partner to commence in November. The Board has arrangements in place to manage current and forthcoming changes in leadership capacity and continuity. Board succession planning, skills and development needs and individual objectives continue to be reviewed alongside delivery of the Trust's strategy and the requirements arising from the NHS 10-Year Health Plan.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served.	**Leadership and the acute collaborative** The Trust has taken a significant step in appointing Dr Richard Jenkins as Interim CEO. The Interim CEO is also the existing CEO of both Barnsley NHS Foundation Trust and The Rotherham NHS Foundation Trust, whose partnership arrangements have been in place for close to seven years. The appointment will advance partnership working and there will be opportunities for the three DGHs to collaborate further this year. The Interim Chair also brings significant commercial experience in the development and operation of joint venture and collaborative partnerships arrangements. The Trust continues to work in partnership with The South Yorkshire and Bassetlaw Acute Federation and the other four Acute Partner Trusts across South Yorkshire. There is a continued focus on stakeholder workshops relating to fragile services, which were identified following sustainability reviews across all partners. The specific areas of focus identified as fragile include Dermatology, Ophthalmology, Oral and Maxillofacial Surgery (OMFS), Community Paediatrics, Urology and Audiology. Recommendations have been developed jointly and trust executive teams across South Yorkshire are progressing them. A dermatology operating model to support partnership working has been approved by partner executive teams. An OMFS model has been developed, which was led by DBTH's Deputy Chief Executive, and Sheffield Teaching Hospitals (STH) is working with commissioners on it. For ophthalmology, a new model to strengthen out-of-hours provision across South Yorkshire and Bassetlaw is being agreed and the detail is being worked through. For audiology, new models of care that move more care out of hospital and closer to home are being explored, led by DBTH's Deputy Chief Executive. **Quality and clinical collaboration** Through the SY Acute Federation and System Quality Group, the Trust has contributed to collaborative quality improvement initiatives, particularly through the South Yorkshire Tissue Viability System Improvement Group, led operationally by DBTHs Nurse Consultant for Skin Integrity. This work has delivered a 23% reduction in Hospital Acquired Pressure Ulcer episodes across the system with a 30% reduction below the system average at DBTH, and a 41% reduction in variation in wound care products used across partner organisations. The programme has also supported the development of shared clinical pathways and generated estimated recurrent savings of £215k through standardisation and procurement improvements. The Trust is also part of the South Yorkshire Imaging Network, led by DBTH's Chief Executive. Collaborative mutual aid arrangements between trusts continue to support patient access and service resilience. Progress is being made on digital transformation initiatives, including cross-site reporting and the implementation of new digital tools to support productivity and improve efficiency, helping make better use of capacity across South Yorkshire.

	Workforce and digital The Trust has continued to support collaborative workforce solutions across South Yorkshire. Building on previous work to establish a single recruitment process for newly registered nurses, provider Chief Nurses have worked together to align workforce approaches, including harmonisation of nursing bank arrangements, and supporting the ongoing single recruitment approach to Midwifery recruitment, initially supported by the ICB and now transferred to providers. An acute federation workforce group is well established, supported by each provider trust. The Trust is engaged on a joint electronic patient record deployment with STH. The two trusts have developed a shared governance and decision-making framework and an 'adopt, not adapt' approach so that they are aligned and can share better staff in future, which is prompting wider clinical integration discussions such as joint formularies. **Service redesign with partners** Through the Shape of DBTH programme and the wider Acute Federation arrangements, the Trust continues to work with partners to redesign services, working with Rotherham, Doncaster and South Humber Healthcare NHS Foundation Trust (RDASH) in supporting Health on the High Street with the Waterdale development, working with the Sheffield Children's Hospital, ICB and the acute federation to develop a dental surgical hub for paediatrics at DBTH, resulting in tangible benefits for children and reducing the paediatric exodontia waiting list by 32%, with high levels of patient satisfaction reported. The Trust's shape programme envisages a progressive concentration of complex acute service at the Doncaster Royal Infirmary (DRI) site balanced with more cold / elective services positioned at Bassetlaw and Montague. **Governance and challenge** The Board oversees significant partnership and collaborative activity through its established governance arrangements, including relevant Board committees and the BAF, with Executive Directors participating in system and Acute Federation governance through their respective professional and partnership groups. The Board recognises that increasing operational and financial pressures across the system make effective collaboration and collective decision-making increasingly important, including where solutions require organisations to work beyond individual organisational interests. The Trust will continue to develop its partnership arrangements and use the Shape of DBTH programme and Acute Federation to identify opportunities for greater service integration, productivity and improved outcomes for the populations served.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	**Cyber security** Cyber security is a core part of the Digital Enabling Plan 2025-2029, within the 'Digital Foundations' ambition. The Audit and Risk Committee receives a detailed cyber security update twice a year and has agreed 'significant assurance' ratings for each of the updates provided in the last 12 months. The Trust has been fully compliant with the Data Security and Protection Toolkit (DSPT) and its predecessor for 17 years, and this year's internal audit by 360 Assurance gave a low-risk assurance rating across all five Cyber Assessment Framework objectives, with a high confidence level in the independent assessment. The Trust is subject to extensive annual cyber security audits, including a subset of DSPT aspirations and routine penetration testing, and benchmarks well against peers on the effectiveness of its local and infrastructure security controls. Governance arrangements are regularly assessed, and the Trust monitors how the cyber threat is changing regionally and nationally so that it can act where necessary.

	Board oversight and risk Digital opportunities and risks are a core part of Board discussions. The Finance and Performance Committee reviewed progress on the Digital Enabling Plan in July and September 2026, noting the expected progress in year one, an improved Digital Maturity Assessment score (2.6, up from 2.4 and in line with expectations for a trust without an electronic patient record) and an improved risk profile. The Board has received cyber training through the Acute Federation, and Board digital literacy will shortly be reassessed. BAF Risk 7 covers the risk that "*If DBTH fails to develop robust and resilient digital, data and technology services, including cyber resilience, there is an increased risk of key system failure, service disruption, and negative impacts on patient care"*; it is scored 15. 11 digital risks on the corporate risk registers are linked to it. **Digital as an enabler** The Trust's digital plans are linked to, and consistent with local priorities, through the Acute Federation Digital Alignment Board, and with national priorities, including the analogue-to-digital shift in the 10-Year Health Plan for England. Digital technology is fundamentally transforming healthcare, and over the past 12 months the Trust has implemented a new radiology information system (quality and safety); expanded a shared record system (quality, productivity and safety); replaced patient self-check-in kiosks (productivity and access); upgraded critical electronic systems (quality and safety); deployed mobile devices (quality and safety); upgraded WiFi and network infrastructure (quality and safety); introduced voice-recognition digital dictation (productivity and quality); expanded virtual wards (quality and safety); and used artificial intelligence in imaging to improve the quality and speed of care (quality and safety). The Trust plans to implement a new integrated electronic patient record system, ORBIT, in late 2027, which will be a fundamental shift in patient care for future generations.

II. Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	**Basis for rating:** *The Trust has established quality governance from ward to Board, triangulated assurance and strong patient experience results. The issues preventing a Green rating are: (i) delivery of the Urgent and Emergency Care action plan following the CQC section 29A warning notice is not yet complete; (ii) the Board recognised in 2025 that data reporting needed to become more triangulated, and this is still being embedded; and (iii) cultural improvement work is under way in operating theatres and paediatrics, and the external review of patient experience will report in Q3. Actions are described under statements 6 to 8.* **Governance** The Board's Quality Committee, which meets bi-monthly, ensures that relevant NHS England guidance, CQC information and local quality metrics are routinely considered and triangulated across assurance, risk management and improvement activity. The quality governance framework provides a route from ward to Board through service and divisional governance, executive oversight, the Quality Committee and the Trust Board. It is supported by the governance structures of the Chief Nurse and Medical Director, which monitor trust-wide assurance on areas such as safeguarding, radiation, mortality and incidents. The Quality Committee receives reports showing that required standards are achieved, performance issues are tackled, continuous improvement is fostered, best practice is shared and risks are managed. **Triangulation and Board visibility** The Trust does not rely on any single source of assurance and over the last year has put renewed focus on explicit assurance ratings and on triangulating assurance methods. The Board and Quality Committee receive an integrated quality and performance report with supporting assurance reports covering patient safety incidents and learning responses, mortality, infection prevention and control, workforce and safe staffing, safeguarding, maternity and neonatal safety, patient experience and engagement, regulatory findings, clinical audit and external review. Board members visit clinical and non-clinical areas through the Board visits programme, and the Board has formalised a structured suite of engagement activity: informal executive walkabouts, structured executive and non-executive assurance visits, responsive or risk-based visits aligned with patient safety priorities, and staff-requested visits. The intention is a flexible and purposeful model of engagement with colleagues. Clinical Director leadership development sessions are held quarterly. **Patient safety incidents** Patient safety incidents are considered through the Trust's Patient Safety Incident Response Framework (PSIRF) arrangements, with a proportionate and systems-based approach used to determine the appropriate learning response. Over the course of the last year a thematic analysis has been undertaken in each Division reviewing the last 5 years to identify themes and strengthen future improvement planning. An externally commissioned thematic analysis of incidents, claims and

wider quality intelligence informed the required review of the patient safety incident response plan where the Trust's patient safety priorities were identified, these include but are not limited to deterioration and sepsis, access and transfer of care, communication and documentation, and CTG interpretation and response. The Trust's PSIRF arrangements resulted in a significant assurance audit rating from the Trust's auditors 360.
The Quality Committee receives a monthly report for assurance on these arrangements and outcomes.

Complaints and patient experience

Complaints, concerns, Patient Advice and Liaison Service (PALS), Friends and Family Test (FFT), national patient surveys are used alongside patient safety and performance information. Established reporting routes provide the Quality Committee and Board with oversight of complaints performance and patient experience. The internal audit identified that there is a clear internal reporting structure with regular reporting Quality Committee and the Board. A planned programme of digital patient stories are received by the Quality committee, the programme is structured to provide a triangulated patient story, with evidence of improvement actions a key requirement. There is regular engagement with seldom heard groups, to inform and support improvement planning. A programme of quarterly community patient engagement events has also been established in the last year. With the first event focusing on interpreter services and accessibility.

Medical performance and patient flow

Substandard performance in the medical workforce is addressed through Maintaining High Professional Standards.
A medical job planning process is in place, with a trust-level consistency group monitoring job plan compliance (including formal notice where needed) and reporting to the Effective Group. An appeal and mediation process strengthened with clear timescales, and focused work in specialties with complex rotas and job plans.

The Trust works collaboratively with system partners to maintain oversight and escalation of patients who no longer require hospital-based care. Delays to discharge are addressed through a multi-agency approach. Longer length of stay reviews are undertaken on a weekly basis to identify and address any barriers to progressing care plans or discharge.

Maternity and paediatrics

The Trust has refined the approach to maternity and neonatal safety and incorporated more explicit paediatric oversight over the course of the last year, the Chief Nurse chairs a Paediatric and Perinatal Safety and Quality Group, of which the Chief Medical Officer attends. The work of the Group supports executive oversight and the work of the well-established maternity and neonatal safety champions. Oversight includes performance against the Maternity and neonatal three-year delivery plan, reviews of safety intelligence, complaints, patient experience feedback, workforce metrics and compliance with national maternity and neonatal requirements, the baseline assessment against the 10-point recommendations has been completed for timely submission and will be monitored via these routes to Quality Committee and Trust Board.

Regulatory findings

The Trust has responded proactively to regulatory findings arising from Care Quality Commission inspections. During 2026 particular focus has been placed on delivery of the Urgent and Emergency Care action plan as a result of the section 29a.

	With enhanced executive oversight of divisional governance arrangements and a structured three cycle assurance process to ensure actions are embedded and improvements sustained. Progress has been demonstrated in a number of areas including environmental standards, patient involvement, nurse recruitment, training compliance, complaints monitoring and paediatric nursing workforce metrics. A number of metrics remain in delivery, and oversight is maintained via executives, the Quality Committee and the Trust Board of Directors. The Trust also underwent an unannounced inspection of Children's and Young People's services during the early part of 2026 and received a Good rating.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	The Board recognised in its 2025 submission that further work was needed to turn data reporting into more meaningful, triangulated information and insight on delivery and outcomes. This has been achieved through more focussed assurance reports that display more data than narrative assurance. There has also been review of the IPR, and BAF frameworks along with assurance rating levels to provide more clarity at board level. **Clinical effectiveness and mortality** The Trust monitors multiple sources of data. An active clinical audit programme, focused on national and National Institute for Health and Care Excellence (NICE) guidance, feeds through audit meetings to the Effective Group, chaired by the Chief Medical Officer, which reports to the Quality Committee. The Effective Group uses a standard divisional template covering audit, NICE compliance and venous thromboembolism (VTE), among other areas; results are scrutinised and plans put in place where needed. Dashboards track quality measures such as sepsis care, which the sepsis action group uses to improve care. Mortality is tracked at trust level and by diagnosis and specialty so that improvement can be focused on areas of concern and is triangulated with structured judgement reviews (SJRs) and measures such as readmission rates. A mortality data quality workstream has improved the Trust's depth of coding from well below the national average to broadly in line with it, so that comorbidities and diagnoses are captured correctly. **Nursing and midwifery oversight** The Chief Nurse oversight framework provides systematic oversight of the quality and safety of nursing and midwifery care. It combines the Care Accreditation and Recognition for Excellence (CARE) programme, quality dashboards, Tendable audit data, patient feedback, unannounced peer reviews and professional oversight to identify emerging concerns, recognise excellence and support improvement. Concerns are escalated through quality summits chaired by the Chief Nurse, enhanced surveillance and divisional performance reviews, so that risks are identified early and improvement support is targeted. The framework was extended to all outpatient departments over the last year. **Culture of improvement** All newly qualified registrants who join the Trust are required to undertake a supported Quality Improvement project as part of their preceptorship and there are various development programmes open to Nurses, Midwives and Allied Health Professionals (NMAHPs) and our recent matron development programme also included several QI projects, one of which resulted in the patient digital stories programme.

	In recognition of the need for continuous improvement, The Trust continues to strengthen its culture of evidence-based practice, research and innovation as key enablers of continuous improvement. The Chief Nurse Fellows programme provides opportunities for NMAHPs to gain exposure to research, quality improvement and service development activities, helping to build confidence in the use, development of and application of evidence within clinical practice. This supports the Trust's ambition to strengthen NMAHPs research, contribute to the professional evidence base and ensure that improvement activity is informed by robust evidence and evaluation. This year the accreditation programme has received 3 applications for accredited plus status, which is only offered when a ward/dept has achieved accredited status for 3 years consecutively and are able to demonstrate a quality improvement project with measurable outcomes, this application is then considered by a panel prior to any approvals.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Reporting to the Board** The Board's Quality Committee receives a comprehensive patient experience and engagement report alongside the integrated performance report, which sets out key metrics including FFT and complaints responses. The Board's annual effectiveness survey confirmed that it receives timely information on quality and that it has the right blend of skills, expertise and experience to face present and future challenges, including those relating to quality. **Monitoring patient experience** The Trust has established systems to monitor patient experience through a range of complementary sources including complaints, concerns, PALs, FFT, Care Opinion, national patient surveys, patient stories and engagement activity. Feedback from these sources is triangulated to identify themes and understand the experience of different patient groups, including through the Chief Nurse oversight framework, and is reported through divisional governance, the Quality Committee and the Board so that the patient voice influences operational and strategic decisions. A planned programme of digital patient stories, each triangulated and required to evidence improvement actions, is received by the Quality Committee. Internal audit found a clear reporting structure with regular reporting to the Quality Committee and Board. A gap analysis against the NHS England Experience of Care framework has been completed and reported to the Quality Committee, and an external review of patient experience arrangements has been commissioned to provide further objective assessment around how effectively the patient voice informs quality improvement and organisational decision-making including learning from complaints and contact; its recommendations will be considered in Q3. The Trust will also consider how the NHS England Experience of Care Improvement self-assessment can shape future direction. **Involving patients and communities** The Trust has an established group of Patient Safety Partners who attend relevant forums, and community stakeholders attend and give feedback through the Maternity and Neonatal Safety Champions. The community collective patient

	engagement group has supported implementation of Martha's Rule, veterans' covenant arrangements and fit note implementation and has contributed to patient leaflets such as those on infection prevention and control. The Trust engages regularly with seldom-heard groups and has established quarterly community patient engagement events, the first of which focused on interpreter services and accessibility. Over the past year the Trust has strengthened the approach outlined in 2025 through greater triangulation of feedback sources and increased focus on evidencing the improvements made as a result of patient feedback. **Survey evidence** Recent national survey results provide significant assurance regarding compassionate, respectful care, with the Trust performing strongly in both the Urgent and Emergency Care and Maternity surveys. The Urgent and Emergency Care Survey showed DBTH ranked 11th out of 56 trusts (Picker) for overall patient experience, with improvements in overall experience, communication and involvement in decision-making, and no areas performing significantly worse than comparator organisations. The Maternity Survey found performance broadly in line with national benchmarks, with strengths in dignity, confidence in staff, decision-making and postnatal support. The 2025 Cancer Patient Experience Survey similarly identified compassion, professionalism and staff support as areas of strength whilst highlighting opportunities to improve communication, appointment management and care coordination across organisational boundaries. The National Inpatient Survey identified areas of good patient experience, particularly in relation to dignity, respect, communication and confidence in staff, whilst highlighting opportunities to further improve discharge communication and information sharing. The National Audit of Care at the End of Life (NACEL) also provided positive assurance regarding the quality and compassion of end-of-life care arrangements, supported by established governance and improvement actions. **Escalating safety concerns** The Trust has clear and established routes for the escalation of safety concern from frontline services to the Board. Concerns can be raised through incident reporting arrangements, patient safety investigations, mortality reviews, complaints and concerns processes, safeguarding systems, freedom to speak up routes, quality visits and executive walk rounds. Where concerns have been raised actions have been outlined and implemented, for example, the Trust commissioned *Civility Saves Lives* to undertake work with the multidisciplinary teams in operating theatres, and commissioning "A kind life" to support work on cultural improvement in paediatrics.

III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	**Basis for rating:** *Staff survey results are stronger than the previous year, appraisal completion exceeds the standard for the third consecutive year and Freedom to Speak Up governance is well developed. There are robust recruitment, training, appraisal, leadership and development processes, and succession planning in place. The issues preventing a Green rating are: (i) engagement is below the sector average; (ii) SET compliance of 85.98% is below the 90% standard; and (iii) the Board recognised in 2025, and external reviews confirmed, that consistent behaviours still need to be embedded through the Culture and Leadership programme established in 2026. Actions are described under statements 9 to 11.* **Sources of feedback** Staff and learner feedback is used to improve the quality of care and to monitor colleague experience. Sources include the national staff survey (with free-text comments), the General Medical Council (GMC) survey, the National Education and Training Survey, and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results. The annual staff survey, WRES and WDES results are reported to the People Committee and Board and have informed People Plan action planning and the Culture and Leadership pillar developed in 2026. **Culture and Leadership programme** The comprehensive Culture and Leadership programme of work was established in 2026, building on the existing People Plan, DBTH Way and cultural workstreams and considering feedback from multiple sources of data, colleague feedback and local intelligence. This includes feedback from the annual staff survey, free-text comments from the staff survey, externally commissioned culture review (DBTH Way in Action), Well-Led review, external Freedom to Speak Up peer review, themes from FTSU concerns and other people metrics. The 'Line in the Sand' video and supporting engagement campaign is a key part of this cultural improvement work and was developed with colleagues in response to feedback about some inconsistencies in standards and behaviours across the Trust. This approach builds on the guiding principles set out in our DBTH Way, which was itself co-designed with a wide range of colleagues and leaders through open engagement sessions. The Line in the Sand has received positive attention nationally and the Chief People Officer has met with representatives from trusts across the country, who made contact through a national network supporting civility at work linked to improving patient care. Colleague feedback and engagement was also used to identify the three focus behaviours for 2026/27 within the DBTH Way framework as part of the Culture and Leadership work. These are Speaking Up for Patient Safety, Personal Accountability and Collaborative Relationships. Over 500 colleagues contributed towards selecting these focus behaviours and a plan is being enacted to incorporate the behaviours into ongoing activities, e.g. FTSU month in October is centred around Speaking Up for Patient Safety.

	Staff survey In the 2025 staff survey, the Trust was above national sector average in six of the seven People Promise themes and in line with sector average in the seventh ('we are a team'). For the additional elements in the survey, the Trust was above average for 'morale' and below average for 'engagement'. This represents a stronger comparative position than in 2024, where the Trust was above sector in four People Promise themes and below sector in three themes. Across individual questions, 7% improved significantly, 17% declined significantly and 76% showed no significant change from 2024. There was a 54% response rate, in comparison with the sector average of 47%, therefore providing a meaningful dataset and rich feedback in relation to colleague experience. **Staff engagement and acting on feedback** There is a clear approach for engagement in relation to the staff survey results at the Trust, with expectations set out for leadership teams to hold engagement sessions with their teams to formulate action plans that target improvements. There is Executive oversight of local staff survey action plans through the performance review meetings, as well as through the Chief People Officer. Local action plans in the last year have included a focus on improving questions in relation to recommending DBTH as a place to work and as a place to receive care or treatment. As part of its approach to colleague engagement, the Trust has launched the DBTH Assembly, with representatives from across the Trust; its first meeting in September 2026 was well attended and positively received, covering the additional questions for pulse surveys, branding for the DBTH Charity and an overview of the NHS Staff Standards. A refreshed approach to quarterly pulse surveys is being introduced, with additional questions shaped by colleague feedback. Staff networks have been relaunched and new ones created with executive sponsorship, following the earlier BAF action, and the Trust continues to use the Team Engagement and Development (TED) tool to gather feedback from local teams. Staff survey and learner feedback continues to be used to improve care and monitor colleague experience, with formal surveys including the national staff survey results alongside the free-text comments, GMC survey and National Training and Education survey. In addition, outcomes from the WRES and WDES are reviewed and analysed to provide further data on colleague experience. The annual staff survey, WRES and WDES results are reported to the People Committee and Board, and the feedback has been used to inform People Plan action planning on an ongoing basis and the development of the Culture and Leadership pillar of work in 2026. The Trust received bronze accreditation from the NHS North West BAME Assembly for work on anti-racist framework.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development	**Recruitment, appraisal and succession** There are robust recruitment processes in place with training available for recruiting managers, including on inclusive recruitment practices. The appraisal process at the Trust enables an annual evaluation of colleague skills and training, learning and development needs. This is supported by career development and talent management conversations, utilising the Scope for Growth framework, and succession planning for leadership and other key posts. The DBTH Scope for Growth framework has been adapted from the national model and succession planning is undertaken by leadership teams on an annual basis.

programmes in place at all levels	The completion rate for the 2026 appraisal season (held April - July 2026) was 91.63% against the 90% standard, and this is the third consecutive year where the 90% standard has been exceeded. **Learning and leadership development** The Trust also carries out an annual Learning Needs Analysis aligned to appraisal and business planning processes. This provides valuable input for education and development programmes and supports identification of future needs. The apprenticeship levy is used effectively to complement internal and external training courses, and NHSE CPD funding is used in full, with oversight from the Chief Nurse as well as through the educational governance structure. There are leadership development programmes in place within the established Leadership Prospectus, alongside opportunities for facilitated 360 feedback and coaching. There has been a full review of our leadership development offer as part of the Culture and Leadership work, with a refreshed leadership prospectus to be launched in Q3 2026/27. Within this refreshed offer there is a new managers' competencies training package for aspiring and existing managers, which brings together existing training and introduces new modules. The Culture and Leadership programme is strategically aligned with the Leadership and Management Framework. **Statutory and essential training** Statutory and Essential Training (SET) compliance was 86.0% in August 2026 against a standard of 90%. The People Committee receives detailed SET updates at every meeting, and there is also executive oversight at the monthly Performance Review Meetings and regular reporting to the Workforce and Education Group, chaired by the Chief People Officer. Managers are sent a regular notification of compliance rates and areas that require focus. Data analysis is undertaken by professional group, division/directorate and topic area to identify areas of non-compliance and support improvement with targeted actions. A risk-assessment approach with prioritisation is used where there are areas of underperformance. There are Education Leads within the clinical divisions, supported by a Trust-wide multi-professional education team. The Trust is aligned with the NHS England mandatory and statutory training project and has consistently been on track with milestones and deadlines. The Mandatory Learning Oversight Group has been implemented with a governance route to the Hospital Leadership Team in relation to approval of any changes, additions or removals of training requirements. This process includes statutory, mandatory and role-specific training.
11. Staff can express concerns in an open and constructive environment	**Reporting to the Board** The People Committee and Board receive Freedom To Speak Up (FTSU) reports biannually with the most recent being June 2026 at People Committee and July 2026 at Board. Reports are provided in a format that is aligned with the 2024 - 2028 Speaking Up Plan. Consideration has been given to the format of reporting to People Committee and Board by the People Committee at their June 2026 meeting and the approach has been reaffirmed. This format ensures that the Board receives information in relation to performance across the strategic themes, the impact of national policy and guidance on performance, and local data themes, feedback themes and reporting trends. Progress against the priorities and actions set out in the Speaking Up Plan delivery plan is reported at People Committee and Board. The FTSU Reflection and Planning Tool is reviewed by People Committee each year and presented in Board reports,

	with performance against its actions monitored biannually as part of the FTSU reporting process. The Trust is broadly in line with the national sector average in the raising concerns sub-score within the 2025 staff survey, with a score of 6.33 against the average of 6.40, although this is a decline from the Trust score of 6.43 when the national average was 6.42. **Board engagement** The Board demonstrates commitment to listening to and learning from Speaking Up concerns, through regular planned discussions between the FTSU Lead Guardian and the Chief Executive, the Executive Lead for Speaking Up (Chief People Officer) and the Deputy Chief Nurse. Additionally, there are quarterly joint meetings between the FTSU Guardians, the Executive Lead for Speaking Up (Chief People Officer) and the Non-Executive Director with the Speaking Up portfolio. **Strengthening the service** The FTSU Guardian service has been strengthened by an additional Guardian alongside the Lead Guardian. All three levels of Speaking Up training are mandated within the SET+ framework and compliance is monitored. The internal publication 'Sharing what we have heard and learnt' shares data on concerns raised, feedback themes, learning and action taken. The FTSU Guardian is an active member of wider cultural workstreams to ensure feedback and learning is shared, including Just Culture and the Data Triangulation Group which reviews people and patient metrics to identify any areas of concern for escalation. The staff survey results and feedback are reviewed by the FTSU Guardian, as part of the established approach to staff survey engagement. **Learning from external review** The Board recognised in 2025 that further work was required to embed consistent, positive behaviours and address cultural issues identified through colleague feedback. An external FTSU Review was commissioned in 2025 and reported back in January 2026. The themes and feedback from the review have been shared with the Speaking Up Forum, People Committee, Board, through Trust-wide communications and in engagement sessions held across the three sites. They have also provided any input to the Culture and Leadership pillar in 2026, alongside other sources of data, survey feedback and intelligence. Feedback themes and learning from the FTSU peer review and the DBTH Way in Action review have been incorporated into the FTSU Reflection and Planning Tool and action plan for the Speaking Up Plan, which is reviewed through the Speaking Up Forum with oversight of progress at People Committee.

IV. Access and delivery of services

Capability statements	**Proposed domain rating**
	Red

12. Plans are in place to improve performance against the relevant access and waiting times standards	**Basis for rating:** *A positive self-assessment cannot be made because the Trust is off track against national access standards for emergency care, diagnostics and elective care, remains in Tier 2 for elective waits and is delivering an Urgent and Emergency Care action plan following a CQC section 29A warning notice. Actions are described under statements 12 to 14.* **Current position** The Trust is currently off track with NHS planning guidance national access standards relating to emergency care, diagnostics and elective care. The Trust is meet the NHS planning guidance national access standards relating to cancer care. Recovery plans are in place for emergency care and elective care, and remedial action plans are in place for MRI and audiology, the two diagnostic services driving under-performance against the DM01 standard. **Elective care** At the time of the 2025 submission the Trust was in Tier 2 for elective waits, with plans to achieve full compliance with the 65-week standard by December 2025 and the 52-week standard by March 2026. 65 weeks and RTT remains a challenged position and DBTH remains in Tier 2, meeting fortnightly with NHSE to review the position. Opportunities created by shared leadership arrangements will be utilised to strengthen recovery plans, for example through mutual aid of other providers to treat longer waiters and improved utilisation of the shared elective orthopaedic facility at Mexborough with Barnsley and Rotherham Foundation Trusts. Shared leadership arrangements will be used to strengthen recovery plans, for example through mutual aid from other providers to treat longer waiters and better use of the shared elective orthopaedic facility at Mexborough with Barnsley and Rotherham. **Urgent and emergency care** Access standards relating to UEC have demonstrated some improvement in particular months through 2026; however, the focus is now on sustained and accelerated improvements to meet the planning trajectories. The issues are well understood and actions for example, the establishment of an Extended Emergency Medicine Ambulatory Care (EEMAC) at DRI, are demonstrating improvements. Other challenges, for example the emergency surgical pathway and its impact on patient waiting times withing the Emergency Department, still require improvements at pace. The Trust continues to implement and embed the relevant operational actions from the CQC action plan, following unannounced inspections in 2025 and early 2026 (statement 6). **Oversight** The Trust Board of Directors and Finance and Performance Committee have oversight of the monthly performance position and the factors driving any areas of underperformance. The Board receives monthly performance against national access and waiting time standards and agreed trajectories in the IPR. Monthly operational performance reports to the Finance and Performance Committee track delivery against all national waiting time standards, with exception reporting and bi-monthly deep-dive reviews where performance is off trajectory. The Board has reviewed the RTT recovery plan for Trauma and Orthopaedics, giving direct Board oversight of recovery in an area of significant elective challenge.

	The monthly IPR provides the Board with oversight of performance against national access and waiting time standards and agreed trajectories. This is supported by more detailed oversight through the Finance and Performance Committee, including exception reporting and deep dives where performance is off trajectory. The Board has also reviewed the RTT recovery plan for Trauma and Orthopaedics, providing direct Board oversight of recovery in an area of significant elective challenge. Monthly Performance Review Meetings (PRMs) provide Executive-level oversight of Divisional delivery against agreed trajectories, with areas of underperformance subject to escalation and recovery action. This is supplemented by weekly operational oversight and reporting through to the Executive Team. The Trust is also subject to NHS England IQIG oversight, providing external scrutiny and assurance of performance, recovery actions and delivery against agreed trajectories. During 2026/27, access and waiting time improvement has also been incorporated within the Trust's three-year plan and Reset programme, strengthening the connection between operational recovery, productivity, workforce and financial improvement. Access and Flow is one of the five Reset pillars. The Board recognises that delivery of access standards remains a significant area of operational challenge and continues to require sustained improvement rather than performance monitoring alone.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	The Trust continues to implement its Health Inequalities Strategy and has significantly strengthened its ability to identify inequalities in access and waiting times during 2025/26. The Trust Equity Index has now been completed and is being implemented across DBTH, providing a systematic approach to identifying statistically significant inequalities by factors including deprivation and ethnicity and enabling areas of greatest inequality to be targeted for improvement. Of the measures assessed through the Equity Index, inequalities have been identified in specific areas rather than being consistently present across services. **Elective care** For elective care, the Equity Index has not demonstrated inequalities in patients waiting over 18 or 52 weeks by deprivation or ethnicity. However, the Trust recognises that this does not mean there are no inequalities in access, as some groups experience barriers to accessing non-emergency healthcare and therefore getting onto waiting lists in the first place. A dedicated waiting-list dashboard enables analysis by age, ethnicity, sex, deprivation, care-home status and marital status, including at specialty level. DBTH is also implementing BEACON, a South Yorkshire health inequalities scoring tool designed to identify patients at greater risk of disadvantage and support more equitable clinical prioritisation and waiting-list management. **Did Not Attend and emergency care** The Trust has also developed dedicated Did Not Attend/Was Not Brought (DNA/WNB) and Emergency Department health inequalities dashboards. The DNA/WNB dashboard was developed in response to inequalities identified through the Equity Index and enables analysis and monitoring by deprivation, ethnicity, age and sex, including at specialty and clinic level. Emergency care analysis has identified inequalities in a number of measures, particularly by ethnicity, and the ED dashboard enables these to be monitored and targeted for improvement.

	Targeted work has continued for inclusion health groups, including people experiencing homelessness, sex workers and people with substance misuse issues, with improved links between ED teams, community and voluntary sector organisations and partner agencies. **Governance** Governance has also strengthened during 2025/26, with a Health Inequalities Oversight Group chaired by the Deputy Chief Executive and formal six-monthly reporting to the Board. Health inequalities impacts are now required within Trust coversheets and business cases, and the Board has undertaken a national Health Inequalities Self-Assessment to establish a baseline for further improvement. **Further development** The Trust recognises that further development is required, including embedding routine monitoring of the Equity Index measures over time, demonstrating the impact of interventions and addressing remaining gaps in the availability of inequalities data across some clinical areas.
14. Appropriate population health targets have been agreed with the ICB	The Trust's strategic priorities remain aligned with the population health needs identified through the Joint Strategic Needs Assessment, ICB priorities and the Core20PLUS5 framework. The Trust works with South Yorkshire ICB and Place partners on shared population health priorities, including inclusion health, women's health and reducing inequalities in access to care. During 2025/26, DBTH has strengthened its approach to identifying and measuring inequalities through development of the Trust Equity Index and associated dashboards, enabling inequalities in access, experience and outcomes to be identified and monitored. The Health Inequalities Oversight Group provides executive oversight, with formal reporting to the Board.

V. Productivity and value for money

Capability statements	**Proposed domain rating**
	Amber-Red
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board	**Basis for rating:** *The Trust's implied productivity is top quartile nationally; however, conversion of productivity improvement into recurrent financial benefit is not yet complete and agency spend remains in the worst national quartile.* **Position** Latest published Model Health System data (to March 2026) show that the Trust's implied productivity increased by 11.3% during 2025/26, making it the 5th-highest performer of 134 organisations nationally, and that it is now 0.4% above pre-Covid (2019/20) levels, a top-quartile position nationally. These measures are reported to the Finance and Performance Committee each month in the Finance and Activity Report.

and other guidance as relevant	At the time of the 2025 submission, implied productivity had improved by 4.8% over the preceding 12 months, ahead of the 2.6% regional average, but remained around 11.4% behind pre-Covid levels, compared with a 6.8% regional average shortfall. **Approach** The Trust continues to use NHS Model Health System data and other benchmarking sources to identify opportunities for improvement in Urgent and Emergency Care, theatres and outpatients, and to track progress against plans. Productivity improvements continue to be delivered through a coordinated approach to benchmarking, embedded through the Finance and Performance Committee, with opportunities identified through the Model Health System and other sources of benchmarking. These inform improvement priorities in urgent and emergency care, theatres, outpatients, workforce, temporary staffing, medicines and estates. Opportunities are identified and tested using Model Health System, NHS Benchmarking Network data and other national and peer benchmarking, alongside internal operational and financial intelligence. These inform improvement priorities across areas including workforce, temporary staffing, theatres, outpatients, medicines, estates and urgent and emergency care. The Trust's approach has increasingly moved from identifying individual efficiency schemes towards systematically understanding and closing evidenced productivity gaps. **Plans and governance** Productivity improvement is a core component of the three-year plan and Reset programme. The productivity and financial sustainability pillar brings benchmarking and productivity intelligence together with operational and financial improvement, rather than treating productivity as a standalone financial measure. Delivery is overseen through executive oversight of the Reset programme and Performance Review Meetings, with Board-level assurance through the Finance and Performance Committee, so that productivity is considered alongside activity, workforce, quality and finance and is escalated where improvement is not progressing as planned. The Trust is a member of the NHS Benchmarking Network and its Chief Finance Officer chairs the Network's Steering Group. Its approach has increasingly moved from identifying individual efficiency schemes towards systematically understanding and closing evidenced productivity gaps. **Challenge** The Board recognises that the significant improvement in overall productivity does not mean that all identified opportunities have been realised. Delivering the three-year plan requires further productivity improvement and the conversion of identified opportunities into recurrent operational and financial benefits; the Trust's financial position (statements 16 and 17) shows that this conversion is not yet complete.

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Red
16. The trust has a robust financial governance framework and appropriate contract management arrangements	**Basis for rating:** *A positive self-assessment cannot be made because the Trust is off track against its committed financial plan at month 5 (£11.9m year-to-date deficit excluding DSF, £2.6m worse than plan), the Provider Assurance Model forecasts show the plan will not be delivered in any scenario, £11.1m of net risk remains, and planned reductions in bank and agency spend are not being fully delivered. Actions are described under statements 16 to 18.* The Trust continues to maintain a robust financial governance framework and appropriate contract management arrangements. That said, the Trust is off track with delivery of its committed financial plan at the month 5 reporting point (£11.9M year to date deficit excluding deficit support funding (DSF), £2.6M worse than the £9.3M deficit planned, £15.7M deficit full year plan). The Trust recognises that more needs to be done; the actions taken since August 2026 are set out in the final paragraph and under Statement 17. **Self-assessment and oversight** The Finance and Performance Committee has overseen delivery of the action plan to strengthen consistency of controls on the back of the self-assessment using the HFMA Improving NHS Financial Sustainability: Are You Getting the Basics Right tool referenced in last year's return where 24 items were scored at '3 - holds true about half the time'. Updates were reviewed by the committee in November 2025 ('*HFMA Checklist Action Plan Update*') and March 2026 ('*Update on HFMA Checklist and Strengthening Financial Management Action Plan Implementation')*. The Trust has also completed the NHSE: Strengthening Financial Management self-assessment process and again the Finance and Performance Committee has overseen the results and implementation of the resultant action plan. The assessment and initial action were reviewed by the committee in January 2026 ('*Strengthening Financial Management Self-Assessment Checklist*') and a further review of progress made in March 2026 ('*Update on HFMA Checklist and Strengthening Financial Management Action Plan Implementation')*. Since the interim Chief Executive Officer took up post in August, the Executive Team has re-assessed the Trust against the NHS England tool, and a prioritised action plan is being finalised. **Audit and contracts** The 2025/26 internal audits of Estates and Facilities Contract Management and of Data Quality - Cancer Metrics gave significant assurance and limited assurance respectively; all five actions agreed from the cancer metrics audit were completed within the agreed timescales. The 2026/27 Internal Audit programme includes audits of Costing Arrangements and Workforce Planning Including Establishment Controls.

	There have been no significant contractual disputes in the last 12 months. The Trust remains in dialogue with South Yorkshire ICB in respect of growth funding for 2026/27 and an outcome from those discussions is expected in the next 2 fortnight. **Alignment of staffing, finance and operations** There is good alignment between staffing, finance and operational systems and controls. For example, in January 2026 the Board approved the *Skill Mix Business Case - Registered Nurse* to increase registered nurse skill mix on acute adult inpatient wards from 57% to 60%, with phased recruitment matched to graduate availability and operational need and partly funded by a reduction in bank and agency spend. For the medical workforce, the Trust now monitors the programmed activities (PAs) actually delivered against plan. **Temporary staffing** Model Health System benchmarking (January 2026) places the Trust in the worst national quartile for agency spend (2.5% of total pay, ranked 176 of 195), the best quartile for bank spend (3.4% of pay, ranked 26 of 195) and the second-best quartile for overall temporary staffing spend (5.9% of pay, ranked 65 of 195). The 2026/27 committed plan assumes significant reductions in both agency and bank expenditure, and at month 5 these are not being fully delivered. **Actions taken** Since the Trust's new Chief Executive Officer took up post in August the Trust has: - Appointed a Turnaround Director; - Launched a Mutually Agreed Resignation Scheme (103 applications had been received (at the time of drafting this submission) since the scheme opened on 11 September, the scheme closes to applications on 16th October); - Re-reviewed itself against the NHSE Strengthening Financial Management checklist. A prioritised action plan to address the opportunities identified through the re-review is currently being finalised; and - The Executive Team therefore agreed on 16 September 2026 to establish a Trust-wide Medical Workforce Bank and Agency Control Panel, whose first meeting is scheduled for 1 October 2026.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	**Risk position** The Trust has 11 financial risks on its corporate risk register, with current scores between 9 (likelihood 3 × consequence 3) and 20 (likelihood 4 × consequence 5), and a financial strategic risk on the Board Assurance Framework. Financial risks are reported to the Finance and Performance Committee each month in the Finance and Activity Report, which shows that gross risk to delivery of the 2026/27 financial plan has reduced from £45.7m at the planning submission to £24.1m at month 5, and net risk from £38.9m to £11.1m. **Assessment** Financial risks are well understood but are not yet managed well enough to give sufficient assurance that the committed plan will be delivered. The Trust is off track at month 5 (£11.9m year-to-date deficit excluding DSF, £2.6m worse than the £9.3m planned, and a £15.7m full-year planned deficit).

	The Provider Assurance Model forecasts show that the Trust will not deliver its committed plan in the worst, mid-range or best-case scenarios, although there was some improvement in the forecast outturns for all three scenarios between the month 4 and month 5 submissions and actual performance in August was better than the month 4 mid-range prediction. £11.1m of net financial risk remains. The Board regards this position as needing urgent action. **Protecting quality** A Quality and Performance Impact Assessment (QPIA) process is used to identify and mitigate the potential effects of proposed changes on the quality of patient care or on organisational performance. **Action since August 2026** Since the new Chief Executive took up post, the Trust has appointed a Turnaround Director; launched a Mutually Agreed Resignation Scheme (123 applications received since it opened on 11 September; it closes to applications on 16 October); re-reviewed itself against the NHS England Strengthening Financial Management checklist, with a prioritised action plan being finalised; and agreed to establish a Trust-wide Medical Workforce Bank and Agency Control Panel, which meets for the first time on 1 October 2026.
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	The Trust engages with system partners on the optimal use of NHS resources, including through the Chief Finance Officer's roles on the South Yorkshire CFOs' Group and as Chair of the South Yorkshire Acute Collaborative Procurement Board. The Trust takes part in system-wide financial planning and works with partners to identify where resources can be used more effectively across organisational boundaries, including shared services, workforce initiatives and service transformation. This is complemented by collaborative approaches to productivity, procurement, workforce and service delivery through the Acute Federation and wider system arrangements. DBTH is a significant component of the South Yorkshire financial position, so delivery of the Trust's own financial recovery is material to the system's planned outturn. The Trust's three-year plan and Reset programme focus on productivity, recurrent efficiency and reducing the underlying financial deficit, with delivery contributing directly to improvement in the wider system financial position. The Trust's current off-plan position (statement 17) is adverse to the system outturn, and delivering its recovery is the most important contribution it can make. The Board recognises that financial sustainability cannot be considered at individual organisational level alone. Given DBTH's material contribution to the South Yorkshire position, there is a dual responsibility to deliver the Trust's own recovery plans and to work with partners on opportunities that require collective decisions about capacity, workforce and resources across the system.

Signed on behalf of the Board of Directors

Chair: Mark Bailey

Signature: _____ Date: 2 October 2026

Signed on behalf of the Board of Directors

Chief Executive: Richard Jenkins

Signature: _____ Date: 2 October 2026

2611 - H2 BOARD OF DIRECTORS WORK PLAN

Information Item | Brenda Thomas, Interim Company Secretary | 12:40

REFERENCES

Only PDFs are attached

H2 - Board Work Plan.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE								
				27/01/2026	24/03/2026	05/05/2026	07/07/2026	01/09/2026	03/11/2026	05/01/2027	02/03/2027
OPENING ITEMS											
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Chair's Report (including partnership updates and impact on DBTH)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Chief Executive's Report (including partnership updates and impact on DBTH)	Chief Executive	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
BOARD LEARNING & REFLECTION											
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	x							
PATIENTS											
Prev known as Maternity & Neonatal Update (Perinatal Safety & Quality Report)	Director of Midwifery	Every meeting	Nov-26	x	x	x	x	x	x	x	x
Clinical Negligence Scheme for Trusts Board Declaration	Director of Midwifery	Annual	Jan-27	x							
Learning from Deaths	Executive Medical Director	Quarterly	Jan-27		x		x	x		x	
Patient Experience Annual Report	Chief Nurse	Annual	Sep-27					x			
Winter Plan	Chief Operating Officer	Annual	Sep-27					x			
Quality Accounts	Chief Nurse	Annual	Jul-27				x				
Safeguarding Annual Report	Chief Nurse	Annual	Sep-27					x			
Infection Prevention & Control Annual Report	Chief Nurse	Annual	Sep-27					x			
~~Antimicrobial Resistance (PRN02235)~~	Chief Nurse	Annual	Mar-26								
PEOPLE											
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Nov-26		x		x		x	x	x
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-27				x				
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-27				x				
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Jan-27		x		x			x	
Staff Survey Results	Chief People Officer	Annual	May-27			x					
~~Maternity Workforce~~	Director of Midwifery	Bi-annual									
Research & Innovation Case Study	Chief People Officer	Annual	Jul-27				x				
DBTH Way in Action & Well-led Review Progress Update	Acting Chief Executive	Alternate	Jan-27			x		x		x	x
PARTNERSHIP											
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	Jan-27			x	x	x		x	
Wider Partnership updates	DCEO	As required	As Req'd								
POUNDS											
Financial Plan	Chief Financial Officer	Annual	TBC		x						
Going Concern	Chief Financial Officer	Annual	May-27			x					
Delegation for the Approval of Annual Accounts and Annual report	Chief Financial Officer	Annual	May-27			x					
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Sep-27					x			
Annual Business Plan	Chief Financial Officer	Annual	Jan-27		x						
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-27				x				
ASSURANCE & GOVERNANCE											
Integrated Quality & Performance Report (**to include financial position wef Janary 2026**)	COO/CN/EMD/CPO	Every Meeting	Nov-26	x	x	x	x	x	x	x	x
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Nov-26	x	x	x	x	x	x	x	x
Board Risk Appetite	Deputy Chief Executive	Annual	May-27				x				
Review of Strategic Risks	Deputy Chief Executive	Annual	May-27				x				
~~2026/2027 Strategic Priorities Success Measures~~ Medium Term Plan	Deputy Chief Executive	Annual	May-27			x					
Delivery Update ~~2025/26 Strategic Priorities Success Measures~~ Medium Term Plan / Reset Programme/Imperatives	Deputy Chief Executive	Every meeting	May-26			x	x	x	x	x	x
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-27					x			
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-26						x		
Chair's Assurance Log - Finance & Performance Committee (**append Imperative Report wef Nov 2026**)	F&P Chair	Post Committee	Nov-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Nov-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Nov-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Nov-26		x	x	x	x			x
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-27								
Board Work Plan (approval)	AD of Strategy, Partnerships & C	Annual	Jan-27	x							x
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annually	Jan-27	x						x	
Trust Seal	AD of Strategy, Partnerships &	Annually	Nov-26						x		
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & C	Annual	May-27			x					
Board Effectiveness	AD of Strategy, Partnerships & C	Annual	2027								
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & C	Annual	May-27			x					
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & C	Annual	May-27			x					
Terms of Reference - People Committee	AD of Strategy, Partnerships & C	Annual	May-27			x					
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & C	Annual	May-27				x				
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	CFO/DCEO	As Req'd	As Req'd			x (HI)			x (HI)		
Mortuary Annual Report	Executive Medical Director	Annual	Jan-27						x	x	
ENABLING STRATEGIES											
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027								
People Strategy 2023/27	Chief People Officer		2027								
Research & Innovation Strategy 2023/28	Chief People Officer		2028								
Speaking Up Strategy 2024/28	Chief People Officer		2028								
Tackling Health Inequalities 2023/28	~~Director of Recovery, Innovation & Transformation~~		2028								
Digtal Enabling Plan	Chief Finance Office		2029								
TRUST POLICIES											
CORP/FIN 1 - B Standing Financial Instructions	Chief Finance Officer	Annual	Nov-26					x	x		
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	Nov-26					x	x		
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships & C	Annual	Nov-26						x		
INFORMATION											
Work Plan	AD of Strategy, Partnerships & C	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Appointment of External Auditors	Chief Financial Officer	As Req'd	As Req'd								
Appointment of Internal Auditors	Chief Financial Officer	As Req'd	As Req'd								
CLOSING ITEM											
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd	x	x	x	x	x	x	x	x

2611 - I INTEGRATED ASSURANCE

12:40

2609 - 11 TRIANGULATION OF INFORMATION TO IDENTIFY AGENDA ITEM THEMES

Discussion Item | Mark Bailey, Interim Chair | 12:40

5 minutes

2611 - I2 BOARD EFFECTIVENESS & DEMONSTRATING THE DBTH WAY

Discussion Item | Mark Bailey, Interim Chair | 12:45

- Was sufficient time allocated to enable focused discussion for items?
- Did papers contain the appropriate level of detail?
- Was open and productive debate achieved?
- What could we do less of ? more of going forward?
- Were discussions courteous and in line with the DBTH Way?

5 minutes

2611 - J CLOSING ITEMS

12:50

2611 - J1 PRE-SUBMITTED QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS

Discussion Item | Mark Bailey, Interim Chair | 12:50

10 minutes

2611 - J2 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Mark Bailey, Interim Chair | 13:00

10 minutes

DATE AND TIME OF THE NEXT MEETING

Information Item | Mark Bailey, Interim Chair | 13:10

Date: Tuesday 5 January 2027
Time: 09:30am
Venue: Boardroom, Doncaster Royal Infirmary