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Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Final Well-led Review Report

November 2025

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Executive Summary

Executive Summary

This Executive Summary, summarises the key findings from our independent Well-Led review for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The summary provides a high level overview of the review's findings. We are grateful to Board members, staff, and partners who contributed openly and constructively to the review process.

Board and Executive effectiveness and culture

- At the Executive Team meeting, Directors engaged in cross-portfolio debate and constructive challenge. Executives also described respectful but robust challenge at private Board sessions. However, at the July 2025 public Board meeting, we observed Executive contributions were more limited.
- We observed Board and committee meetings were generally well chaired, with open, respectful, and inclusive discussion. Evidence of unitary decision making was observed, with all members given the opportunity to challenge assurance levels proposed by committee chairs.
- Levels of Non-Executive challenge varied across committees. This resulted in questions relating to how assurance was effectively gained.
- Board members expressed confidence in overall capability of the Board but noted the absence of a formal Board development programme.
- Lack of ethnic diversity across the Board, Executive Team, and Council of Governors is recognised. Current Non-Executive recruitment presents an opportunity to address this.

Assurance Arrangements

- The extent to which the Board sub-committees uses effective and triangulated evidence to set their assurance levels was a concern identified in this review.
- The Board and committees should review processes, including, standard definitions for assurance levels, alignment with internal audit opinions, use of outcomes data, and greater external validation.

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- The Trust has introduced a revised Performance Accountability Framework (PAF) setting out its approach to performance assurance. There is not however, a broader organisational accountability framework that clearly defines roles and responsibilities of Board of Directors, Council of Governors, CEO, Executive Team, Board sub-committees, Trust Leadership Team, management groups, and accountability arrangements within the clinical divisions and corporate directorates.

Trust Leadership Team (TLT) – Role and Effectiveness

- There are inconsistencies between the Terms of Reference and draft wiring diagrams regarding the management groups reporting into TLT and reporting upwards.
- Our review raised some concerns regarding TLT's central role in the governance framework, including the infrequency of meetings, and the limited evidence of broader engagement and decision making.

Senior leadership, collaboration, and decision making

- Some senior leaders raised concerns over what they consider to be a siloed approach between medical, nursing and operational leadership.
- Concerns were also raised about the role of divisional leadership in informing decision-making and assurance. There is limited evidence of divisional leaders' input to Board and its sub-committees.

Embedding Patient and Lived Experience

- The Quality Improvement and Innovation Strategy 2024–2028 identifies patient and service user involvement as a priority, but we note that progress has been limited.
- The meetings and evidence reviewed demonstrate limited reference to the role of patient and carer lived experience in shaping and developing services. The Quality Committee receives and assures a patient experience report only once a year and lived experience does not feature prominently in the Trust Strategy, Board Assurance Framework, or Integrated Performance Report.

Executive Summary

Vision, Values, Behaviours and Culture

- There is a need to review the People Plan and further develop approaches that describe how agreed values and behaviours will be embedded and monitored through business as usual processes and activities.
- Staff consistently reported that many teams do not hold regular meetings, limiting connection between their teams and the wider organisation. Expectations for strengthening the role of team leaders in ensuring regular team-based communications should be reflected in the People Plan.
- Feedback from staff indicated that finance is seen as the prominent priority of the 4Ps. Staff described DBTH as financially driven, with some concern that this is affecting care quality and patient safety.
- Some staff reported a perceived gap between the Board/Executive and the wider organisation, reinforced by communications that can appear to emphasise a 'them and us' culture.
- Many staff described their immediate teams and line managers as caring and supportive. However, other staff highlighted bullying and harassment as ongoing concerns. Some senior staff also reported feeling disconnected from the wider organisation.

Learning, Improvement, Innovation

- The Quality Improvement and Innovation (QII) Strategy 2024–2028 is structured around the four priorities of Patients, People, Partnership, and Pounds, and is aligned with the NHS IMPACT model.
- The latest update report for the QII strategy showed mixed delivery and highlighted some issues of concern.
- Staff told the review team that many teams and departments do not hold regular QII huddles. This was described as affecting staff connection to both their teams and the wider organisation as well as staff involvement in quality improvement, some reporting they feel they must seek permission to pursue local projects.

Executive Summary

Strategy

- The Trust Strategy *Healthier Together – Doncaster and Bassetlaw Teaching Hospitals Strategy 2025–2029* approved in July 2025, is high level. Links between Trust values, the DBTH Way, strategic priorities, and ambitions could be clearer. It reflects the Government's 2024 strategic shifts, and the Board has recognised the need for agility following the NHS 10-year plan, *Fit for the Future*.
- Enabling plans were written prior to the Strategy and cover varying time periods (2023 – 2028). These should be refreshed to ensure alignment and assured through relevant sub-committees.
- The new Strategy does not set out a clear direction for future service profiles at Bassetlaw and Montagu Hospitals. Some external partners and staff raised concerns about this lack of clarity.

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Background

Background

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) provides acute services to more than 440,000 people across South Yorkshire, North Nottinghamshire, and the surrounding areas. The Trust delivers a full range of hospital and community-based services across three main sites: Doncaster Royal Infirmary, Bassetlaw Hospital, and Montagu Hospital.

DBTH employs over 7,000 colleagues and, as a teaching hospital, trains 25% of the region's medical students and 30% of all other healthcare professional students.

The Trust has commissioned thevaluecircle to conduct an independent Well Led review, alongside an organisational review of culture and staff experience, as part of the Trust's regular cycle of good governance and in line with national best practice.

This report looks at the Trust's performance against the CQC's updated single assessment framework, with specific focus on the Well-Led domain. This Well-Led review aims to highlight areas of strength and identifies opportunities for improvement.

The review has applied the governance assessment lens of 'mechanics&dynamics' to the key lines of enquiry. This helps to provide balance in the detailed analysis of both the structural elements of the organisation and give the equal weighting and importance to behaviours.

We would like to thank all of those who took part in the review for being engaged, open, and willing to share their time and support the Trust in this review.

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Approach and Method

Approach and Method

Triangulation with a culture review

While undertaking the well-led review, thevaluecircle also undertook a culture review for the Trust Independent Culture Review Report. This enabled the review team to cross reference findings and strengthen triangulation through staff engagement.

Documentation Review

thevaluecircle conducted a detailed review of relevant and identified documentation submitted by the Trust. We evaluated key documents relating to organisational and clinical governance. This included a review of the documentation set out in the appendix A.

Observations

We observed the following key meetings:

- Board of Directors (Public)
- Quality Committee
- People Committee
- Audit and
- Finance and Performance Committee
- Risk Management Group
- Risk Committee
- Trust Leadership Team
- Executive Team

We assessed the dynamics and effectiveness of the leadership teams within these meetings, how decisions are made, the level of accountability, and the quality of information presented.

Staff engagement and Interviews

As part of the culture review, 32 listening groups were held with staff, designed to provide a safe and open space for colleagues to share their views, concerns, and suggestions. In addition, the review team conducted walkabouts across the Doncaster Royal Infirmary, Bassetlaw, and Montagu sites. These activities enabled triangulation of findings and exploration of themes against the Key Lines of Enquiry within the updated CQC Well-Led single assessment framework, with a particular focus on the culture review KLOEs.

We worked with the Trust to identify and interview 20 individuals including senior leadership, staff representatives, and external stakeholders. The themes from these interviews were then triangulated with documentary evidence and staff engagement throughout the review.

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Findings

Shared direction and culture

Strategy

"Healthier Together - Doncaster and Bassetlaw Teaching Hospitals Strategy 2025 to 2029" was approved by the Board of Directors on 1 July 2025. Members of the Board were positive about their engagement in the development process, and information shared demonstrates engagement has been undertaken with DBTH staff, members of local communities, and external stakeholders.

The Strategy itself is high level. The links between the Trust values, the DBTH Way, the strategic priorities and the strategic ambitions could be made clearer. The Government's 2024 three strategic shifts are referenced and reflected within the Strategy, and the Board acknowledged the need for an agile approach following the publication of the 2025 10-year plan for England, *Fit for the Future,* with the commitment to refresh the Strategy as required.

An outline evaluation approach for the Strategy was agreed by the Board at the July meeting. We recommend that the Trust incorporates quantitative measures within the planned six-monthly evaluation reports, as well as narrative updates. The evaluation should draw on both internal and external data and reporting to assess progress against the Trust's strategic priorities and ambitions.

The role of the Board Assurance Framework (BAF) in overseeing progress was highlighted at the July Board meeting. In the context that the trust has new strategy we suggest that the BAF is updated to reflect the new strategic ambitions.

The enabling plans referenced within the Strategy were written prior to the new strategy being developed. The plans cover marginally different time periods but generally cover 2023-2028, except for the Green Plan which is not dated. We recognise that the Board approved a refreshed strategy 'Green Plan' in September 2025. The introductory section on the Trust's website acknowledges that the enabling plans pre-date the Strategy but states they remain "still relevant". We recommend that the enabling plans are reviewed and refreshed to ensure full alignment with the new Strategy. Revised versions should be assured through the relevant Board sub-committees.

The new Strategy does not set out a clear direction for future service profiles at Bassetlaw and Montagu Hospitals. Some external partners and staff raised concerns about this lack of clarity, while senior leaders highlighted the need for greater focus on taking difficult decisions. This could present efficiency opportunities across the Trust. We recommend the Trust work with its strategic commissioners and wider partners to establish the strategic direction for Bassetlaw and Montagu Hospitals as part of its implementation of its new strategy.

Shared direction and culture

Vision, Values, Behaviours and Culture

This report sets out findings relating to the culture element of well-led. The Independent Culture Review Report contains more detailed findings on the broader culture within the organisation.

The one-page "Our Strategy at a Glance" graphic within the 2025–2029 Strategy sets out a summary of the Trust's vision, strategic priorities, and strategic ambitions. It also signposts the DBTH Way and the organisation's agreed values and behaviours. A separate one-page summary outlines the "We Care Values" and the "DBTH Way".

Whilst the importance of successful implementation of the People Plan is emphasised in the strategy, the People Plan available on the internet does not provide information on how the *We Care* values, and the associated example behaviours expected from staff, will be embedded into business as usual. It is also unclear how the behaviours will be monitored, or how their impact is expected to influence key measures such as staff satisfaction, engagement, and morale.

We recommend that the Trust considers how the DBTH Way and We Care values and example behaviours could be operationalised and monitored in line with the People Plan.

Many staff reported that their team or department do not hold regular team meetings. The review team were told that this directly affects staff connection to both their team and the wider organisation. Staff noted that time set aside for meaningful team-based communication would be welcomed. We recommend that the Trust considers strengthening the People Plan by identifying the responsibility of team leaders to ensure regular communication and engagement with their staff.

Staff told the review team that, of the 4Ps (Patients, People, Partnerships, and Pounds), Pounds (finance) is consistently the most prominent. Staff we spoke with described DBTH as a financially driven organisation, a perception acknowledged by some Executive Directors. Staff shared concerns that the current financial focus may be affecting the quality of care, including patient safety. Examples cited included delays to clinician appointments due to the vacancy control process, challenges in achieving enhanced care staffing levels when required, and the introduction of new processes and practices aimed at improving organisational efficiency and reducing cost. The team review recognises the difficult environment that DBTH is currently operating within and the broader NHS financial and operational landscape.

The review team heard staff concerns regarding recently introduced practice to reduce costs, waste, and support

Shared direction and culture

patient flow. They described limited opportunity to challenge or shape these changes, even when concerns related to patient care or service impact were highlighted.

During listening groups and walkabouts, staff at multiple levels expressed concern about a perceived gap between the Board/Executive Team and the wider organisation. One example noted by the review team, which may reflect a 'them and us' culture, was a presentation to the Trust Leadership Team (TLT)in July 2025. This included a slide titled *"What the Executive expects from you"* followed by *"What you can expect from us"*. Such language may unintentionally reinforce a sense of separation, rather than promoting a shared "one team" ethos.

There is an opportunity to shift from a culture that can feel like a "we are telling you" approach towards a more collaborative way of working, drawing on staff experience.

We recommend that the Trust strengthens its approach to engaging frontline leaders in service improvement and efficiency initiatives, and reviews its corporate communications to ensure the language reflects a shared purpose and a 'one team' ethos.

The culture at DBTH is regarded by some Board members as being caring and friendly to work in. This has been reflected by some staff during our wider engagement across the Trust in relation to their local teams. We heard that at a local level the culture within immediate teams is often positive, supportive, and kind, this includes staff relationships with their immediate line managers.

Some staff told the review team that at times senior medical staff are treated differently to other staff groups. Staff described the medical model as traditional, with examples including individual consultants or their personal assistants populating theatre lists. The review team also observed the allocation of named parking spaces. Staff highlighted that this can create an imbalance between staff groups and may contribute to a culture where poor behaviours are not consistently addressed. For example, it was reported that some medical staff are not always held to account for inappropriate behaviours towards colleagues.

The review team heard mixed views from staff about the extent to which they feel supported by their line managers and more senior levels of management. In interviews with Board members, there was recognition that bullying and harassment remains a live concern within the organisation.

We recommend that the Trust reviews current expectations, processes, and cultural norms in relation to medical leadership and engagement with medical staff. The Trust should ensure consistency in how professional behaviours are modelled and addressed across all staff groups to support an inclusive and equitable working culture.

Capable, compassionate, and inclusive leaders

Board Effectiveness and Culture

As part of this review, the team were invited to observe the July 2025 Board meeting held in public, but not the private session of the Board. Minutes of previous private Board meetings were received; the associated papers were not shared.

The items discussed at the private meeting of the Board appear appropriate to not be considered at the public meeting, apart from an item for the BAF strategic risk covering Partnerships (March 2025). Whilst it is acknowledged that some conversations relating to partnerships may need to be confidential, the Board should consider whether discussion on this strategic risk needs to be excluded from public scrutiny.

The review team observed limited contributions from Executive Directors during the public Board meeting, with few examples of participation outside of individual portfolios. In contrast, during the observation of the Executive Team meeting, Directors appeared comfortable contributing beyond their portfolios and engaging in respectful challenge. We were also told that robust but respectful challenge takes place between Board members during private Board meetings. These observations were consistent with individual feedback from Executives, who described cross-portfolio engagement and effective challenge occurring in forums other than the public Board.

The Board demonstrated unitary decision making. All members of the Board are given the opportunity to challenge the assurance levels proposed by committee chairs.

The Board and committee meetings observed were well chaired and managed, with discussion that was respectful and open.

Mixed levels of NED challenge were observed during the review.

At the F&P Committee and Board there was a good level of NED engagement and challenge, with a sense of collective accountability. During our observation of the F&P Committee, it was agreed that there should be a high support, high challenge approach by the NEDs in their ways of working with the Executives.

During the Quality Committee, challenge was less robust. Non-Executive Directors were observed seeking clarification rather than offering probing questions. There was a tendency to accept Executive reassurances based on their oversight of issues and actions, rather than seeking assurance through constructive challenge or generating actions for further evidence to be brought back to the committee.

Capable, compassionate, and inclusive leaders

At the People Committee the NEDs asked relevant and probing questions, and the executives and other senior team members present answered these questions well. Interactions indicated a healthy level of challenge and scrutiny is carried out in a respectful and professional way. NEDs were knowledgeable and informed, and executives had a good grasp on their respective portfolios.

During our observation of the Audit and Risk Committee, discussions were encouraged and the Chair actively invited members to raise points. An open and inclusive culture was evident, with all attendees treated professionally and with respect. There were clear opportunities for contribution, and discussion was allowed to flow with minimal curtailing of discussion. The discussions and interactions observed between the attendees indicated that the DBTH values were upheld.

The review team did not observe Chairs of the Board, its committees, or other meetings reflecting on whether the way meetings were conducted aligned with principles of the DBTH Way, We Care values, and behavioural expectations.

We recommend that the Trust considers introducing a standing agenda item across its governance meetings to reflect on whether the content and conduct of the meeting were consistent with the Trust's values and agreed behaviours.

Board Composition, Capacity, and Capability

Board members are mostly positive about the level of Board capability. However, there is no active Board development programme in place. Some members expressed a need for development that focuses on how the Board operates as a team, including how members work with one another. In relation to building Board capability, many senior colleagues, both inside and outside the Trust, welcomed the recent introduction of the Deputy Chief Executive post.

Feedback from some Board members identified that Board dynamics have improved and there is now a more unitary approach to decision making and collective accountability. These views are supported by our observations as outlined above.

There is a lack of ethnic diversity within the membership of the Board, the Executive Team, and the Council of Governors. This is acknowledged by both Board members and Governors. There is evidence of Executive Directors

Capable, compassionate, and inclusive leaders

playing an active role in improving equality, diversity and inclusion (EDI), including acting as sponsors for staff networks and participating in the Board mentoring scheme. Executive and Non-Executive Directors also identified the current Non-Executive recruitment cycle as an opportunity to actively address the lack of representation on the Board.

Senior leadership visibility, collaboration, and decision making

The review team heard mixed views from staff regarding the visibility of the Board and wider senior leadership. Some leaders were aware of walkarounds taking place, including those involving Non-Executive Directors, and shared some positive feedback about their value.

However, there is a consistent view from staff was that there is a lack of visibility and presence of the Executive Team in clinical areas. This contradicts the collective view of Board members, who were generally more positive about the visibility and accessibility of leadership across the organisation.

We recommend that the Trust reviews its approach to leadership visibility, including the frequency, format, and purpose of Executive and Non-Executive walkarounds. Consistent and visible engagement by senior leaders, particularly in clinical areas, would help build staff trust and reinforce the organisation's values.

Staff reported a concern that not enough meetings are held face to face, with a reliance on MS Teams. Views were expressed that this can have a negative impact, reducing the sense of colleagues coming together as a team, and being able to better connect with and support each other.

We noted that approximately half of the public meetings are held on MS Teams and half in person meaning the Board only meets publicly, in person, three times a year. This virtual approach is consistent in other leadership forums such as the Board sub-committee meetings, the Trust Leadership Team meeting, and the Risk Management Group.

We recommend that discussions are held with leaders across the Trust, to develop a consensus on the balance between holding meetings face to face and via Teams.

Capable, compassionate, and inclusive leaders

Some of the senior leaders raised concerns over what they consider to be a siloed approach between medical, nursing and operational leadership. Some made this point in relation to the Executive triumvirate, whilst others raised concerns about a lack of an integrated leadership approach within the divisions.

In relation to both aspects, concerns were raised about the equity with which decisions made at Executive level are enacted within staff groups. There was a view from some staff that decisions are implemented differently with medical staff. An example cited was the less rigorous application of agency management for medical staff when compared to nursing.

We also heard there is not widespread clarity regarding the individual and collective accountabilities of the Divisional Directors, Divisional Nurses and General Managers amongst medical and nursing staff. Addressing this deficit will be important for ensuring the effectiveness of the divisional triumvirates and for decision making within the organisation.

There are broader concerns regarding whether the divisional leadership triumvirates play a pivotal role in decision making and informing assurance assessments. These relate to the effectiveness of the Trust Leadership Team and the volume and level of decisions being made at the Executive Team, and the absence of direct divisional contributions to Board sub-committees (please see the Governance and Management section).

We could not find evidence of input from the divisions at Quality Committee (on an as and when its beneficial basis) or other sub-committees, and there does not appear to be an opportunity for Board members to receive summary updates from each division on their current risks, issues and success stories.

Divisional leaders are members of the Patient Safety Group and divisional highlight reports are considered here. The information presented may be useful for the Quality Committee and Board to receive, at least for information.

We recommended that the Trust undertakes development work with divisional leadership teams on how they work and lead on an integrated basis. This should incorporate a review of how the leadership teams inform Trust-wide decision making and assurance assessments.

Governance, management and sustainability

Integrated Quality Performance Report (IQPR)

The IQPR is included as an agenda item for the Board of Directors public meeting. It includes data on key metrics under the following domains – Access, People, Quality, Finance. Cover sheets state the report is authored by the four directors accountable for these domains. Metrics under development are included at the end of the report.

The report incorporates statistical process control (SPC) charts and commentary. Assurance reports describe challenges and risks, actions being undertaken, timescales, relevant assurance meetings and risk register entries, for each metric.

We found the content of the IQPR provides more reassurance than assurance to the Board and Committees. Benchmarking, wider system performance data, and other external sources are limited. The absence of improvement trajectories also limits Non-Executive Directors ability to hold the Executive to account for progress towards targets.

The data included in the IQPR under Access and People is predominantly presented as percentages of patients/staff hitting or achieving targets. We suggest that the Board considers including numbers alongside percentages to better understand the impact of missed targets.

The IQPR currently does not include data on health inequalities and prevention which is a Trust strategic ambition. There was also limited financial information in the IQPR received at the July Board. We recommend the Trust reviews what information is included in the IQPR on health inequalities and finance.

The IQPR does not demonstrate a fully integrated approach to performance assurance. It does not reflect outputs from executive discussions on triangulation across the four domains, for example the extent to which financial management measures may be impacting on quality of care, staff experience, or access to services.

It is not clear whether governance arrangements are in place to facilitate triangulation at the Executive level or directly below. The Integrated Performance Report does not appear to be reviewed at either the weekly Executive Team meeting or the Trust Leadership Team business meeting.

We recommend that the Trust strengthens the Integrated Performance Report by using benchmarking, external data, improvement trajectories, and clear measures linked to the Trust's strategic ambitions. This will support moving to assurance rather than reassurance.

Governance, management and sustainability

Quality Committee

A review of the papers for, and observation of the Quality Committee highlight significant limitations on assurance processes and triangulation.

The Integrated Performance Report is not included within the papers. There was limited evidence of the Committee triangulating whether actions to address under-performance against access and finance targets could be resulting in unintended consequences for quality.

There is limited evidence of the Committee systematically assuring operational oversight of metrics, apart from the papers covering the ward to board oversight framework and its accompanying approach to peer accreditation and quality summits.

We observed several instances where NEDs accepted Executive reassurance on oversight of issues, rather than seeking assurance through challenge or requesting evidence to be brought back to the Committee. There was little evidence of external audit or review being used to provide assurance, with a heavy reliance on self-assessment. Although members were asked after each item whether they were assured, it was unclear on what basis significant assurance was concluded. In the absence of sufficient external and independent evaluation, assessments appeared subjective and not consistently underpinned by robust evidence.

The BAF is a standing item for the Committee, including consideration of the high risks contributing to the one strategic risk within its remit. However, at the meeting observed there was little discussion of the BAF and no consideration of whether the risk score reflected the Committee's view.

We noted the BAF has risks where controls do not appear to be mitigated but have been assessed as giving significant assurance. There was limited consideration given to the effectiveness of risk-mitigating actions and the process for reviewing risk scores. The committee should review the BAF to assure itself of the controls and risk ratings provided.

The minutes of the April Quality Committee meeting (and discussions at the July Board meeting) illustrate questions and answers regarding the current SHMI (Summary Hospital-level Mortality Indicator) rate that have resulted in reassurance rather than assurance. The Committee minutes state it took partial assurance from the report. The elevated SHMI rate is not identified as a risk in the Trust Risk Register or within the relevant strategic risks in the BAF.

Governance, management and sustainability

We recommend the Trust includes the actions being undertaken in relation to the elevated SHMI rate within the Trust Risk Register and consideration is given to appropriate inclusion within the BAF.

Finance and Performance (F&P) Committee

Finance and operational performance reports to previous Committee meetings lacked information that could provide assurance. The narrative focused mainly on describing problems rather than setting out clear actions. There was inadequate explanation of how these actions would lead to improved performance, and we heard that action is underway to address this issue.

The Committee Chair and NED members should hold the Executives to account for providing assurance rather than reassurance. To support this papers should include, external assessments, audits and robust benchmarking information, as well as internal performance data against trajectories.

NEDs requested assurance from executives that they are actively triangulating finance, people and activity information in the context of the cost improvement programme (CIP). There was less of a focus in the discussion on triangulation with quality data. The F&P Committee could benefit from input from senior clinical leaders to ensure effective quality triangulation.

The Committee has oversight for four of the strategic risks on the BAF. Two risks are reviewed at each meeting. The papers included significant information on the management of risks on the Trust Risk Register relating to Strategic Risk BAF 4, but there was minimal information on Strategic Risk (BAF 5). We understand these risks are currently being reviewed.

BAF 4 is the highest scoring BAF risk. While the Trust recognises long-standing problems with the estate at DRI (Doncaster Royal Infirmary), the Committee Chair's highlight report to the Board did not reflect the severity of these issues, the limited assurance from risk management reports, or identify matters for escalation.

The information that was included under BAF 4 primarily provided reassurance rather than assurance. Where significant assurance was reported for risk controls, the supporting information did not appear to provide this level of assurance.

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For example, there is Significant Assurance assigned for GC1 (planned preventative maintenance plan), but the action section in the document states the business case for funds to address the risks was not approved. A related risk in the Trust Risk Register is scored 25 (ID 12) however, there are no actions requiring review. The Significant Assurance rating for this element should be re-assessed.

We recommend the Board receives detailed information and assurance on actions being taken to mitigate the impact of the estate condition at the DRI, on Trust finances, quality, access, and staff experience.

Strategic Risk BAF 7 includes EPRR and business continuity arrangements as a Primary Risk Control. This is assessed as Partial/ Limited Assurance. In the Trust Risk Register EPRR arrangements are rated as 20 (ID 3627), with no actions requiring review. This area was assessed as having Limited Assurance by Internal Audit in 2024/25.

A new policy was approved in February 2025 to address the identified shortcomings, and the annual EPRR report was considered by the ARC in July. However, the current action included within the BAF only offers reassurance around processes – *"Business continuity managed through the EPRR steering group, chaired by the COO and reported through to Audit and Risk Committee."*

Given the importance of business continuity arrangements, the high scoring related risk, and the internal audit findings, we would expect to see stronger assurance provided in the BAF. The Trust should consider the BAF content for business continuity to strengthen assurance.

Governance, management and sustainability

People Committee

At the Committee, the chair checked with each member their levels of assurance on each agenda item. This appeared to be done without reference to specific criteria for the levels of assurance.

During discussions we observed both quality and finance matters were referenced, but these were not specifically referred to as part of the process for agreeing assurance levels. There is scope for greater triangulation of data sources.

The focus on system-level working on workforce collaboration across the ICS and Place, could be strengthened, linked to shared care models and system-wide talent strategies. It would be helpful for there to be more explicit reference to developing the leadership pipeline and succession planning within the Terms of Reference for the Committee.

Strategic Risk 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*. The current BAF rating for this risk is 12. The Trust should review this rating considering the findings of the Well Led and Culture Review.

9 out of 10 of the Primary Risk Controls have an assurance level of 'significant assurance'. Examples include;

- Equality Diversity & Inclusion Improvement Plans
- People Engagement Strategic Approach
- Speaking Up Process and Partnering Activities

The content for this Strategic Risk is brief and high level, which may reflect the high proportion of Significant Assurance ratings agreed.

The Trust Risk Register includes one risk relating to the risk controls listed above. Risk ID 19 *Inability to engage with and involve colleagues, learners and representatives to improve experiences at work* and has a current risk score of 8, with no actions requiring review.

Governance, management and sustainability

The above information indicates the Risk Management Group, People Committee, and the Board are significantly assured as to how the Trust listens, engages and support staff and about there being an open and inclusive culture. In the context of the culture review the Board sub-committees should consider reviewing this level of assurance.

Audit and Risk Committee (ARC)

At the meeting observed all attendees were asked to confirm that they were in agreement before concluding each agenda item. The evidence provided supported the decisions of the Committee. There were times where the evidence was challenged (Bank & Agency for instance) and explanations were provided to support the opinion expressed.

However, there were no specific examples of requests or attempts to triangulate information presented to the ARC with information received by other committees, which may affect the efficacy of the decisions reached and assurance levels agreed.

The latest version of the BAF was included within the papers but it was not reviewed in detail. The focus of discussion was primarily around ensuring other Board sub-committees are reviewing their sections of the BAF in a timely way. A summary report was provided, showing where scheduled reviews have not taken place.

There was not a detailed discussion regarding BAF content, or a conversation about how the content needs to be reviewed and updated in the context of the new Trust Strategy.

Governance, management and sustainability

Assurance to the Board

Chairs of sub-committees produce highlight reports to the Trust Board covering matters of concern, key work underway, levels of assurance, and decisions made. In July, only one matter of concern was reported across the Finance and Performance, Quality, and People Committees. Prompted by committee assessments, the Board agreed that significant assurance should be drawn from each, following a check-and-challenge request from the Board Chair.

In triangulating Committee assurance levels, we noted:

- The BAF assurance levels align with those stated by the Quality and People Committee Chairs for the strategic risks within their remit.
- The F&P Committee reported more varied and lower assurance levels for the four strategic risks it oversees, compared with the overall Significant Assurance rating.
- There are concerns about how assurance levels have been determined
- Internal audit reports in 2024/25 provided limited and moderate assurance on topics within the scope of all three Committees.

We recommended that the Board and its committees undertake a review of their processes for generating assurance outcomes, including working to the current standard definitions for each level of assurance. This should be informed by a review of controls and assurance levels within the BAF, alignment with latest internal audit opinions, robust outcomes data, and enhanced levels of external validation.

Board and sub-committee cover sheets require the author to select one or more of the following requirements – Assurance, Decision Required, Information, Discussion. We identified a number of examples where the author has included an alternative requirement within the Recommendation section of the cover sheet, for example, “Approve”. We would suggest the Board reviews the requirements for Board cover sheets to then be applied consistently.

The volume of papers for the Board and its sub-committees should be reviewed. For some meetings, the size of the meeting packs indicate an opportunity for papers to be more concise, with content focused more on assurance.

Governance, management and sustainability

Executive Team

The Executive Team meeting takes place on a weekly basis, and is supported by formal papers, with cover sheets, a clear agenda, minutes and an action log. The meeting observed was generally well chaired. The Chair ensured actions were clearly stated at the end of each agenda item. Some discussions went into relatively deep detail, as a result the meeting overran.

There was a sense of collective responsibility with members supporting each other and operating outside of their portfolios to make constructive comments and suggestions. There is a good balance of strategic and operational agenda items, with the former allowing for open discussions regarding partnership working within the context of the Trust Strategy.

Trust Leadership Team (TLT)

The TLT business meeting operates on a bi-monthly basis. The Terms of Reference (ToR) state TLT reports into the Board of Directors, however on the draft wiring diagrams, TLT reports into the Executive Team, as part of the operational accountability structure. There is also a difference between the ToR and the draft wiring diagram, with regards to the management groups that report into TLT.

The meeting held on 14 July was the first business meeting held since 10 March 2025. Recognising development sessions are held inbetween the bi-monthly TLT meetings, the four-month gap between these meetings could indicate TLT is not an essential element of the Trust's operational governance structure.

The duration of the meeting (excluding the CEO update and strategic stock take briefing item) was approximately one and a quarter hours. Two policies were presented for approval, but apart from these items, the agenda content was for noting or discussion. Whilst there are minutes produced there is not an action log for the meeting.

Outside of Executive Director contributions there was limited active engagement by other TLT members at the meeting observed. There were few questions raised and relatively low levels of debate and challenge, despite a good attendance level. There was also a general lack of specific questions posed by leads for agenda items, to encourage engagement and debate.

The ToR states TLT will receive escalations from groups that report into it. At the July meeting, reports or escalations were not included from a significant number of the reporting groups listed in the ToR or shown on the draft wiring

diagram. The groups omitted included the PODER Senior Leadership Team, Divisional Performance Review Meetings, the Health Inequalities Steering Group, and the Corporate Investment Group. It is unclear where these groups report into.

Escalations from the Risk Management Group (RMG) are intended to be considered by TLT. In practice, we were told, that the time between business meetings means risks are often escalated to the Executive Team meeting. A report from RMG was included on the agenda and contained two escalations, these were not highlighted by the lead nor discussed by members.

The agenda included a financial position update, but no equivalent items on quality or performance. The review team noted that it is unusual far a Trust Leadership Team meeting not to receive reports on theses areas, at least for the purpose of escalation. While a CQC action plan update was noted, the inclusion of updates and escalations from divisional performance review meetings would have helped to address this imbalance.

Under the strategic stocktake item, the Chief Executive provided an update on the NHS 10-year plan and its potential implications for DBTH. It was unclear how TLT members will be engaged in further discussion of this alongside the Executive.

The review team observed that the role of TLT is not central to operational governance, decision-making, or strategic planning. Instead, it is functioning primarily as a forum for information sharing as emphasised in the points raise above.

The format and content of TLT raises the question of the extent to which Clinical Directors and divisional leaders are involved in operational governance and decision-making.

We recommend that a review is undertaken of the purpose and role of TLT. This review should consider the balance between decisions made at the Executive Team meeting and the TLT, and the degree to which the divisions are involved in Trust-wide decision-making processes.

Governance, management and sustainability

Performance Review Meetings (PRMs)

Our review did not include observations of divisional PRMs. We did however receive and review the papers for May 2025 PRMs. We heard the Executive has tried to reset these meetings, with an aim of holding people to account in a supportive way and to include a focus on celebrating successes.

The PRM packs include a comprehensive, standard agenda and divisionally populated slides covering the expected core elements. Standardised slides on risk management are also included. An area for improvement highlighted by the review team would be the consistent use of SPC charts for time-series data across all PRM domains, as currently SPC is applied mainly to quality data.

It was unclear from the document review and observations where key outputs and escalations from divisional performance review meetings (PRMs) are considered and triangulated with the IQPR, and other sources of data.

The new Performance Assessment Framework (v12) shows Performance Review Meetings (PRMs) reporting directly into the Executive Team. During the review, it was noted that PRM escalations are also included as agenda items for the Trust Leadership Team (TLT), which is not referenced in the Framework. Based on this evidence, the escalation route from PRMs remains unclear, specifically whether they report into TLT or the Executive Team. The review team suggest that the escalation routes from PRMs are clarified.

In addition to the comments included on TLT and the role of the divisional leadership teams in Trust-wide decision making, we also heard from staff about concerns relating to the level at which operational decisions take place.

We heard of frustration from managers in divisions about the limited autonomy they have for decision-making. This includes but is not limited to, concerns over the vacancy control process for recruiting to a fully funded vacancy, and the levels of approval required for routine changes to clinic and theatre lists. Managers expressed that this lack of autonomy in decision making negatively affects their working lives.

Governance, management and sustainability

Assurance frameworks

The recently revised Performance Accountability Framework (PAF) sets out the Trust's approach to performance assurance. However, it does not provide a live document setting out comprehensive accountability arrangements (beyond the Scheme of Delegation), including the roles and responsibilities of the following:

- Board of Directors
- Council of Governors
- CEO
- Executive Team
- Board sub-committees
- Trust Leadership Team
- Management groups
- Accountability arrangements within the clinical divisions and corporate directorates

Review of the draft wiring diagrams highlighted inconsistencies with the Terms of Reference for some forums. It is recognised that further work on accountability arrangements is planned.

We recommended that an organisational accountability framework document is developed, aligned to the Performance Assessment Framework, the scope of which covers governance arrangements from service level to the Board.

Quality governance

The Operational Assurance and Information Flows wiring diagram illustrates how quality governance is organised under three groups headings: Patient Safety, Caring, and Effective align with the CQC domains.

The groups report into the Executive Team. However, the ET agendas reviewed did not include reports from these three groups under the 'Patients' agenda item. We recognise that the wiring diagram is work in progress and that only a small sample of ET papers was reviewed, so this gap in reporting may already have been addressed. However, we suggest adding a standing agenda item for these groups to provide regular reports to the Executive Team.

The terms of reference for the new Caring Group, produced in May 2025, state the Group reports to the Quality and Assurance Committee, despite the wiring diagram showing the reporting line to the Executive Team.

Governance, management and sustainability

The 'System Working' section of this report highlights concern that the lived experience of users does not appear central to how services are delivered and improved. The Terms of Reference for the Caring Group contain relatively passive wording on this point, stating it should "ensure the Trust has a patient engagement programme which also includes interaction with patient support groups and encourages involvement in the redesign of services."

The Quality Committee receives and assures a patient experience report only once a year. This is less frequent than expected and raises concern about how effectively the Committee can assure data and actions relating to patient experience, PALS contacts, and complaints.

We recommend the Caring Group discusses how to ensure that lived experience is better harnessed and used within DBTH. This should be done in collaboration with DBTH-i, given the concerns expressed in the latest quarterly report on the implementation of the QII strategy about inconsistent patient/service user involvement in service improvement projects.

The mortality governance policy roles and responsibilities are clearly described and are consistent with best and statutory practice. This includes reporting mechanisms both internally for learning and quarterly at Trust Board level.

Learning from deaths is overseen by the Mortality Governance Group, with themes shared with Divisions through quarterly reports to Divisional Clinical Governance meetings. The policy describes a process for reporting poor care identified through Structured Judgement Reviews to the Patient Safety department for further action, supported by clear reporting forms in the appendices. A Learning from Deaths Quarterly Report is also received by the Quality Committee.

The Patient Incident Response Policy aligns the four key aims of PSIRF with the Trust's values. It is supported by a Patient Safety Incident Response Plan, which sets out how the policy will be implemented and identifies DBTH's patient safety priorities. The Plan is a living document, reviewed every 12–18 months to remain current with improvement work and stakeholder engagement. It is essential that PSIRF continues to be central to learning and improvement in the Trust.

We heard from multiple conversations that in 2024 there had been delays in getting serious incidents (SIs) reported

in a timely manner, but that this has now been addressed. However, we could not find data to validate this improvement within the papers we reviewed.

The Standard Infection Prevention and Control Precautions Policy provides detail on a number of IPC measures and cross references more detailed policies. It is an easy-to-read document and covers the content we would expect to see in such a policy. One area for improvement is the lack of assessment guidance for risk assessments for infection.

The Clinical Site Management Team Operational Policy reviewed was out of date, with the last review due in August 2021. This policy does not cover several elements that would normally be expected, including:

- escalation levels and action cards for each level (except for safe staffing which are included)
- internal professional standards
- SOP for daily operational meetings that is tiered to account for different escalation levels.

The Trust should maintain an up-to-date Clinical Site Management Team Operational Policy, consistent with good practice.

The 2024 General Medical Council National Survey showed overall improvement compared with previous years, when concerns were raised about induction (2023) and educational supervision and local teaching (2022). This reflects an organisation responsive to its training responsibilities, with actions outlined in the paper reviewed. The overall satisfaction score placed DBTH 6th out of 14 in the region, an improvement from 8th in 2023.

There were notable improvements in Anaesthesia, Medicine and Haematology and one deterioration in General Surgery which in the report is an outlier for workload. The paper states that this is being addressed by workforce expansion but without more detail it is difficult to see how this would support trainees.

The Guardian of Safe Working (GOSW) presented a quarterly report to the July Board meeting held in public. The Board agreed that significant assurance could be taken from the report.

It was noted however that only one person had attended the last Resident Doctor's Forum. The GOSW provided

assurance about attempts to encourage attendance. This should be followed up and re-assessed by the Board as part of the next quarterly report discussion.

The report stated, "*monthly rota vacancies have stayed stable at 46 WTE*". There was no further information shared to indicate whether 46 WTE is a high, medium or low number compared to expectations and other similar sized trusts.

Risk management

The BAF structure broadly reflects good practice and could be strengthened by adding a column to capture a clear description of the threat before the "Primary Risk Control."

The content of the BAF should be reviewed to address concerns highlighted previously about assurance. Current sources of assurance are largely processes or meetings, rather than outcomes from data or reports, and therefore provide reassurance rather than assurance. We advise reviewing all risk controls rated as 'Significant Assurance' against internal and external data, audits, and benchmarking, where this has not already been done.

The review of the BAF highlighted that some sections contain less information and evidence than required to provide assurance. The content will also need to be updated to reflect strategic threats to delivery of the new Trust Strategy, including the revised priorities and ambitions.

BAF papers for Board and Committees do not include reference documents on the agreed scoring methodology. We suggest that these are included moving forward.

The presentation of BAF papers differs across Board sub-committees. For example, assurance levels and the three lines of defence are included in the F&P Committee but not consistently elsewhere. There is also an opportunity to increase the time spent reviewing the BAF, as observed discussions and papers placed less emphasis on confirming and challenging the content than expected.

We recommend that the BAF is strengthened to ensure clear threat descriptions, outcome-based assurance sources, alignment with the new Trust Strategy, consistency in committee reporting, and sufficient time for Board review and challenge.

Governance, management and sustainability

Processes for tracking risks and addressing previously identified issues are improving, including a reduction in extreme risks and those open for extended periods. The risk management policy has recently been updated, with a helpful 'policy on a page' summary of arrangements and a new section on ward-to-board escalation and de-escalation. This clarifies how risks move up to committee and Board level. However, as noted earlier, the escalation route from RMG requires review and clarification.

Risk management processes were reported to us as becoming more robust, but further progress is needed to improve outcomes. Actions in both divisional and corporate risk registers are variable, with some risks lacking actions and others containing only minimal narrative.

There are still multiple risks that have been open for longer than one year, and there are a high number (58) of extreme (15+) risks. At the July RMG it was agreed to develop trend data and targets for improvement, against which the Group can be held accountable. It was also agreed that the focus of the next 12 months should be on improving the assurance that comes out of the process, including for example, improved management of risks that have been live for over 12 months.

Our assessment is that the RMG is maturing as a forum and is moving from commentating on risks, to focusing on actions. Challenges and views are welcomed. However, this could be strengthened through improved information, as described above. There appears to be an appetite to ensure continuous improvement and focus on outcomes in the risk management process.

We heard some concerns in relation to risk management arrangements within the divisions. Junior/ middle management staff commented that they receive limited feedback on actions undertaken, after risks are escalated.

There is a need to improve the top-down approach through the RMG and consider how risk management is transacted at service level. Staff should be regularly asked about their experiences and their ideas for improvement should feature at RMG.

A report was considered by the ARC in July, that set out compliance of the Trust in respect to the current Risk Management Policy (noting an updated policy was presented to the Committee for approval). A further report provided an annual review of Risk Management Group. An update was provided on compliance against internal audit actions in relation to risk management.

Governance, management and sustainability

The comments earlier in this section regarding improvement actions for risk management are mostly reflected in the papers considered by the July ARC, with relevant information provided on the Trust's risk management policy, governance and outputs. One area of concern is the inclusion of the following statement in the report to the ARC, *"RMG will maintain its direct reporting line to the Trust Leadership Team (TLT)".* As highlighted previously RMG reporting into TLT is currently problematic, however was not highlighted in the ARC report.

Freedom to Speak Up

The Trust has established Freedom to Speak Up (FTSU) systems and processes. The FTSU Guardian reports to the Chief People Officer, the Executive Lead for Speaking Up, and there is a named Non-Executive Director for FTSU. We were told there are good connections between the FTSU Guardian and the Executive Team.

Capacity has been strengthened through the addition of a developmental guardian role. The FTSU service, would welcome further opportunity to proactively support the Trust's culture improvement workstream.

The Trust has 62 FTSU champions in place, supported by a partnership approach that enables staff to consider all available routes for speaking up.

Despite the above arrangements, staff expressed mixed views on the effectiveness and confidentiality of the process. We acknowledge that the Trust has worked with the General Medical Council to strengthen perceptions of psychological safety in speaking up and to improve medical colleagues' confidence in the process. However, listening groups identified that some colleagues still lacked confidence. In addition, some staff reported they were unsure how to access the FTSU service.

We recommend that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all. The review team acknowledge that there is a peer review underway.

Freedom to Speak Up is discussed at several groups and committees, including the Speak Up Forum, Just Culture Group, and PSIRF Implementation Group. Triangulated and anonymous data is presented to the People Committee quarterly, alongside a bi-annual report highlighting areas of success and recommendations for further development.

The Trust Board receives FTSU reports bi-annually. However, the most recent Board review did not detail learning or actions taken. In listening groups, staff highlighted that they were often unaware of learning and actions from the FTSU process and reported receiving inadequate feedback on the outcome of their submissions.

We recommend that FTSU reports to the Board includes learning and actions to strengthen the feedback and learning loop.

Workforce, equality, diversity, and inclusion

An Equality, Diversity and Inclusion (EDI) action plan has recently been assessed by Internal Audit, with a rating of Significant Assurance, which aligns with the BAF assessment. The auditors found that reporting to the EDI forum and People Committee was adequate to allow members to be assured on the progress of the action plan.

The People Committee receives two EDI reports a year, including the gender pay gap, and considers two WRES/DES reports. The EDI Forum is accountable to the People, OD, Education and Research (PODER) Leadership Team.

Despite the assurance received via Internal Audit there was some concern expressed amongst Board members about how the Board articulates what EDI means and what it looks like for staff. There were also concern raised through the culture review regarding what EDI means in practice for staff.

The People Committee receives reports four times a year on *The DBTH Way, including Trust Leadership and Development programme*. In addition, the Committee receives two reports per year on the *National Staff Survey plus in-year surveys report*. We understand the Trust is planning to launch a staff engagement enabling plan.

The People Committee receives quarterly reports on *The DBTH Way, including the Trust Leadership and Development Programme,* and bi-annual reports on the National Staff Survey plus in-year surveys. We understand the Trust is planning to launch a staff engagement strategy. The Operational Assurance and Information Flows wiring diagram does not show a forum specifically addressing staff engagement. Given this, and the findings of the Culture Review, we recommend that the Trust reviews whether its operational assurance arrangements as set out in the Operational Assurance and Information Flows wiring diagram for staff engagement are sufficient.

The 2024 staff survey results were considered by the People Committee in April and by the public Board meeting May 2025. 4,500 members of staff participated in the survey, representing a 62% response rate, against a national average for acute and acute & community trusts of 49%.

Compared to the sector average DBTH scored significantly worse for Staff Engagement, no significant difference for Morale and Significantly Better for 2 of the 7 People Promises.

Compared to 2023 results there was significant decline in the scores for staff engagement and for morale, and for 5 out of the 7 People Promises.

The report to the Board states *the results indicate that while some scores have dipped, DBTH continues to perform relatively well against the sector in key areas such as colleagues feeling valued, maintaining a positive culture and providing development opportunities.*

Workforce, equality, diversity, and inclusion

The conclusion states - *The NHS Staff Survey results affirm DBTH's relatively strong performance in several areas while also highlighting targeted opportunities for improvement. The ambition remains to further improve colleague experience, ensuring that DBTH continues to grow a supportive and high-performing workplace culture, and work continues as part of our year-round cycle of engagement*.

We found that the content of the People Plan and progress updates to the People Committee focus mainly on the mechanics of staff engagement, such as staff surveys, recognition schemes, flexible working policies, appraisals, FTSU, and training and education.

There is limited evidence of efforts to understand how staff want to be engaged, or how effectively the DBTH Way and behaviours framework are being used to improve staff engagement and their working lives. The proposed staff engagement strategy should provide a platform to address these concerns.

<u>Feedback received from listening groups and walkabouts undertaken</u>

We heard positive feedback about flexible working policies.

Staff expressed concern about the unpaid break arrangements (60 minutes per shift). They felt the stated rationale of improving wellbeing by ensuring breaks was not the primary driver, and that financial savings were the main reason for the change. Concerns also centred on whether staff could consistently take the full break given workload pressures, and frustration about the requirement to 'pay back' breaks with an additional shift each month. Overall, communication and messaging around the change have contributed to frustration and a perception that financial priorities being placed above staff welfare.

There was concern expressed by staff how changes were communicated and managed in relation to care support Workers (CSWs) and Health Care Assistants. This has resulted in some staff not feeling valued and concerned that their contracts and job descriptions have yet to be changed to reflect their new duties.

Staff raised concerns about the number of unconnected IT systems and their impact on workforce efficiency. Many were unaware of the EPR project, despite its potential to address many of these issues. We would suggest that communications on the EPR project, timescale and expected benefits, are shared in an easily accessible way with staff.

Workforce, equality, diversity, and inclusion

We heard mixed views about how the Trust currently communicates with staff. Many felt there is too much reliance on email, with limited time during work hours to read messages. Staff also noted that not all use Facebook, and that the feed can be impractical as key communications are often missed once pushed down notifications.

There was a request for more face-to-face communication. This could be addressed through team meetings and huddles in departments.

We recommend that the Trust strengthens workforce engagement and communication, ensuring changes to policies, roles, and systems are clearly explained to staff.

Multiple staff from different disciplines and levels expressed a concern over the volume of national statutory education and training (SET) packages they have to complete. Concerns include applicability of modules to some roles, and the inability to complete the training during working hours.

Staff were generally positive about the resources available for wellbeing support. The Health and Wellbeing Forum reports into the PODER Senior Leadership Forum. A bi-annual report is considered by the People Committee, with wellbeing also included as a quarterly agenda item.

We also heard positive feedback about the support provided for staff recruited internationally covering practical, pastoral and training support. Most staff reported positive feedback about support and opportunities to develop their skills and their careers at DBTH.

We heard from some staff about the impact poor patient flow can have on working lives. This includes members of staff in some departments using language and tone on calls that causes stress for the recipient, as bed capacity is being managed. We also heard views that it can feel like bed capacity is prioritised over quality of care for patients.

Partnerships and communities

Local authorities and Integrated Care Boards regard DBTH as a supportive, open and positive partner organisation. The Trust supports work on wider determinants of health and is regarded as operating as an anchor institution for its local population. Partners also gave positive feedback on the leadership of DBTH.

The Trust is exploring options for vertical integration and recognises the need to respond positively to the ten-year health plan *Fit for the Future*. Partners supported the need for the DBTH Board to consider service developments beyond a traditional acute model and to increase its appetite for innovation and risk-taking.

There were some concerns voiced about a propensity for the Trust to externalise challenges it faces. There were calls for more focus on internal root causes, as well as national and system causes.

There are some concerns in relation to Bassetlaw health and care provision now being part of the Nottingham and Nottinghamshire ICS arrangements. There is a request however for clearer mechanisms to ensure Bassetlaw population's localised needs are meaningfully incorporated within DBTH's strategic planning.

In relation to Bassetlaw Hospital and the Trust's plans for future local provision, there is a request for this to be more clearly addressed in the Trust's strategic planning and communications. It is noted that the recently approved Strategy does not cover this issue.

From a partnership perspective DBTH is seen to work well with its governors, supporting its connection to the local population. There is recognition that the Trust has been through a period of change but is now entering a more stable phase. This stability brings a renewed need to strengthen engagement with governors and ensure the public voice is actively sought.

Amongst the governor body there is a view that there is an opportunity to improve governor contributions to improve and maximise their input. A review of the constitution and governor engagement arrangements is underway to understand how engagement could be increased. There are mixed views on the degree to which the governors feel they are listened to.

There are still concerns amongst some governors about the relatively recent decision to stop the practice of governors observing Board sub-committees. There is a need to review how the Council of Governors meeting can be improved to help address the issues flagged above.

Partnerships and communities

The Trust offers opportunities, underpinned by structured programmes that begin with early engagement in schools. This includes partnerships with 'foundation schools for health' that raise awareness of NHS careers beyond clinical roles, encouraging interest in a wide range of jobs, such as cooks, painters and plumbers. The Trust is active in school and career fairs and supports placements for individuals with specific needs, for example autism. This outreach approach is seen as a key part of building local pride and connection.

Lived Experience

Patient stories are not included as an agenda item for Board meetings held in public. There was limited direct reference in the meetings we reviewed to the importance of patients and carers lived experience in assessing and developing Trust services.

Whilst the Quality Plan references the use of lived experience to drive service improvement, it is not prominent in the Trust Strategy, the Board Assurance Framework (BAF), the Integrated Performance Report, or Quality Committee agendas. For example, the forward programme for the Quality Committee includes only an annual patient experience report.

The Quality Improvement and Innovation (QII) Strategy 2024-2028 prioritises better patient/service user involvement in service improvement projects, but progress to date has been limited.

Concern was expressed by partners over the loss of the dedicated service user management role at DBTH, and whether the incorporation of this responsibility within the PALS team, could dilute the depth and focus of user engagement.

We recommend that the Board considers the assurance it receives with regards to how patient and lived experience is central to monitoring and driving service improvement, and how it can elevate prominence at Board meetings.

Learning, improvement, and innovation

The Quality Improvement and Innovation (QII) Strategy 2024-2028 is structured around the four strategic priorities of Patients, People, Partnership and Pounds and aligns with the NHS IMPACT Model. It links to other strategies such as People, Nursing, AHP and Quality, Tackling Health Inequalities, Digital Transformation and Research and Innovation.

The Strategy includes five aims, underpinned by a series of milestones/ objectives. The Strategy states that progress against the milestones/ objectives should be reported to the Finance and Performance Committee, via the Trust Executive Group as part of the Recovery Innovation and Transformation reports. However, the F&P Committee work plan indicates the Committee does not receive these reports. Furthermore, the "Operational Assurance and Information Flows at DBTH" wiring diagram does not include reference to quality improvement reporting.

We recommend that the reporting arrangements for implementation of the Quality Improvement and Innovation (QII) Strategy 2024-2028 are clarified.

A progress update on the QII Strategy was produced in April 2025. Milestones and objectives were RAG rated, with good (green) progress in some areas but a number of concerns highlighted. These raise questions about the sufficiency of senior leadership oversight and support for the strategy and its component programmes. Several concerns align with issues flagged elsewhere in this report, including:

- Inconsistent patient/service user involvement.
- There is a limited approach to measurement and evaluation, which reduces assurance on progress against strategy objectives. No formal evaluation tool is in place beyond a survey sent to some project participants after completion of improvement projects.
- There is a relatively low level of regular team QI huddles supported by visual management techniques. Currently, 8 wards and 3 departments/teams use visual huddle boards, equating to around 10% coverage, with no significant increase in 2024/25. However, where huddles are in place they include sections on staff wellbeing and improvement.

Some of the feedback from interviews was consistent with the concerns referenced above. This included a recognised need to speed up implementation and application of QI methods, and concern expressed about the relatively low level of tangible service improvements that have been supported by QI methodologies and levels of staff empowerment.

Learning, improvement, and innovation

During conversations with staff, we also heard of concerns from staff that they feel they need to seek permission to undertake local improvement projects.

We did however hear other staff describe feeling supported to undertake quality improvement projects with direct support being available from QI trained staff. Where staff had worked with the QI team there was positive feedback regarding the support they had received.

There was positive feedback from Executives and Non-Executives regarding the development of DBTH-I. There is an expectation this development will help to address the concerns described above.

We recommend that the current approach to quality, improvement, and innovation team meetings and huddles across the Trust is reviewed and actions are agreed to support improvement in line with the QII Strategy objectives.

Environmental sustainability

The new DBTH strategy 2025-29 states;

"Our ambition is to create high-quality care spaces by improving our buildings, changing how we deliver services, and working more closely with community healthcare, whilst also working towards Net Zero."

The organisational Green Plan focuses on ensuring *"healthcare facilities meet the highest standards"*. The plan contains detailed information on current state and future plans, with each section including a *'Measuring Progress'* section.

The Green Plan, available on the Trust internet site does not appear to be dated. However, the current data included within the Plan is framed as 2020/21 with target dates framed as 2025/26. We recognise that the Board approved a refreshed strategy 'Green Plan' in September 2025.

Conversations with leaders from the local authorities demonstrated satisfaction with the DBTH approach to environmental sustainability. A key area of focus for BDC is improving sustainable transport options for patients, with an emphasis on making access to services easier for Bassetlaw residents, and more environmentally friendly.

There was also feedback from discussions with Board members that suggests the Green Plan should receive more airtime at Board meetings.

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Code breakers

Recommendations

Recommendations

Theme	No.	Recommendation
Shared direction and culture	01	We recommend that the Trust incorporates quantitative measures within the planned six-monthly evaluation reports, as well as narrative updates. The evaluation should draw on both internal and external data and reporting to assess progress against the Trust's strategic priorities and ambitions.
	02	We recommend that the enabling plans are reviewed and refreshed to ensure full alignment with the new Strategy. Revised versions should be assured through the relevant Board sub-committees.
	03	We recommend the Trust work with its strategic commissioners and wider partners to establish the strategic direction for Bassetlaw and Montagu Hospitals as part of its implementation of its new strategy.
	04	We recommend that the Trust considers how the DBTH Way and We Care values and example behaviours could be operationalised and monitored in line with the People Plan.
	05	We recommend that the Trust considers strengthening the People Plan by identifying the responsibility of team leaders to ensure regular communication and engagement with their staff.
	06	We recommend that the Trust strengthens its approach to engaging frontline leaders in service improvement and efficiency initiatives, and reviews its corporate communications to ensure the language reflects a shared purpose and a 'one team' ethos.
	07	We recommend that the Trust reviews current expectations, processes, and cultural norms in relation to medical leadership and engagement with medical staff. The Trust should ensure consistency in how professional behaviours are modelled and addressed across all staff groups to support an inclusive and equitable working culture.

Recommendations

Theme	No.	Recommendation
Capable, compassionate, and inclusive leaders	08	We recommend that the Trust considers introducing a standing agenda item across its governance meetings to reflect on whether the content and conduct of the meeting were consistent with the Trust's values and agreed behaviours.
	09	We recommend that the Trust reviews its approach to leadership visibility, including the frequency, format, and purpose of Executive and Non-Executive walkarounds. Consistent and visible engagement by senior leaders, particularly in clinical areas, would help build staff trust and reinforce the organisation's values.
	10	We recommend that discussions are held with leaders across the Trust, to develop a consensus on the balance between holding meetings face to face and via Teams.
	11	We recommended that the Trust undertakes development work with divisional leadership teams on how they work and lead on an integrated basis. This should incorporate a review of how the leadership teams inform Trust-wide decision making and assurance assessments.

Recommendations

Theme	No.	Recommendation
Governance, management, and sustainability	12	We recommend the Trust reviews what information is included in the Integrated Quality Performance Report on health inequalities and finance.
	13	We recommend that the Trust strengthens the Integrated Quality Performance Report by using benchmarking, external data, improvement trajectories, and clear measures linked to the Trust's strategic ambitions. This will support moving to assurance rather than reassurance.
	14	We recommend the Trust includes the actions being undertaken in relation to the elevated SHMI rate within the Trust Risk Register and consideration is given to appropriate inclusion within the BAF.
	15	We recommend the Board receives detailed information and assurance on actions being taken to mitigate the impact of the estate condition at the DRI, on Trust finances, quality, access, and staff experience.
	16	We recommend that the Board and its committees undertake a review of their processes for generating assurance outcomes, including working to standard definitions for each level of assurance. This should be informed by a review of controls and assurance levels within the BAF, alignment with latest internal audit opinions, robust outcomes data, and enhanced levels of external validation.

Recommendations

Theme	No.	Recommendation
Governance, management, and sustainability	17	We recommend that a review is undertaken of the purpose and role of TLT. This review should consider the balance between decisions made at the Executive Team meeting and the TLT, and the degree to which the divisions are involved in Trust-wide decision-making processes.
	18	We recommend that an organisational accountability framework document is developed, aligned to the Performance Assessment Framework, the scope of which covers governance arrangements from service level to the Board.
	19	We recommend the Caring Group discusses how to ensure that lived experience is better harnessed and used within DBTH.
	20	We recommend that the BAF is strengthened to ensure clear threat descriptions, outcome-based assurance sources, alignment with the new Trust Strategy, consistency in committee reporting, and sufficient time for Board review and challenge.

Recommendations

Theme	No.	Recommendation
Freedom to Speak Up	21	We recommend that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all.
	22	We recommend that FTSU reports to the Board includes learning and actions to strengthen the feedback and learning loop.
Workforce, equality, diversity, and inclusion	23	We recommend that the Trust reviews whether its operational assurance arrangements as set out in the Operational Assurance and Information Flows wiring diagram for staff engagement are sufficient.
	24	We recommend that the Trust strengthens workforce engagement and communication, ensuring changes to policies, roles, and systems are clearly explained to staff.
Partnerships and communities – Lived Experience	25	We recommend that the Board considers the assurance it receives with regards to how patient and lived experience is central to monitoring and driving service improvement, and how it can elevate prominence at Board meetings.
Learning, improvement, and innovation	26	We recommend that the reporting arrangements for implementation of the Quality Improvement and Innovation (QII) Strategy 2024-2028 are clarified.
	27	We recommend that the current approach to quality, improvement, and innovation team meetings and huddles across the Trust is reviewed and actions are agreed to support improvement in line with the QII Strategy objectives.

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Appendix

Appendix A- Documentation Reviewed

- BAF May Audit Committee copy V1.0
- Risk Management Policy
- Corporate Risk Register
- Divisional Risk Registers
- Risk Appetite Statement
- DRAFT Board and committees V1.5
- Draft in progress - Trust wiring diagram V1.1
- Organogram of Directors, Deputy Directors and Divisional Leaders
- Trust wiring diagram
- Executive Team Meetings - 2nd April Agenda, Papers and Minutes
- Executive Team Meetings – 9 April Agenda, Papers and Minutes
- Executive Team Meetings - 16 April Agenda, Papers and Minutes
- CORP-FIN-1-C-V13-Reservation-and-Delegation-of-Powers-post-BOARD
- March 2025 - Board IQPR
- dbth 202323 AGS on P156
- C2 Leadership & OD Annual Report 2023
- EDI Annual Report 2022 23 FINAL VERSION 2 June 2023
- EDI Annual Report Apr24
- Gender Pay Gap 2024viii
- Health and Wellbeing Annual Report 2022-2023
- HWB 2024 Annual Report V04 final
- OD annual report PC Jun24
- IA Draft Plan for ARC 25-26
- Interim HoIA opinion 24-25
- 00 - Public CoG Agenda - 07 November 2024
- 00 - Public CoG Agenda - 07 November 2024_V2
- 00 - Public CoG Agenda - 07 November 2024_V3
- 00 - Public CoG Agenda - 07 November 2024_V3
- A2 - Register of Governors Interests 28 October 2024
- B1 - Chair & Non-executive Director Appraisal Process 2023-24
- B2 - NED Recruitment & Succession Planning

Appendix A- Documentation Reviewed

- B3 - Dates for Future Council of Governors Meetings & AMM
- C1-C10 FINAL Council of Governors Presentation
- D1 - Draft Council of Governors Minutes - 26 September 2024 v4
- D2 - Draft Minutes of DBTH AMM - 26 September 2024
- F3 - Governor Questions & Answers - 9 October 2024
- ~$aft Council of Governors Minutes - 07 Novembr 2024_v2
- Action Log Council of Governors- 07 November 2024
- Action Log Council of Governors- 07 November 2024_Updated Jan 25
- Action Log Council of Governors- 07 November 2024_Updated Jan 25_v2
- Council of Governors Minutes - 07 November 2024
- Final Council of Governors Minutes - 07 November 2024
- Council of Governors - 7 November 2024
- Council of Governors - 7 November 2024_v2
- Council of Governors Presentation_V2
- Council of Governors Presentation_V3
- Govsv1
- 00 - Confidential Council Agenda 06 February 2025
- 00 - Confidential Council Agenda 06 February 2025
- A2 - Register of Governors Interests - 30 January 2025
- A4 Draft Confidential CoG Minutes 08 08 24
- B1 - Non-Eexecutive Director Recruitment
- B2 - Non-Executive Director Remuneration
- B2i - Appendix 1 NHS Providers Remuneration Survey 2023-24
- Minutes to approve - Extraordinary Council of Governors 08_08_2024
- CCOG Draft Confidential Minutes - 06 February 2025
- Confidential Council of Governors - 06 February 2025
- Public CoG Agenda -06 February 2025_v7

Appendix A- Documentation Reviewed

- 00 - Public CoG Agenda -06 February 2025_v7
- A2 - Register of Governors Interests - 30 January 2025
- A3 - Action Log Council of Governors- 07 November 2024
- B1 - Extension of Governors' Terms of Office
- B2 - DBTH Membership Process
- C1 - D1 - Council of Governors Presentation
- D2 - Draft Council of Governors Minutes - 07 Novembr 2024
- F3 - Governor Questions&Answers
- F4 - Collective Governor Response N&N ICS - NHS Change Consultation
- ~$aft Council of Governors Minutes - 06 February 2025
- Draft Council of Governors Minutes - 06 February 2025
- Council of Governors - 06 February 2025 v2
- Council of Governors - 06 February 2025
- Council of Governors - 6 February 2025 v3
- Council of Governors Presentation
- July 2024 - Guardian of Safe Working Quarterly Report
- March 2025 - Guardian of Safe Working Annual Report
- NHS Nottingham and Nottinghamshire Integrated Care Board - Our Strategies and Plan, Web Page
- SYICB JFP_EngageDraftFINAL.MARCH25 - NHS Joint Forward Plan for South Yorkshire (South Yorkshire ICB)
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation trust – Our Values and Vision, Web Page

Trust Policies:

- CORP/EMP 14 – Freedom to Speak Up Policy ‘Speak up to make a difference’
- CORP/EMP 29 – Statutory and Essential Training (SET) Policy
- CORP/EMP 59 – Equality Diversity and Inclusion Policy
- CORP/FIN 1 (A) – Standing Orders – Board of Directors
- CORP/FIN 1 (B) – Standing Financial Instructions

Appendix A- Documentation Reviewed

- CORP/FIN 1 (C) – Reservation of Powers to the Board and Delegation of Powers
- CORP/RISK 9 – Business Continuity Management Policy
- CORP/RISK 30 – Risk Management Policy
- CORP-COMM-24-v-4-Social-Media-Policy-Final
- CORP/EMP 20 – Dress Code and Uniform Policy
- CORP/EMP 2 – Disciplinary Procedure
- CORP/EMP 31 – Health and Wellbeing Policy
- CORP/EMP 32 – Appraisal Policy
- CORP/EMP 35 – Doncaster and Bassetlaw Teaching Hospitals – Roster Policy
- CORP/EMP 36 – Recruitment and Selection Policy
- CORP/EMP 38 – Appraisal Policy for Medical Staff of DBTH as Designated Body
- CORP/EMP 3 – Grievance and Resolution Policy
- CORP/EMP 48 – Flexible Working Policy
- CORP/EMP 49 – DBTH Leave Policy (including Annual, Professional and Duty for all staff, including medical)
- CORP/EMP 57 – Reasonable Adjustments Policy
- CORP /EMP 58 – Civility Respect & Resolution Policy
- CORP EMP 63– DBTH Financial Wellbeing Policy (Including Salary Sacrifice)
- CORP/EMP 9 – Restructure, Reorganisation, Redeployment and Redundancy Policy
- CORP/HSFS 5 – Violence, Prevention & Reduction Policy
- CORP/RISK 14 – Being Open, Saying Sorry and Duty of Candour Policy
- CORP/RISK 35 – Mortality Governance Policy
- CORP/RISK 36 – Patient Safety Incident Response Policy (PSIRF)
- PAT/IC 19 v.8 – Standard Infection Prevention and Con
- PAT/PS 26 v.1 - Sexual Safety Policy
- CORP/EMP 27 – Equality Analysis Policy
- CORP/COMM 28 – Quality Performance Impact Assessment Policy
- CORP/EMP 13 – Conduct, Capability, Ill Health and Appeals Policies and Procedures for Practitioners
- CORP/COMM 25 – Establishment and Administration of Committees Policy

Appendix A- Documentation Reviewed

- CORP/EMP 25 – Capability Procedure: Managing Poor Performance
- CORP/EMP 56– Pay Progression Policy
- CORP/HSFS 1 v.7 - Health and Safety Policy
- People Strategy 23-27 Final
- The DBTH way 2023 Final
- DBTH Web Page - Quality Improvement and Innovation
- Board of Directors Public Agenda - 3 September 2024 v5
- Board of Directors Public Agenda - 4 March 2025 v5
- Board of Directors Public Agenda - 5 November 2024 v3
- Board of Directors Public Agenda - 7 January 2025
- Public Board of Directors DRAFT Minutes - 4 March 2025
- Public Board of Directors Minutes - 3 September 2024
- Public Board of Directors Minutes - 5 November 2024
- Public Board of Directors Minutes - 7 January 2025
- Confidential Board of Directors Minutes - 4 March 2025
- Confidential Board of Directors Minutes - 5 November 2024
- Confidential Board of Directors Minutes - 7 January 2025
- Performance Assurance Framework V11
- Performance Assurance Framework V12
- RMB Agenda 19 May 2025
- MAY Draft RMG Minutes 190525
- RMG Action Log - June 25
- RMG Risk Review Log - June 25
- DRAFT Risk Report - June 2025 v1
- 15+ Risk Summary - June 2025
- RMG Workplan schedule - Progress 2
- New Risks RMG June 2025
- Longest duration risks - no change in risk score
- Risk ManagementPolicy v6.... Document version 1.2 TEP (1)

Appendix A- Documentation Reviewed

- Doncaster Staff Survey Benchmark 24
- Staff Survey Report for PC Apr25
- Staff Survey Report for Board May25
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust CQC Inspection report - September 2023
- CQC Action Plan
- QI Strategy Progress Mapping Updated
- dbth.nhs.uk-Quality Improvement and Innovation Qii.pdf
- EQIA (Equality Impact Assessment)
- HEAT_simplified_version-ODT
- QPIA Template
- SLEC A4 poster
- GMC results update PC Oct 24
- Audit_and_Risk_Committee_17 April 2025_v2
- Audit_and_Risk_Committee_13 February 2025_v3
- Audit_and_Risk_Committee_24.10.24_Portfolio_v2
- Audit_and_Risk_Committee_ 24 July 2025
- Finance_and_Performance_Committee_Portfolio_ 24 April 2025_V2
- Finance_Performance_Committee_27 February 2025_v2
- Finance_Performance_Committee_25 March 2025
- Finance_and_Performance_Committee - 29 May 2025 v3
- Finance and Performance Committee ToR
- People Committee - 15.4.2025
- People Committee - 17 December 2024 v3
- People_Committee_ FINAL 18 02 25
- People Committee TOR
- Quality Committee - 3 April 2025 V2
- Quality_Committee_Portfolio_04 December 2024
- Quality_Committee- 11 February 2025_v2
- Quality Committee TOR
- Speaking Up (FTSU) Bi-annual Report - Final - May 2025
- Speaking Up (FTSU) Bi-annual Report to Board - 5th November 2024 - Final

Appendix A- Documentation Reviewed

- Speaking-Up-Strategy-2024-28
- Speaking Up Process, Standard Operating Procedure (SOP)
- Speaking Up R&P Tool June 2024
- Speaking Up policy v10 2024
- DBTH Leadership and Development Prospectus 25/26
- PRM - Medicine 04-2025
- PRM AD Log - Medicine (5)
- PRM Agenda - Medicine - 01-05-2025
- PRM - A&D Log - Surgery (7)
- PRM Agenda - Surgery - 30-04-2025
- Surgery - PRM - 2025-04
- PRM Agenda - W&C 29-04-2025
- WC Performance Review Meeting 04-2025
- WC PRM Action Log (5)
- CSS Performance Review Meeting 04-2025
- PRM - AD Log - CSS (7)
- PRM Agenda - CSS - 01-05-2025 (1)
- PRM - UEC 04-2025
- PRM AD Log - UEC (7)
- PRM Agenda - UEC - 30-04-2025
- Engagement Leadership PC Feb25 – RR
- TLT – April
- TLT Development Session 10.02.25
- TLT January 2025 v3
- TLT January Minutes
- TLT March 2025 V2
- TLT TORs
- Diagnostics Programme Board Terms of Reference
- A - PSC Minutes - Oct V2 Approved
- Agenda 22.11.24
- Agenda 30.8.24
- Agenda 7.3.25 v2
- Caring Group TOR May 2025 – draft
- Item 2.1 - Approved PSC Minutes - 21.02.25 SB Checked

Appendix A- Documentation Reviewed

- Patient Safety Committee - Terms of Reference - Amended Nov 2024
- PSC Approved Minutes - Dec 2024
- 30.2 Patient Safety Committee - Terms of Reference
- 642 Meeting Timetable
- 6-4-2 ToR
- Cash Committee ToR (amended Dec 23) v2
- Draft ToR - Outpatient Improvement Board 25-26
- EDI Committe ToR 09.05.2024 – FINAL
- HI TOR v0.8
- HWB Committee Terms of Reference - October 2024 – FINAL
- People Systems Steering Group_TOR_April 2025
- Terms of Reference CIG - Jan 19
- Terms of Reference -OP utilisation group
- Theatre Scheduling ToR
- Theatres Improvement Programme Board ToR
- ToR - UEC & LoS Improvement Programme Board 25-26
- ToR Performance Review Meeting
- Nominations and Remuneration TOR
- DBTH Equality, Diversity and Inclusion – Web Page
- Leadership & OD Annual Report 23
- EDI Annual Report 2022 23
- EDI Annual Report Apr24
- Gender Pay Gap 2024
- Health and Wellbeing Annual Report 2022-2023
- HWB 2024 Annual Report
- OD annual report PC Jun24

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