



Board of Directors: Public

Schedule	Thursday 2 October 2025, 9:00 AM — 12:15 PM BST
Venue	Room 9, Education Centre, Barnsley Hospital
Organiser	Godfrey Mugoti

Agenda

9:00 AM	1. Introduction	(10 mins)	1
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	2.1. Staff Story To Note - Presented by Steve Ned		19
9:30 AM	3. Governance	(15 mins)	20
	3.1. Board Assurance Framework/Corporate Risk Register For Assurance/Approval - Presented by Peter Walsh		21



9:45 AM	4. Assurance	(60 mins)	67
	4.1. Quality and Governance Committee Chair's Log: 27 August/24 September 2025 For Assurance - Presented by Gary Francis		68
	4.2. Finance & Performance Committee Chair's Log: 28 August /25 September 2025 For Assurance - Presented by Alison Knowles		94
	4.3. Audit Committee: Nil return For Assurance - Presented by Stephen Radford		104
	4.4. People Committee Chair's Log: 23 September 2025 For Assurance - Presented by Kevin Clifford		105
	4.5. To be the best Plan For Assurance - Presented by Lorraine Burnett		110
	4.6. Fire Code Statement For Assurance/Approval - Presented by Michael Wright		121
10:45 AM	Break	(10 mins)	126
10:55 AM	5. Performance	(50 mins)	127
	5.1. Maternity - Perinatal Quality Assurance Scorecard : Tracy Taylor and Sarah Petty in attendance For Assurance - Presented by Sarah Moppett		128
	5.2. Integrated Performance Report For Assurance - Presented by Michael Wright		164



	5.3. Annual Trust Self-Assessment for Education and Training: To follow after ET For Discussion/Approval - Presented by Simon Enright	211
	5.4. Annual Report of Workforce, Race and Equality Standard: Pauline Garnett in attendance For Assurance/Approval - Presented by Steve Ned	212
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	5.7. Communications Strategy For Approval - Presented by Emma Parkes	325
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	7.3. 2025/2026 Work Plan To Note - Presented by Michael Richmond	367



12:05 PM	8. Any Other Business	(10 mins)	375
	8.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Michael Richmond		376
	8.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Michael Richmond		377
	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.		378
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1. Introduction

1.1. Welcome and Apologies

Apologies:

To Note

Presented by Michael Richmond

1.2. Declarations of Interest

To Note

Presented by Michael Richmond

1.3. Minutes of the Previous Meeting: 7 August 2025

To Review/Approve

Presented by Michael Richmond



**MINUTES OF THE MEETING OF THE Board of Directors: Public HELD ON Thursday
7 August 2025, 9:30 AM — 12:00 PM BST**

PRESENT:	Mike Richmond	Chair
	Richard Jenkins	Chief Executive
	Michael Wright	Managing Director
	Simon Enright	Medical Director
	Sarah Moppett	Director of Nursing, Midwifery and AHPs
	Steve Ned	Director of People
	Lorraine Burnett	Chief Operating Officer
	Stephen Radford	Non-Executive Director
	Gary Francis	Non-Executive Director
	Alison Knowles	Non-Executive Director
	Nicky Clarke	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	David Plotts	Non-Executive Director
	Robert Paskell	Deputy Director of Finance (standing in for CT)
	Richard Billam	Deputy Director of IT (standing in for TD)
IN ATTENDANCE:	Emma Parkes	Director of Communications & Marketing
	Mark Strong	Associate Non-Executive Director
	Peter Walsh	Interim Director of Corporate Affairs
	Godfrey Mugoti	Deputy Director of Corporate Affairs(minutes)
	Mathew Hall	Staff Governor
	Janet Hall	Public Governor
	Steve Lobaz	Consultant in Anaesthetics and Intensive Care
	Medicine, min ref: 25/67	
	Sarah Petty	Joint Director of Midwifery, min ref: 25/74
	Rob MacCabbinn	Managing Director- BFS, min ref: 25/73
APOLOGIES:	Angela Wendzicha	Director of Corporate Affairs
	Chris Thickett	Joint Director of Finance
	Tom Davidson	Director of IT

	Introduction	
BoD: 25/60	Welcome and Apologies Mike Richmond welcomed members, attendees and observers to the meeting. Apologies were noted as above.	
BoD: 25/61	Declarations of Interest Richard Jenkins, Emma Parkes and Peter Walsh noted their standing declarations of interest due to their joint roles at Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). Mark Strong's declaration of Interest on Teaching Hospital Status update item was noted.	
BoD: 25/62	Quoracy The meeting was quorate.	

BoD: 25/63	Minutes of the Previous Meeting: 5 June 2025 The minutes of the meeting held on 5 June 2025 were reviewed and approved as an accurate record of events.	
BoD: 25/64	Action Log The action log from the previous meeting was received and progress against outstanding actions was noted	
	Culture	
BoD: 25/65	Patient Story: Sarah Petty In attendance The session began with SP introducing a video with R's patient story, which had a profound emotional impact on the team. SP's narrative encouraged staff to reflect deeply on the importance of empathy in healthcare and particularly the need to "put yourself in the other person's shoes." This message resonated strongly and set the tone for a conversation focused on compassion, inclusion, and systemic improvement. Following video presentation, several improvements were discussed. The 15 Steps Programme was highlighted as a framework for enhancing patient experience. Staff training initiatives were underway, with a focus on accessibility and inclusion. Physical upgrades included accessible toilets and a refurbished birth centre, both aimed at improving comfort and dignity for patients. A key development was the provision for partners to stay overnight, supported by better bed space, comfortable chairs, and a shift in culture and education to support family involvement. The story underscored the importance of inclusive care, with emphasis on using appropriate language, recognising carers, and supporting diverse needs. Tools such as the disability passport and personalised care plans were introduced to ensure that care is tailored to individual circumstances. A previous complaint was anonymised and shared with staff to promote learning and transparency. In June, the unit received a visit from local MP, who was reportedly overwhelmed by the positive energy and dedication of the team. This external recognition served as a morale boost and validated the ongoing efforts to improve maternity services. The discussion turned to the culture within maternity services. SR expressed satisfaction that actions were being addressed, while SP acknowledged the challenges of busy wards. SM noted that cultural transformation was underway, and RJ raised questions about the timing of the case and its relevance to national issues. The conversation touched on leadership, teamwork, and the national recommendations, with a	

	shared commitment to “doing the right things,” reflecting, and improving care to reduce child risks. SP emphasised the importance of continuity of care. AK highlighted the role of patient R’s husband as a carer, and SP reiterated the need to include partners in care planning and decision-making. The story reinforced the value of systemic support, inclusive culture, and birthing partner engagement. GF described the story as powerful and asked how its lessons would be captured, suggesting simulation and communication training. SP agreed, noting the need to adapt care plans and rethink previous and current practices. MS stressed the importance of staff understanding of expected standards, and SP spoke about engagement with staff and the role of mandatory training. SM mentioned a paper coming to ET in September. MR discussed remedial action, emphasising that every patient experience should lead to learning and reassurance. SP highlighted the importance of communicating the story’s impact to colleagues. KC shared a personal experience, reinforcing the value of learning from others within the Trust. The session concluded with MR thanking SM, SP and the team for their powerful contribution.	
	Governance	
BoD: 25/66	Board Assurance Framework/Corporate Risk Register The Board of Directors received an update on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), following a series of reviews with risk owners, Executive Leads, presentation to Executive team meeting and assurance Committees. The report highlighted the Trust’s commitment to robust internal control and risk management, aligning with strategic goals such as workforce stability, patient care quality, performance against national standards, partnership working, place-based health improvement, and environmental sustainability. A key focus of the discussion was the recommendation to increase the residual risk score for Risk 2592 relating to the inability to deliver constitutional and other regulatory performance or waiting time standards, from a score of 15 to 20. This reflects heightened scrutiny and performance management from NHS England, as well as ongoing challenges in meeting targets for patient diagnosis and treatment. The Board acknowledged that while mitigations are in place, the risk environment has intensified, warranting a higher score.	

	There was debate about whether some mitigations could justify a lower score, but the consensus was that the current pressures, including increased A&E attendances and regulatory oversight, justified the increase. The Board also discussed the need for a deeper dive into the underlying causes of these risks, particularly in relation to budget constraints and space limitations. Issues such as the lack of adequate facilities (highlighted in Risk 2557) and the impact of industrial action on workforce costs (as seen in Risk 1199) were explored. The Board asked if scoring could be reviewed for Risk 2557 regarding space and facilities. Further, the Board discussed the scoring for risk 1713 relating to the inability to deliver the in-year financial plan, and agreed with the Finance and Performance Committee recommendation for a review of the risk score, given concerns about efficiency plan delivery and the potential loss of deficit support funding. The Board also discussed the importance of oversight for corporate risks that score below 15 on the CRR, ensuring that emerging threats are not overlooked.	GM LB GM CT
BoD: 25/67	Risk Management Committee Terms of Reference Board members received and Approved Risk Management Committee Terms of Reference subject to minor adjustment.	
BoD: 25/68	Teaching Hospital Update SL described the extensive consultation and benchmarking process undertaken as part of the Teaching Hospital application. Meetings with key figures, including MS, and benchmarking visits to organisations such as Pinderfields, helped shape the Trust's approach. The Board discussed the importance of using the name change as an opportunity to reset education across all departments, making it a true Trust strategic pillar. There was strong support from the Executive Team for this direction, with a focus on improving relationships with partners and ensuring management oversight. The Board emphasised the need to share resources, protect education space, and ensure the clinical faculty covers all specialities, supporting a culture of excellence and recruitment, as seen at Pinderfields. The aim is to submit the application by September, with a new educational structure and rebranding to be implemented by April 2026. SE thanked the team for their efforts, while NC highlighted the importance of ensuring the initiative is not too narrowly focused on clinical staff, but also includes non-clinical colleagues. The Board discussed budget considerations, including CPD (Continuing Professional Development) funding, and SL stressed that funding should be accessible for everyone, not just those in medicine. SR raised the importance of engaging with external partners, such as Sheffield and local colleges, and SL confirmed	

	ongoing discussions with these institutions to broaden the Trust's educational reach. The Board reflected on the outputs of focus groups, with KC emphasising the need to clearly articulate the benefits of Teaching Hospital status to all stakeholders. SE noted that this is just the start of the process, and RJ asked what tangible difference the change would make, particularly in terms of care, compassion, and leadership. The discussion also touched on the potential for growth in finance, estates, and commercial aspects, with MS highlighting the ambition to become more research-active and provide better care in the future. AK stressed the importance of focusing on EDI (Equality, Diversity, and Inclusion), community engagement, and links with local education providers. The Board agreed on the need for clear communication around the name change, with EP tasked with leading this effort. GF raised potential obstacles, and the Board reiterated the importance of strategic support and endorsement at all levels. MR expressed concern about the concept of rebranding, cautioning that communication must make it clear that the initiative is not just about medical teaching, but also about all colleagues, PLACE (Patient-Led Assessments of the Care Environment) and supporting the overall health of Barnsley. The Board agreed that this is a major agenda item and requires ongoing attention and balance. Action: GM to update work plan.	EP GM
	Assurance	
BoD: 25/69	Quality and Governance Committee Chair's Log: 25 June/30 July 2025 GF presented Chair's logs from Quality and Governance Committee's meetings on 25 June and 30 July 2025 which covered a wide range of topics, with a focus on assurance, learning, and continuous improvement. During the Board discussion, several key themes were raised. There was a strong focus on improving the experience for people with learning disabilities, including the need for quiet areas and noise-cancelling technology in A&E. The Board acknowledged the positive feedback received and the ongoing efforts to enhance patient experience, with recognition of the hard work and commitment of staff. Infection prevention remained a priority, with a slight increase in C. difficile cases compared to last year, but actions were in place using quality improvement methodology and a multidisciplinary approach. The Board noted that two out of three key metrics were showing improvement, and a deep dive into infection rates was planned. The importance of evidence-based action and national benchmarking was emphasised, with the expectation that further reductions in infection rates should be achievable. The Board also	

	discussed the value of external review and maintaining a long-term perspective on quality and governance challenges	
BoD: 25/70	Finance & Performance Committee Chair's Log: 2025 AK presented Chairs logs for Finance & Performance Committee meetings held on 26 June and 31 July 2025. During Board discussions, several key points were raised. The ED business case and medical staffing challenges were highlighted, with the need for a robust three-year financial recovery plan. Circulation of the "Back to Balance" paper post meeting was agreed by Board. Following discussion there was an agreement by Board members for an assurance finance paper to be presented at every Board meeting. Board heard that the Health on the High Street building work was progressing as planned, with facilities and benefits discussed. Business security, winter planning, and offsite water and security issues were addressed, with assurance provided by BFS team. Cyber security was a major topic, with ongoing monitoring, external penetration testing, supplier management, and national team support. Staff training, including phishing quizzes, was underway, and the strategic context was informed by national news. The supplier landscape and procurement space were discussed, with assurance that not too much data was in the cloud. System C and AI developments were mentioned. The Winter Plan was discussed, focusing on patient flow, confidence in delivery, and collaboration with community partners. Updates to the executive team were planned, and reliance on external factors was acknowledged. The Board also discussed the importance of ongoing monitoring, external reviews, and maintaining a long-term perspective on financial and operational risks.	GM
BoD: 25/71	People Committee Chair's Log: 29 July 2025 KC presented the People Committee Assurance Report, highlighting the Committee's oversight of workforce, organisational development, and cultural change strategies. The Committee had recently reviewed and approved the new Health and Wellbeing Strategy, pending minor amendments and the addition of the CEO's foreword. This strategy was commended for its focus on supporting staff wellbeing and was shared with the Board for assurance and information. Progress against the People elements of the Trust Objectives was reviewed and recommended to the Board as part of the overall objectives review. Updates from the People and Engagement Group and the Barnsley	

	Strategic Workforce Group's Proud to Care Hub were also received for information. During the Board discussion, members acknowledged the Committee's proactive approach to staff wellbeing, workforce planning, and equality, diversity, and inclusion. The Board supported the ongoing work to address workforce risks, improve job planning and appraisal processes, and implementation of the Health and Wellbeing Strategy and Anti-Racist Action Plan. strategy	
BoD: 25/72	Audit Committee Chairs Log: July 2025 Stephen Radford, presented Audit Committee Chairs' log from a meeting convened on 9 July 2025. The Committee discussed losses and special payments, with particular attention to stock and pharmacy issues, as well as the latest audit report. Assurance was provided that actions are underway to strengthen internal controls and policies to minimise future losses, including those related to expired pharmacy stock and salary overpayments. During the Board discussion, SE highlighted that the job planning audit received limited assurance, indicating there is still a significant amount of work to do. The process is ongoing, with key performance indicators (KPIs) being closely monitored. An action plan is in place aiming for 95% completion of job plans by the end of the year, and delivery of this plan remains a priority. SE noted that further work is required on job planning and group processes, with JG tasked to bring detailed plans to the People Committee for review. The People Committee will continue to monitor progress on job planning to ensure improvements are sustained	
BoD: 25/73	Barnsley Facilities Services Chair's Log DP presented Barnsley Facilities Services Ltd (BFS Chairs logs for the month of June and July 2025. The reports highlighted continued progress on key estates projects, including the near-completion of the Education Centre refurbishment and ongoing expansion of the operating theatre suite. DP mentioned that financial performance remained on track, with budgets and savings targets being met, and procurement processes operating within governance standards.	
BoD: 25/74	Green Plan RM presented Barnsley Hospital NHS Foundation Trust's Green Plan 2025–2028 which sets out a comprehensive and ambitious sustainability strategy, aligning with NHS England's requirements for all Trusts to achieve net-zero carbon emissions by 2040 for direct emissions and by 2045 for indirect emissions. Board members hear that the plan is structured around nine interlinked focus areas: Workforce and Leadership, Medicines, Supply Chain & Procurement, Digital Transformation, Estates & Facilities,	

	Adaptation, Net Zero Clinical Transformation, Travel & Transport, and Food & Nutrition. Each area includes targeted initiatives designed to embed sustainability into every aspect of hospital operation, from clinical care and procurement to energy use and waste management. RM described the Sustainable Action Plan as a “living document,” evolving through continuous improvement and regular review. Implementation is overseen by established governance structures, with progress monitored at executive and board levels. The plan also aligns with the United Nations Sustainable Development Goals, reinforcing the Trust’s commitment to global sustainability standards. RM mentioned that key actions included promoting low-carbon prescribing, expanding virtual care, decarbonising the estate, supporting active travel, embedding social value in procurement, and building climate resilience. Board members heard that the plan emphasises practical, measurable steps to reduce environmental impact, improve resource efficiency, and deliver high-quality, sustainable healthcare for the community. Board members endorsed the 2025-2028 Green Plan.	
	Performance	
BoD: 25/75	Perinatal Quality Assurance Scorecard: Tracy Taylor and Sarah Petty in attendance The Board presentation by Sarah Petty provided a comprehensive update on perinatal quality assurance, focusing on both service performance and the cultural climate within Barnsley Hospital NHS Foundation Trust’s maternity and neonatal services. The presentation highlighted that the three-year delivery plan remains on track, with structured oversight of key themes such as listening to families, workforce development, and sustaining a culture of safety and learning. The Board noted progress in upskilling staff, thematic reviews of complaints, and the implementation of the LMNS Equity and Equality action plan, all of which underpin the Trust’s commitment to providing safe, equitable, and personalised care. A significant portion of the discussion centred on culture and staff experience. Results from the staff pulse survey and SCORE culture metrics indicated improvements in leadership and psychological safety, but also revealed that staff desire greater involvement in decision-making and clearer communication about staffing changes. The Board acknowledged these findings and discussed ongoing efforts to embed an open-door policy, regular one-to-ones, and closed-loop feedback systems to foster a more supportive and happier workplace. MS raised concerns about cultural	

	issues, particularly the decline in the proportion of midwives recommending the Trust as a place to receive treatment, which dropped from 81.6% in 2023 to 72% in 2024. This prompted further discussion on the need to address cultural challenges to improve both staff and patient experience. The Board also discussed quantitative data from staff pulse checks and SPC (Statistical Process Control) charts, which tracked key metrics such as early booking, breastfeeding initiation, and compliance with mandatory training. Improvements in breastfeeding rates were attributed to better data management and increased attendance at harvesting clinics. Patient experience survey results were discussed, showing strengths in compassionate care but also highlighting areas for improvement, such as involvement in antenatal care decisions and communication. The Trust's performance was benchmarked against national trajectories, with a focus on reducing stillbirth and perinatal mortality rates to align with national targets. The Board emphasised the importance of creating a positive culture and a happy place to work, recognising that this is essential for delivering safe, high-quality care. SM led a discussion on the perinatal scorecard, which tracked compliance with CNST standards, training, and patient safety indicators. The Board reviewed staff survey results and discussed ongoing improvement work to engage teams and maintain compliance	
BoD: 25/76	Integrated Performance Report The Integrated Performance Report, was received and noted by the Board.	
BoD: 25/77	Trust Objectives 2025/26: Quarter One MW presented the Trust Objectives for quarter one 2025/26, which was received and approved by the Board.	
BoD: 25/78	Mortality Six Monthly Report SE presented the report to the Board which confirmed that Barnsley Hospital's mortality statistics remain within statistically expected limits, with the Hospital Standardised Mortality Ratio (HSMR) at 79.04 and the Summary Hospital-level Mortality Indicator (SHMI) at 98.21, both classified as "expected" and favourable compared to comparable peers. SE mentioned that the Trust continues to demonstrate good assurance in its mortality review processes, with all non-coronial deaths reviewed by the Medical Examiner Service and all requested Structured Judgement Reviews (SJRs) completed. Board members heard that any identified poor care is escalated to the Patient Safety Panel (PSP), and learning themes are shared across clinical teams. During the Board discussion, several important points were raised. NC highlighted the importance of learning from child deaths and the use of suicide prevention toolkits. SE was tasked to look into these issues in detail,	

	emphasising the need for qualitative learning from deaths and the value of multiple markers. The Board discussed the complexity of mortality data and the need for reassurance in practice, with MR seeking assurance that clinical teams are fully involved in the review process. Benchmarking against comparable peers was noted by AK, and the Board agreed that rolling deprivation data should continue to inform service improvement. The Patient Safety Panel reviews all issues from the previous week, ensuring that assurance and learning are embedded in practice. The Board also agreed that qualitative insights from deaths are essential for improvement, and that the Q&G Committee will continue to monitor and address any emerging concerns.	SE
	Break	
	System & Partnership	
BoD: 25/79	System Partnership Update: RJ and MW provided an overview of the partnership update, which highlighted key activities across the South Yorkshire ICB System, Barnsley Place and the ongoing partnership with TRFT.	
	For Information	
BoD: 25/80	Chair Report The Chair's verbal report, provided a summary of events, meetings, publications, and decisions that require bringing to the attention of the Board and was received and noted.	
BoD: 25/81	Chief Executive Report The Chief Executive Report, which provided information on several internal, regional and national matters that had occurred since the last meeting, was received and noted by the Board.	
BoD: 25/82	NHS Horizon Report The report, which provided an overview of NHS choices reviews, was received and noted by the Board.	
BoD: 25/83	2025/2026 Work Plan The work plan, was included for information and was noted by the Board.	
	Any Other Business	
BoD: 25/84	Questions from the Governors regarding the Business of the Meeting A question was raised by a public Governor relating to long waiting times, staffing shortages, and barriers to booking at the Community Diagnostic Hub at the Glassworks.LB confirmed that the question related to commissioning and that discussions were currently underway with the relevant commissioners to explore and implement appropriate solutions to these challenges.	
BoD: 25/85	Questions from the Public regarding the Business of the Meeting No questions were raised by members of the public.	

	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Affairs Team at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
BoD: 25/86	Date of next meeting: Thursday 2 October 2025 at 9.00 am, Room 9, Education Centre, Barnsley Hospital	

1.4. Action Log

To Review

Presented by Michael Richmond

Due Date	Action	Progress / Notes	Assigned To	Status	Meeting Date
2 Oct 2025	Circulation of the "Back to Balance" paper post meeting was agreed by Board. Following discussion there was an agreement by Board members for an assurance finance paper to be presented at every Board meeting.	Paper circulated to Board members post meeting. Work plan updated for the Finance update paper to every Board meeting.	Godfrey Mugoti	Complete	7 Aug 2025
2 Oct 2025	During the Board discussion, several important points were raised. NC highlighted the importance of learning from child deaths and the use of suicide prevention toolkits. SE was tasked to look into these issues in detail, emphasising the need for qualitative learning from deaths and the value of multiple markers. The Board discussed the complexity of mortality data and the need for reassurance in practice, with MR seeking assurance that clinical teams are fully involved in the review process.	Re Child deaths: • None of the three young people who died from self-harm were known to the trust prior to their deaths. • Public health are taking forward suicide prevention actions in the community as part of the suicide contagion meetings. • From an acute perspective, we have an all age mental health liaison team, safeguarding attend twice daily SLT meeting to identify any patients/attendances of concern. Early escalation and collaborative working with CAMHS supports prevention and early intervention for patients presenting with a mental health need. • Amparo https://amparo.org.uk/ were brought in to provide support to staff and continue to do so. • This is accessible for all staff and/or patient's families affected by Suicide • The local authority have shared training for staff Barnsley Metropolitan Borough Council Training Sessions Papyrus and offers different levels of training dependent upon the likely role of the staff in the case of suicide. The levels start with suicide awareness and prevention and moving up to interventions. This is an online course and free to access.	Simon Enright	Complete	7 Aug 2025
2 Oct 2025	Further, the Board discussed the scoring for risk 1713 relating to the inability to deliver the in-year financial plan, and agreed with the Finance and Performance Committee recommendation for a review of the risk score, given concerns about efficiency plan delivery and the potential loss of deficit support funding.	Risk reviewed in August and September 2025. Score increased to 16 following review.	Chris Thickett, Collette Gerraghty, Godfrey Mugoti	Complete	7 Aug 2025
2 Oct 2025	The Board agreed that the Teaching Hospital Status update is a major agenda item and requires ongoing attention and balance. Action: GM to update work plan.	Work plan updated for Teaching Hospital Update to come to Board every 2 months. Next update is expected in November Strategic session.	Godfrey Mugoti	Complete	7 Aug 2025
2 Oct 2025	The Board asked if scoring could be reviewed for Risk 2557 regarding space and facilities.	Risk reviewed in September, no change in scoring.	Lorraine Burnett, Godfrey Mugoti	Complete	7 Aug 2025
5 Feb 2026	The Board agreed on the need for clear communication around the name change (Teaching Hospital Status), with EP tasked with leading this effort. GF raised potential obstacles, and the Board reiterated the importance of strategic support and endorsement at all levels. MR expressed concern about the concept of rebranding, cautioning that communication must make it clear that the initiative is not just about medical teaching, but also about, all Directorates, PLACE (Patient-Led Assessments of the Care Environment) and supporting the overall health of Barnsley.	Update scheduled for February 2026 Board meeting	Emma Parkes	In progress	7 Aug 2025

2. Culture

To Note

2.1. Staff Story

To Note

Presented by Steve Ned

3. Governance

3.1. Board Assurance

Framework/Corporate Risk Register

For Assurance/Approval

Presented by Peter Walsh



Report to the BoD of Directors			REF:	BoD: 25/10/02/3.1		
SUBJECT:	BOARD ASSURANCE FRAMEWORK and CORPORATE RISK REGISTER					
DATE:	02 October 2025					
PURPOSE:		Tick as applicable			Tick as applicable	
	For decision/ approval	✓		Assurance	✓	
	For review	✓		Governance	✓	
	For information			Strategy		
PREPARED BY:	Peter Walsh, Director of Corporate Affairs Godfrey Mugoti, Deputy Director of Corporate Affairs					
SPONSORED BY:	Peter Walsh, Director of Corporate Affairs					
PRESENTED BY:	Peter Walsh, Director of Corporate Affairs					

STRATEGIC CONTEXT

The Board of Directors is required to ensure there is in place a sound system of internal control and risk management, including the oversight and approval of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

The report aligns with all Strategic Goals:

- **Best for People:** Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26
- **Best for Patients and the Public:** Achieve quality of care consistent with a CQC outstanding rating and perform at top quartile in patient experience surveys by 2028/29.
- **Best for Performance:** Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29 delivered by the following key priorities for 2025/26.
- **Best for Partners:** Work with our partners to deliver the Integrated Care Partnership Strategy and Joint Forward Plan across South Yorkshire including an increased collaboration with TRFT in 2025/26
- **Best for Place:** We will continue to work with partners across place with a commitment to improving population health, reduce health inequalities supporting delivery of key Place priorities in 2025/26
- **Best for Planet:** Deliver energy efficiencies and refinement of plans in 2025/26 to enable a platform to make meaningful progress against the ambition for 80% reduction in direct emissions between 2028 and 2032

EXECUTIVE SUMMARY

This report provides an update following the reviews of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) that have been held throughout September 2025. The risks were reviewed in a series of meetings held with the Executive Directors/Risk Leads to ensure that they accurately reflect the current position. In addition, the BAF and CRR were discussed at the Executive Team Meeting (ETM) on 10 September, People Committee on 23rd September, Quality and Governance Committee on 24th of September and Finance and Performance Committee on 25th of

September 2025.

All changes made to both documents since the last presentation are shown in appendix 1 and 2 highlighted in in red text for ease of reference.

RECOMMENDATION

The Board of Directors is asked to:

- Receive and discuss the current position in relation to the BAF and CRR, noting the reviews of the risks that have been completed since the presentation to Board meeting in August 2025.
- Approve the proposed Increase of residual risk score for Risk 1713 from 12 to sixteen.
- Approve the proposed Increase of residual risk score for Risk 2527 from 8 to twelve.
- Agree to new score increase for risk 2695 to 15 and escalation to the Corporate Risk Register.
- Approve the updated Board Assurance Framework and Corporate Risk Register.

Introduction

The following report illustrates the position in relation to the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) for September 2025 both of which have been reviewed in conjunction with the relevant Executive Director/Risk Leads.

1. Board Assurance Framework (BAF)

- 1.1 Details of the current BAF risks can be found in Appendix 1, with updates provided in red text for ease of reference. There is a total of 13 BAF risks and the Board will note that there are three BAF risks scored as extreme (two at 16 and one at 15) and Three scored as high (12). The Board will note that the remaining BAF risks are scored at 4, 6, 8 and 9.

- 1.2 The table below illustrates the high-level summary of the BAF Risks scoring 12 and above.

Risk	Previous Score (July 2025)	Current Score (September 2025)	Update
2845: Inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	No change
1713: Inability to deliver the in-year financial plan	12	~~12~~ 16	Proposed Score increase to 16
2592: Inability to deliver constitutional and other regulatory	20	20	No Change
2557: Lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	16	16	No Change
2527: Risk of failure to develop effective partnerships	8	12	Proposed Score increase to 12.
2122: Risk of computer systems failing due to a cyber security incident	12	12	No change
2605: Risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities	12	12	No change

A number of updates have been made to the risks, with two changes being recommended to the residual risk score as detailed below:

Risk 1713: Risk There is a risk of failing to deliver the in-year financial plan, (excluding non-recurrent deficit support funding), includes any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.

- Following a discussion at the F&P Committee and BoD where it was recommended that risk score be reviewed for a potential increase to 20
- Following review by the Chief Finance Officer, it was recommended to increase the residual risk score to 16 (4 x 4).
- Decision on continuation of receiving deficit support funding is expected following submission of month 5 actuals.

Risk 2527: There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.

- From a Place perspective, no reduction in demand has been observed.
- This continues to negatively affect both four-hour performance and bed availability.
- Following a review of the risk with the Managing team, it is recommended that the residual risk score be increased to 12 (4 x 3).

2. Corporate Risk Register (CRR)

2.1 The Trust currently has a total of 7 risks on the CRR scoring 15 Or above, details of which can be found in Appendix 2.

2.2 The table below illustrates the high-level summary of the CRR.

Corporate Risk (Risk scoring 15+)	Previous Score (July 2025)	Current Score (September 2025)	Update
2592: Inability to deliver constitutional and other regulatory performance or waiting time targets	20	20	No Change
3014: Risk of lack of Clinical Leadership and inability to meet service demands within OMFS Services	15	15	No change
2557: Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services	16	16	No Change
1199: Inability to control workforce costs	16	16	No Change
1713: Risk regarding inability to deliver the in-year financial plan	12	16	Proposed score increase to 16
2845: Inability to improve the financial stability of the Trust over the next two to five years	16	16	No change
Risk 2695: Risk of failure to reduce hospital acquired Clostridioides difficile infection	12	15	Proposed score increase from 12 to 15.

A number of updates have been made to the risks, with two changes being recommended to the residual risk scores as detailed below.

Key highlights from CRR reviews:

Risk 1713: There is a risk of failing to deliver the in-year financial plan, (excluding non-recurrent deficit support funding), includes any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action.

- There was a discussion at the F&P Committee and BoD in August where it was recommended that an increase to the risk score.
- Following review by the Chief Finance Officer, it was recommended to increase the residual risk score to 16 (4 x 4).
- Decision on continuation of receiving deficit support funding is expected following submission of month 5 actuals.

Risk 2695: There is a risk of patient safety, reputational damage to the Trust and potential financial implications caused by a breach in the hospital acquired C.difficile infection threshold (avoidable and unavoidable), set by NHSEI

- Following review by Director of Nursing and Assistant Director of Infection Prevention and Control, an increase in C. diff cases in quarter one compared to the previous quarter was noted, though there were two fewer cases than the same quarter last year.

- The risk was presented and approved at QRP on 05.08.25 where the score was approved at 15, with agreement that this reflects the seriousness and political sensitivity of the issue.
- Controls and actions updated.
- Risk escalated to the Corporate Risk Register.

3. Recommendations

- The Board of Directors is asked to:
- Receive and discuss the current position in relation to the BAF and CRR, noting the reviews of the risks that have been completed since the presentation to Board meeting in August 2025.
- Approve the proposed Increase of residual risk score for Risk 1713 from 12 to sixteen.
- Approve the proposed Increase of residual risk score for Risk 2527 from 8 to twelve.
- Agree to new score increase for risk 2695 to 15 and escalation to the Corporate Risk Register.
- Approve the updated Board Assurance Framework and Corporate Risk Register.



Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)

September 2025

Strategic Objectives 2025/26	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.	9	Workforce / Staff Engagement	Director of People	Current
Best for People	2596	Risk of inadequate support for culture, leadership and organisational development	Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.	8	Workforce / Staff Engagement	Director of People	Current
Best for People	2598	Risk of inadequate health and wellbeing support for staff	Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.	4	Workforce / Staff Engagement	Director of People	Current
Best for Patients and the Public	2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time	Achieve quality of care consistent with a CQC outstanding rating and perform at top quartile in patient experience surveys by 2028/29.	20	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	16	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance -	2595	Risk regarding the potential disruption of digital transformation	OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	8	Clinical Safety	Director of ICT	Current
Best for Performance -	2122	Risk of computer systems failing due to a cyber securityincident	OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	12	Clinical Safety	Director of ICT	Current
Best for Performance	1713	Risk regarding inability to deliver the in-year financial plan	Deliver our services in line with our board agreed financial plan during 2025/26 whilst developing plans to return to a recurrent sustainable balanced break even position by 2028/29.	~~12~~ 16	Finance / Valuefor Money	Chief Finance Officer	Current
Best for Performance	2845	Inability to improve the financial stability of the Trust over the next 2 to 5 years	Deliver our services in line with our board agreed financial plan during 2025/26 whilst developing plans to return to a recurrent sustainable balanced break even position by 2028/29.	16	Finance / Valuefor Money	Chief Finance Officer	Current
Best for Partner	2527	Risk of failure to develop effective partnerships	Work with our partners to deliver the Integrated Care Partnership Strategy and Joint Forward Plan across South Yorkshire including an increased collaboration with TRFT in 2025/26.	4 x 3 (12) 4x2 (8)	Partnerships	Managing Director of BHNFT	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will continue to work with partners across place with a commitment to improving population health, reduce health inequalities supporting delivery of key Place priorities in 2025/26.	12	Clinical Safety / Patient Experience / Partnerships	Managing Director of BHNFT	Current
Best for Planet	2827	Risk of the Trust impact on the environment	Deliver energy efficiencies and refinement of plans in 2025/26 to enable a platform to make meaningful progress against the ambition for 80% reduction in direct emissions between 2028 and 2032	8	Environmental	Managing Director of BHNFT	Current
Best for Place	1693	Risk of inability to maintain apositive reputation for the Trust	We will continue to work with partners across place with a commitment to improving population health, reduce health inequalities supporting delivery of key Place priorities in 2025/26.	6	Reputation	Director of Communicationsand Marketing	Current

Highlighted above are risks scoring 12+
Highlighted above are risks scoring 15+
Proposed for Closure
NEW Proposed

BAF Risk Profile

Risk profile					
Consequence → Likelihood ↓	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost certain			2592—performance- &-targets	2592 - performance & targets	
4 Likely				2845 – long-term financial stability 2557 - lack of space 1713 – in year financial plan	
3 Possible			1201 - recruitment and retention	2122 - cyber security 2605 - health inequalities 2827 – Environmental risk 2527 - effective partnerships	
2 Unlikely		2598 – staff health and wellbeing	1693 - Trust Reputation	2596 - staff development 2595 - digital transformation 2527 - effective partnerships 2827 – Environmental risk 2527 –effective- partnerships	
1 Rare					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 2025/26

Category	Relative Willingness to Accept Risk					
	Avoid 1	Minimal 2	Cautious 3	Open 3	Seek 4	Mature 5
Commercial						
Clinical Safety						
Patient experience						
Clinical Effectiveness						
People						
Reputation						
Finance/value for money						
Regulatory/compliance						
Partnerships						
Innovation						
Planet						

Assessment	Description of Potential Effect
LOWEST THRESHOLD	
Zero Risk Appetite Score – 1 AVOID	The Trust Board seeks to avoid risks under any circumstances that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Low Risk Appetite Score – 2 MINIMAL	The Trust Board seeks to avoid risks (expect in very exceptional circumstances) that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Moderate Risk Appetite Score – 3 CAUTIOUS / OPEN	The Trust Board is willing to accept some risks in certain circumstances that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
High Risk Appetite Score – 4 SEEK	The Trust Board is willing to accept risks that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
UPPER THRESHOLD	
Very High-Risk Appetite Score – 5 MATURE	The Trust Board accepts risks that are likely to result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

Appendix 1

Risk Appetite and Tolerance Key

Risk Appetite Scale

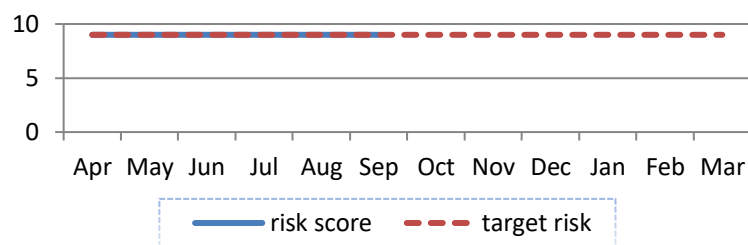
Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

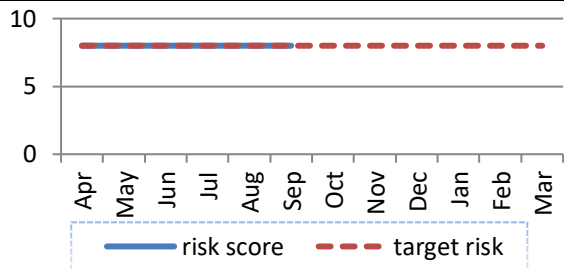
Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

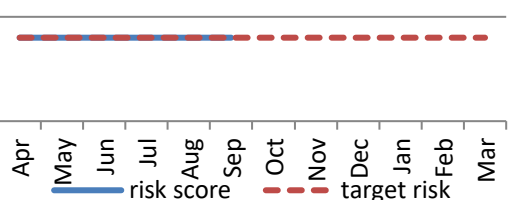
Risk domain	Risk Appetite level
Commercial	SEEK
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	CAUTIOUS
People	OPEN
Reputation	OPEN
Finance / Value for Money	SEEK
Regulatory / Compliance	MINIMAL
Partnerships	SEEK
Innovation	SEEK
Planet	SEEK

CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26						
Strategic Objective 2025/26: Best for People	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks
				The risk score is consequence x likelihood			
Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.	1201	People Committee	Director of People	3x4 (12)	3x3 (9)	3x3 (9)	2334 - nursing staff shortages 2572 - availability of Consultant Anaesthetist hours
Risk Description	Risk Score Movement			Interdependencies			
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, and organisational and talent management due to a lack of financial and human resources this will result in an inability to recruit, retain and motivate staff				Population health needs, service requirements competing organisations, financial pressures, nurse staffing (see risk nursing shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided.			
				Risk Update/Progress Notes			
				September: Following the risk review, no change has been made to the residual risk score of 9. In August 2025, the vacancy rate was reported at 4.17%.			
Risk Appetite				Risk Tolerance			
Open (Workforce / Staff Engagement)				Treat			
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in control			
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	September 2025	November 2025	E Lavery	None identified.			
2. Workforce Planning Steering Group with representation from operational areas of the Trust (ADOs, apprenticeships, nursing, medical, etc.) has the CBU workforce planning packs to provide data for decision-making. The group monitors workforce KPIs including recruitment, supply, capacity and demand, etc.	September 2025	November 2025	E Lavery	None identified.			
3. Staff Redeployment, Staff Recruitment & Retention, Flexible Retirement, Staff Internal Transfer Scheme, Health & Wellbeing, Flexible Working, Rostering, Family Friendly Policies and Procedures	September 2025	November 2025	E Lavery	None identified.			
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	September 2025	November 2025	E Lavery	None identified			
5. Staff nurse recruitment action plan, including recruitment to Trainee Nurse Associate posts and careers pipeline for Nursing Associates to undertake Registered Nurse training through apprenticeship programmes. This action plan is overseen by the Nursing Workforce Group, which oversees nursing workforce numbers, student nurses, nursing vacancy gaps, international recruitment, and standardised newly qualified staff nurse recruitment process across the ICS resulting in successful appointments to increased establishment.	September 2025	November 2025	E Lavery	Continuance of recruitment reliant on successful pipeline.			
6. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5 Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development.	September 2025	November 2025	E Lavery	None identified.			
7. Staff Survey Results – positive results for 2024 which may have a positive impact on recruitment and retention at the Trust.	September 2025	November 2025	E Lavery	None identified.			
8. The Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved Delivery of the strategy is regularly progressed through the Proud to Care Cultural Leadership Group.	September 2025	November 2025	E Lavery	None identified.			
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Received By		Assurance Rating	Gaps in Assurance			
L1 Control 1: National Operational Workforce Plan submission to ICB (annually)	April 2025	Workforce Planning Steering Group	Full	None identified.			
L1 Control 2: Annual CBU Workforce Plans	April 2024	Workforce Planning Steering Group	Full	None identified.			
L1 Control 3: Quarterly Recruitment Metrics Report	August 2024	People & Engagement Group	Full	None identified.			
L2 Control 4 and 5: Nurse Staffing Report	September 2025	People Committee	Full	None identified.			
L2 Control 6: Workforce Insights Report	September 2025	People Committee	Full	None identified.			
L3 Control 7: Staff Survey Results 2024	March 2025	People Committee Board of Directors	Full	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.			
L2 Control 8: Culture and OD Strategy	November 2024	People Committee Board of Directors – to be removed	Full	None identified.			
L3 Control 3: Recruitment and Onboarding Internal Audit report	November 2024	People Committee	Limited	Nine recommended audit actions were given and agreed for completion all completed in May 2025.			
Corrective Actions Required (include start date)				Action Start Date	Action Status	Action Owner	Forecast Completion Date
Control 1: Collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible e.g. The Trust is part of the ICS approach to international recruitment.				N/A	Ongoing	S Ned	2039
Control 4: An Associate Medical Director has been appointed for a 12 months fixed term, and will be responsible for the development of the strategy.					Completed	S Enright	
Control 5: Talent Management and Succession planning framework – see BAF Risk 2596 relating to workforce development. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.				April 2025	In progress	T Spackman	March 2027
Control 8: Proud to Care Cultural Leadership delivery group has been formed to oversee the delivery of the strategy.					Completed June 2024	T Spackman	
Control 3: Internal Audit Action Plan for Recruitment and Onboarding presented to the People and Audit Committees.				April 2024	Completed	Emma Lavery Andrew Wiles	May 2025

CURRENT		BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for People		Risk Ref:	Oversight Committee		Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks
						The risk score is consequence x likelihood			
Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.		2596	People Committee		Director of People	4x3 (12)	4x2 (8)	4x2 (8)	1201 - staff recruitment and retention 2598 - staff wellbeing
Risk Description		Risk Score Movement			Interdependencies				
Risk of inadequate support for culture, leadership and organisational development. There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to succession planning, staff development and leadership development, resulting in poor recruitment and retention and staff engagement.					Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff.				
					Risk Update/Progress Notes				
					September 2025: Following review of the risk, no change has been made to the residual risk score of 8. In August 2025, cumulative turnover was 7.6%, mandatory training 92.3% and appraisals 85.9%. The appraisal cycle ran between April – June.				
Risk Appetite					Risk Tolerance				
Open (Workforce/Staff Engagement)					Treat				
Controls		Last Review Date	Next Review Date	Reviewed by	Gaps in Control				
1. Appropriate staff development programmes in place e.g. Apprenticeship Schemes, Advanced Clinical Practitioner Training Programmes, Trainee Nurse Associate Training Programme. This will support development and upskilling.		September 2025	November 2025	E Lavery	None identified.				
2. Nursing Workforce Development Programme. Current key actions on the plan include increased clinical placements and increased numbers of nurses and non-registered clinical support staff accessing apprenticeships and training through Universities and the Open University.		September 2025	November 2025	E Lavery	Local opportunities for non-registered staff continue to be developed through open university/university of Sheffield – degree apprenticeships.				
3. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing leadership and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high-quality services and patient care and by ensuring that structures are in place to enable their effective delivery.		September 2025	November 2025	E Lavery	None identified.				
4. Training needs analysis model – an annual programme focused on mandatory and statutory essential training, which supports staff development and capability.		September 2025	November 2025	E Lavery	None identified.				
5. Appraisal and PDPs schedule – there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has been updated and rolled out.		September 2025	November 2025	E Lavery	None identified.				
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.		September 2025	November 2025	S Ned	None identified.				
7. Commissioning and completion of externally facilitated Board development programme.		September 2025	November 2025	S Ned	None identified.				
8. Staff Survey Results – positive results for 2024 which may have a positive impact on recruitment and retention.		September 2025	November 2025	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.				
9. Successfully recruited and appointed a People Promise Manager in April 2024, on a 12 month secondment as part of the People Promise Exemplar National Programme. A bid to the Charity has been successful to extend the People Promise manager for a further 12 months.		September 2025	November 2025	E Lavery	None identified.				
10. Annual Calendar – diversity events and staff network activity. Thrive Together Conference held in June 2025 to share stories and to showcase the power of staff networks and international nurses' achievements. Anti-racist framework assessment and action plan towards accreditation commenced in July 2025.		September 2025	November 2025	E Lavery	None identified.				
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent		Last Received	Received By	Assurance Rating	Gaps in Assurance				
L2 Control 1 and 2: Annual apprenticeship report		March 2025	People Committee	Full	None identified.				
L2 Control 2: Nurse staffing report		September 2025	People Committee	Full	None identified.				
L2 Control 3: Workforce Insights Report		September 2025	People Committee	Full	None identified.				
L2 Control 3 and 8: Staff Survey		March 2025	Board of Directors Assurance Committees	Full	None identified.				
L1 Control 3 and 8: Pulse checks		July 2024	People & Engagement Group	Full	None identified.				
L2 Control 3 and 8: HHE Training Doctors Quality Assurance Report		November 2024	Board of Directors Assurance Committees	Full	None identified.				
L2 Control 3: Proud to Care Cultural Leadership Group; commencing in July 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).		September 2025	People Committee	Full	None identified.				
L1 Control 4: Mandatory and statutory training approval panel		September 2025	Executive Team	Full	None identified.				
L1 Control 5: Weekly Appraisal and Mandatory Training compliance reports		September 2025	Executive Team	Full	None identified.				
L1 Control 10: Staff Network Update Report.		July 2025	People & Engagement Group	Full	None identified.				

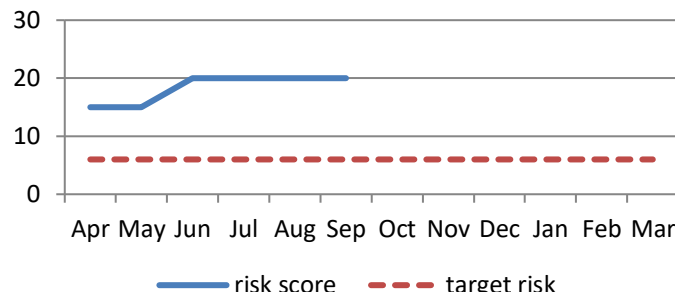
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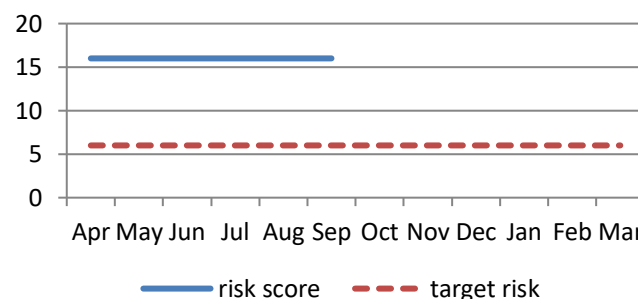
L3 Control 4: Mandatory Training Internal Audit Report	October 2024	Executive Team	Full	None identified.				
L2 Control 3: Guardian of safe working reports	July 2025	People Committee Executive Team Board of Directors	Partial	Junior doctors' accommodation and exception reporting				
L2 Control 10, Anti-Racist Framework Self- assessment and action plan	July 2025	People Committee	Full	None identified				
L1, Control 8, Staff Survey Internal Audit Report	April 2025	Executive Team	Partial	Variable practice found at a local level for developing action plans in response to staff survey results.				
Corrective Actions Required (include start date)					Action Start Date	Action Status	Action Owner	Forecast Completion Date
Control 1: Delivery of the Nursing Workforce Development Plan .					N/A	In progress	B Hoskins	Ongoing
Control 2: Talent Management & Succession planning & leadership development framework. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.					April 2025	In progress	T Spackman	March 2027
Control 3: New Proud to Care Cultural Leadership Group has been formed to oversee the delivery of the strategy.					May 2024	Completed June 2024	T Spackman	
Control 8, People and Engagement Group Forward Planner has been updated to receive CBU and Corporate areas staff survey action plans					May 2025	In Progress	E Lavery	September 2025

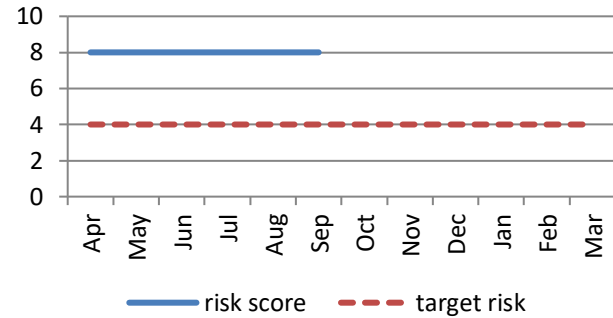
CURRENT				BOARD ASSURANCE FRAMEWORK 2025/26						
Strategic Objective 2025/26: Best for People				Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks
							The risk score is consequence x likelihood			
Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26.				2598	People Committee	Director of People	4x3 (12)	4x1 (4)	4x1 (4)	1201 – staff recruitment and retention
Risk Description				Risk Score Movement			Interdependencies			
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer, due to lack of investment, leading to reduced staff morale, negative impact on health and wellbeing with an adverse impact on staff retention and recruitment.							The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge.			
							Risk Update/Progress Notes			
							September 2025: Following review of the risk, no change has been made to the residual risk score of 4.			
Risk Appetite							Risk Tolerance			
Open (Workforce/Staff Engagement)							Treat			
Controls				Last Review Date	Next Review Date	Reviewed by	Gaps in Control			
1. The Occupational Health and Inclusion and Wellbeing Services have been re-organised to provide two distinct services;1 Occupational Health and Wellbeing Service and 2. Equality, Diversity and Inclusion). This will enable a greater focus on the health and wellbeing offer to staff. Staff can access counselling and/or psychological support services, and can self-refer to occupational health where needed. The Trust has also introduced 'Wage stream' and salary finance – financial support products for staff to address any financial concerns. Quarterly People Pulse checks have commenced to better measure progress against key metrics from the staff survey, which includes the impact on staff wellness. Annual Culture metrics dashboard to measure staff experience and wellbeing and organisational culture has been approved at the People Committee in September 2022. A quarterly H&WB activity dashboard is also presented to the People & Engagement Group. An ICB Health and Wellbeing bid has been awarded to the Trust to pilot the Flourish DX digital stress risk assessment tool.				September 2025	November 2025	E Lavery	None identified.			
2. People Strategy – a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery.				September 2025	November 2025	E Lavery	None identified.			
3.The Trust is also working with the ICS to access wider sources of health and wellbeing support. The SYB ICS Mental Health & Wellbeing hub of online resources, materialsand training courses has been made available to all staff. The Trust has also appointed an Occupational Psychologist post in partnership with Rotherham Trust in February 2023 for a period of 2 years funded by NHS national charities funds. Funding has been agreed for a two year extension by Barnsley Hospital Charities effective from February 2025. The ICS Occupational Health and Wellbeing Road Map, which is a 3 year plan, was launched in April 2024 to support the delivery of the national Growing Occupational Health and Wellbeing Together Strategy. Acute distressing event policy including trauma management practitioners recently supported				September 2025	November 2025	E Lavery	None identified.			
4. The Trust has approved the adoption of the Standards Framework for Counsellors & CounsellingServices for BHNFT and partners to strengthen the wellbeing support offered. An agreement has also been reached to extend the Schwartz Rounds contract for an additional 3 years. The Schwartz Rounds steering group has been re-instated and the programme of Schwartz Rounds sessions agreed and commenced.				September 2025	November 2025	E Lavery	None identified.			
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicatedoversight and assurance that the staff health and wellbeing agenda has a Board level champion. A non-executive director has commenced in the role on 01/10/21.				September 2025	November 2025	E Lavery	None identified.			
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.				September 2025	November 2025	E Lavery	None identified.			
7. Commissioning and completion of externally facilitated Board Development Programme.				September 2025	November 2025	E Lavery	None identified.			
8. The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff.				September 2025	November 2025	E Lavery	None identified.			
9. Staff Survey Results – positive results for 2024 which may have a positive impact on recruitment and retention.				September 2025	November 2025	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.			
10. Annual review and submission of CBU work plans. Work is in progress with the ICB to review the work plans.				September 2025	November 2025	E Lavery	Work in progress.			
11.Health and Wellbeing Survey carried out, closed in May 2024. Results and analysis shared at People & Engagement Group in September 2024 to act upon. Analysis to be taken forward as part of the new health and wellbeing strategy in which is in development. The final draft of the People Health and Wellbeing strategy will be presented to the People Committee in July for approval.				September 2025	November 2025	E Lavery	Work in progress.			
12. Occupational Health User Survey.				September 2025	November 2025	E Lavery	None identified.			
Assurances Received: L1 Operational, L2 Board Oversight, L3 Independent				Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance			
L1 Control 1, 3 and 4: H&WB activity dashboard				April 2025	People & Engagement Group	Full	None identified.			
L1 Control 1, 3, 4 and 8: Bi-Monthly Occupational Health Activity Dashboard				August 2025	People & Engagement Group	Full	None identified.			
L1 Control 1: Pulse checks				July 2024	People & Engagement Group	Full	None identified.			
L2 Control 1 and 5: Health and Wellbeing Annual Report				May 2024	People Committee Executive Team	Full	None identified.			
L2 Control 2 Proud to Care Cultural Leadership Group; commenced in June 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).				September 2025	People & Engagement Group Board of Directors	Full	None identified.			
L2 Control 2: Workforce Insights Report				September 2025	People Committee	Full	None identified.			
L2 Control 2, 6 and 7: The Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved				November – December 2023	People Committee Board of	Full	None identified.			

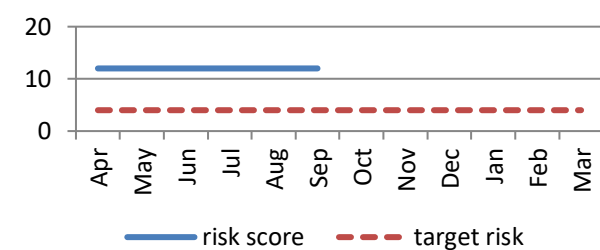
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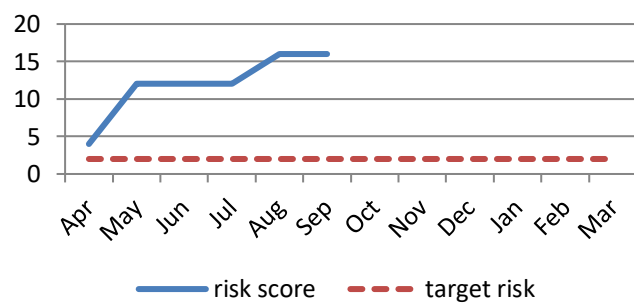
		Directors						
L2 Control 9: Staff Survey	March 25	Board of Directors Assurance Committees	Full	None identified.				
L1 Control 10: CBU Workforce Plans	April 2024	Clinical Business Unit: Performance Review Meetings	Full	None identified.				
L2 Control 11, -People Health and Wellbeing Strategy	July 2025	People Committee	Full	None Identified				
Corrective Actions Required (include start date)				Action Start Date	Action Status	Action Owner	Forecast Completion Date	
Control 2: New Proud to Care Cultural Leadership Group is being formed to oversee the delivery of the strategy				December 2023	Completed	T Spackman	April 2024	
Control 9: Staff survey results action plan agreed and being delivered.				April 2024	Completed	S Ned	September 2025	
Control 11 New operational plan, is being formed to oversee the delivery of the strategy.				July 2025	In Progress	M Shanaghey	July 2027	

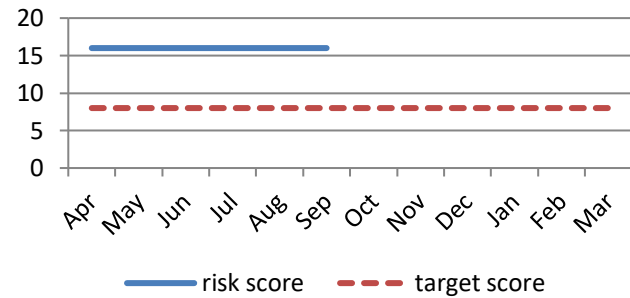
CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26						
Strategic Objective 2025/26: Best for Patients and The Public	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks
				The risk score is consequence x likelihood			
Achieve quality of care consistent with a CQC outstanding rating and perform at top quartile in patient experience surveys by 2028/29.	2592	Finance and Performance Committee	Chief Operating Officer	3x5 (15)	4x5 (20)	2x3 (6)	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement
Risk Description	Risk Score Movement			Interdependencies			
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets ~~There is a risk of patient harm due to the Trust not delivering against operational plans, as agreed in April 2025. failure or delay in patient diagnoses and/or treatment due to the Trust's inability to consistently meet planned performance trajectories aligned to regulatory standards and waiting time expectations.~~	 — risk score - - - target risk			Uncertainties surrounding the continuing industrial action alongside seasonal pressures and a backlog from the pandemic is impacting on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2023/24 are aligned to but not reflective of constitutional target delivery. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. There is an inter-dependency regarding the interrelationship between organisational and system-level management			
				Risk Update/Progress Notes			
				September 2025: Following review of the risk with the Chief Operating Officer, no change has been made to the residual risk score of 20. The Trust has been placed in tier 2 for Urgent and Emergency Care performance.			
Risk Appetite				Risk Tolerance			
Minimal (Clinical Safety)				Treat			
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control			
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	September 2025	November 2025	L Burnett	None identified.			
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	September 2025	November 2025	L Burnett	None identified.			
3. Monitoring of activity, delivery and performance via systems meetings.	September 2025	November 2025	L Burnett	None identified.			
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	September 2025	November 2025	L Burnett	Work on Health Inequalities was presented to the Finance and Performance Committee in June 2024.			
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	September 2025	November 2025	L Burnett	None identified.			
6. Attendance at ICS and acute federation meetings and contributions to the development of the system position.	September 2025	November 2025	L Burnett	None identified.			
7. Regional Tier 2 oversight meeting – fortnightly.	September 2025	November 2025	L Burnett	Several actions sit external to the Trust and therefore not under direct control, ie, Yorkshire Ambulance Service conveyance, Primary Care Access and Community Support.			
Assurances Received	Last Received	Received By	Assurance Rating	Gaps in Assurance			
L1 Operational, L2 Board Oversight, L3 Independent							
L2 Controls All: IPR report	August 2025	Public Board	Full	None identified.			
L2 Control 1,2, 3: Reports against trajectories	August 2025	Finance & Performance Committee	Partial	A number of actions to enable recovery require involvement of Place & System and are not under the direct control of the Trust.			
L2 Control 1, 2, 3, 4: Quality Metric Reports	August 2025	Finance & Performance/ Quality & Governance Committees/ Board of Directors	Full	None identified.			
L2 Control 2: Progress reports - annual business plan	August 2025	Finance & Performance Committee	Partial	None identified.			
L2 Control 2,3 6: NHSI/E reports	August 2025	Executive Team	Partial	None identified.			
L2 Control 3: Report to Trust Board – via Committee Chair's logs Activity Recovery Plans 2023/24 and further updates to assurance committees	December 2024	Finance & Performance/ People/ Quality & Governance Committees	Full	None identified.			
L2 Control 6: Benchmarking reports through ICBS-	August 2025	Finance & Performance Committee	Full	None identified.			
Corrective Actions Required (include start date)				Action start Date	Action Status	Action Owner	Forecast Completion Date
Control 2 and Assurance 5: Adapt performance reporting so that they provide the right assurances on what the Trust has committed to deliver. Started January 21. Incorporate system and place reporting when available				May 2023 August 2025	Completed ongoing	L Burnett/ T Davidson	March 2026
Control 2: Capacity gaps identified in business planning and additional activity requirements discussed with the Finance Director. -Report quarterly to the Executive Team and Report to the Executive Team and Finance & Performance Committee against recovery trajectory and any mitigation, by exception.				May 2023 August 2025	Completed - ongoing	S Garside	April 2026
Control 2 and Assurance 5 & 7: operational exec to ensure robust plans during periods of industrial action to ensure essential staff cover and report on impact to recovery trajectories				March 2023 July 2025	Completed Under review	L Burnett/ Dr S Enright	
Control 4: Clinical exec leads to ensure an appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21-				February 2021 June 2025	Complete — June 2024	Dr S Enright	
Control 5: External support to UEC Pathways and 4-hour performance				July 2025	In progress	L Burnett	December 2025

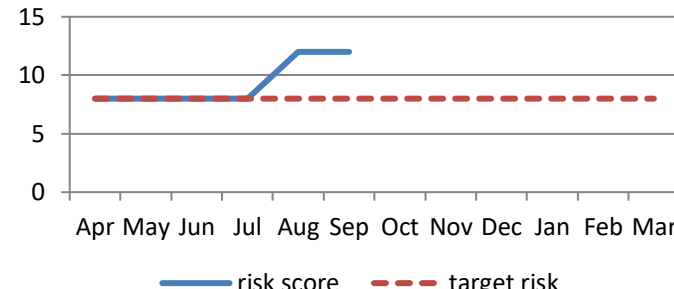
CURRENT		BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Performance	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks		
				The risk score is consequence x likelihood					
OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	2557	Finance and Performance Committee	Chief Operating Officer	4x4 (16)	4x4 (16)	1x2 (2)	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme		
Risk Description	Risk Score Movement			Interdependencies					
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.				There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. Thisrisk is also interdependent on capital finance, digital transformation, and may impact on the trusts ability to deliver the services within the trust 5-year strategy. There is an inter-dependency related to estates work with Barnsley 'place					
				Risk Update/Progress Notes					
				September 2025: Following review of the risk with the Chief Operating Officer, no change has been made to the residual risk score of 16.					
Risk Appetite				Risk Tolerance					
Cautious (Patient Experience)				Treat					
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control					
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	September 2025	November 2025	L Burnett	None identified.					
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	September 2025	November 2025	L Burnett	~~None identified.~~ No current plan for Hilder House.					
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	September 2025	November 2025	L Burnett	None identified.					
4. Space Utilisation Group	September 2025	November 2025	L Burnett	None identified.					
5. Contracts and SLAs between the Trust and BFS	September 2025	November 2025	L Burnett	Review of outpatient pharmacy SLA.					
6. EDMS Project (reduce paper in the Trust and in turn, release space)	September 2025	November 2025	T Davidson	Awaiting completion of project & space release. No space released.					
7. Trust 5-year strategy	September 2025	November 2025	M Wright	None identified.					
8. Development of a frailty same day emergency care unit. ~~Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce the need for inpatient beds~~	September 2025	November 2025	L Burnett	Increased demand for urgent and emergency care against previous year.					
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	September 2025	November 2025	L Burnett	None identified.					
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	September 2025	November 2025	L Burnett	None identified. Suspended until October 2025 due to Senior Management development					
~~11. Bed reconfiguration programme to increase medical bed capacity~~	September 2025	November 2025	~~L Burnett~~	~~None identified.~~					
12 Health on the High Street: development off-site facilities for out-patient services	September 2025	November 2025	M Wright	None identified.					
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance					
L1: Controls All: Regular agenda item on ET	September 2025	Executive Team	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated, business cases expected to include space requirements and plans to provide.					
L1, Control 1, 2, 4, 5: BFS performance chairs log	August 2025	Finance & Performance Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated.					
L1, Control 1, 3, 5, 8, 11, 12: Monthly performance meeting regular agenda item ~~Trust Ops regular agenda item~~	August 2025	Clinical Business Units: Performance Meetings and Finance & Performance Committee	Full	None identified.					
~~L3, Control 7, 8, 12: Item on agendas at Barnsley Place meetings, UECB, planned care & ICP~~	February 2025	~~Place Partnership Delivery Group~~	Full	~~Awaiting business case approval for the intermediate care unit.~~					
Corrective Actions Required (include start date)					Action Start Date	Action Status	Action Owner	Forecast Completion Date	
Control 2: Further review of services that could move off-site or work from home					February 2024	Complete	L Burnett/ S Garside	February 2024	
Control 2: Development of the community diagnostic Centre					February 2024	Complete	L Burnett/ R McCubbin	February 2024	
Control 8: Increase agreed to medical bed base utilizing available ward areas following CCU move					September 2023	Complete	L Burnett		
Control 7, 8, 12: Assurance: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan					June 23	Ongoing	R McCubbin	April 2026	
Control 1, 7, 9 and 12: Development of full business case related to Health on the High Street					July 2024	Complete	S Garside	October 2024	
Control 1, 2 and 7: Executive Team to develop options for utilisation of Hilder House					August 2025	On going	R McCubbin	December 2025	

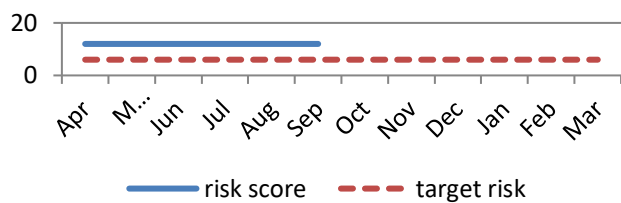
CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Performance	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks	
				The risk score is consequence x likelihood				
OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	2595	Finance and Performance Committee	Director of ICT	4x2 (8)	4x2 (8)	4x1 (4)	1693 - adverse reputational damage to the Trust1 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients - risk closed 2098 - Transformation digital programme – risk closed	
Risk Description	Risk Score Movement			Interdependencies				
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safely and effectively, there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: – Poor understanding and misalignment of the changes to clinical processes,resulting in harm to patients. – Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. – -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. – Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.				BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery.				
				Risk Update/Progress Notes				
				September 2025: Following review of the risk with the Director of ICT, no change has been made to the residual risk score of 12.				
Risk Appetite				Risk Tolerance				
Seek				Treat				
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control				
1. Effective governance via the Digital Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	September 2025	November 2025	Director of ICT	Clinical Risks associated with a fragmented record split across multiple digital health care record systems.				
2. Effective training, project delivery, communications and engagement with all staff in line with an approved project initiation document. Full approval to proceed process with all stakeholders.	September 2025	November 2025	Director of ICT	Potential impacts of external factors such as cybersecurity impacts on infrastructure and therefore delivery (outside of the Trust's control). Challenge with System C, EPR supplier's capability to deliver projects.				
3. External review of processes and implementations via 360 Assurance.	September 2025	November 2025	Director of ICT	None identified.				
4. Digital Transformation Strategy	September 2025	November 2025	Director of ICT	It is not possible for the Strategy to manage unforeseen disruption and clinical risks.				
5.Clinical Workspace launched, which helps coordinate clinical care and reduce the impact of digital transformation disruption	September 2025	November 2025	Director of ICT	None identified.				
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	September 2025	November 2025	Clinical Reference Group/Director ICT	None identified.				
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	September 2025	November 2025	Board of Directors Senior Leaders Group	None identified.				
8. Clinical Digital Safety Group reporting to the Digital Steering Group (which looks at key clinical systems)	September 2025	November 2025	Director of ICT	None identified. Terms of Reference agreed at the Digital Steering Group. TORs presented to F&P in Nov 2023.				
9. Clinical engagement and floor walking support to support a safe and effective transformation from paper to digital.	September 2025	November 2025	Director of ICT	None identified.				
10. Digital Steering Group authorised CBU Governance Teams and Clinical Directors to sign-off on outpatient digital transformation letters.	September 2025	November 2025	Digital Steering Group	Clinical teams need to be reminded of their responsibilities in terms of documenting health care records accurately for their patients.				
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance				
L2 Control 1,5 and 8: Digital Steering Group Chairs Log.	August 2025	Finance & Performance Committee	Full	None identified.				
L2 Control 3: Digital Maturity Assessment – To understand potential gaps in our capability.	January 2025	Finance & Performance Committee	Full	None identified.				
L2 Control 3: Submission of the Digital Maturity Assessment as requested by the Central Team.	January 2025	Finance & Performance Committee	Full	None identified.				
L2 Control 4: Significant Assurance Business Continuity 360 Assurance Audit.	May 2024	Finance & Performance Committee	Full	None identified.				
L2 Control 4, 5 and 8: Quarterly F&P ICT Strategic Update – Digital Transformations in Delivery.	August 2025	Finance & Performance Committee	Full	None identified.				
L2 Control 8: Terms of Reference for the Clinical Digital Safety Group were agreed at the Digital Steering Group, and presented to the F&P Committee for approval.	January 2025	Finance & Performance Committee	Full	None identified.				
Corrective Actions Required (include start date)				Action Start Date		Action Status	Action Owner	Forecast Completion Date
Control 1: Careful monitoring of the programme of digital transformation via all Trust Board Committees.						N/A	Director of ICT	Ongoing
Control 2: Digital Transformation Strategy 5 year plan: 2022 – 2027.				September 2021		N/A	Director of ICT	The completion date will be on the maturity of the strategy.

CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26								
Strategic Objective 2025/26: Best for Performance	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks		
				The risk score is consequence x likelihood					
OPERATIONAL: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/29.	2122	Finance and Performance Committee	Director of ICT	4x2 (8)	4x3 (12)	4x1 (4)	2416 – cyber-security during the pandemic – risk closed 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients – risk closed 2098 - Transformation digital programme – risk closed		
Risk Description	Risk Score Movement			Interdependencies					
Risk regarding Cybersecurity and IT systems resilience If we do not protect the information we hold as a result of ineffective information governance and/or cyber security due to lack of resources there is a risk of the Trust's infrastructure being compromised resulting in the inability to deliver services and patient care resulting in poor outcomes and patient experience. The national heightened status of awareness due to recent cyber security breaches has been reflected as part of the risk assessment.				BAF Risk 1693 - Trust Reputation BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery.					
				Risk Update/Progress Notes					
				September 2025: Following review of the risk with the Director of ICT, no change has been made to the residual risk score of 12.					
Risk Appetite				Risk Tolerance					
Minimal (Clinical Safety)				Treat					
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control					
1. Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally.	September 2025	November 2025	Director of ICT	IT systems and business as usual support continually gets more complex and there are limited resources to ensure the mitigation of all risks.					
2. A regular review of assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment is completed on minor unsupported solutions. A paper was received at ET to approve this approach.	September 2025	November 2025	Director of ICT	None identified.					
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, SIEM solution, Anti-Malware and Patching strategies in place.	September 2025	November 2025	Director of ICT	There are no protections against a zero-day virus. A brand-new virus that cannot be detected by the various scanning techniques. Careful and consistent monitoring of systems needs to be in place through the start of the day checks.					
4. CARECert – Cybersecurity Alerts – for example recent LOG4J alert and remedial actions report to F+P.	September 2025	November 2025	Director of ICT	Full assurance from all suppliers has been sought. Some suppliers have provided workarounds but have not supplied full patches.					
5. Regular briefing and guidance from the South Yorkshire Cyber Security Forum. Relevant actions are implemented.	September 2025	November 2025	Director of ICT	None identified.					
6.. Annual Cybersecurity assessment completed by Certified 3 rd party to ensure all up to date measures are in place.	September 2025	November 2025	Director of ICT	Not all recommendations in the report can be completed; it is a balance of funding/practicality/risk to ensure the most effective cybersecurity controls are implemented.					
7. Cyber Security Assessment Framework review audit completed.	September 2025	November 2025	Director of ICT	None identified.					
8. Review of critical clinical system backups and restore as part of disaster recovery.	September 2025	November 2025	Director of ICT	Considering replacement of backup solution.					
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance					
L2 Control 1: Risk assessment of all cybersecurity and IT risks. Significant Assurance provided from 360 Assurance on out Data Protection Toolkit compliance position – Board approved position.	January 2025	Executive Team Finance and Performance Committee	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.					
L2 Control 3 and 6: Annual Board Cybersecurity Report including Penetration Testing Results.	June 2025 August 2025	Executive Team Finance & Performance Committee Board of Directors	Full	None identified.					
L2 Control 6: Data Protection Tool Kit external audit by ANS, that is part of the South Yorkshire ICS initiative.	June 2025	Executive Team Finance & Performance Committee	Partial	Only covers specific areas of cybersecurity.					
L1 Control 1 and 4, 5: National Cybersecurity active monitoring and reporting frameworks.	January 2025	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-Committees.					
L2 Control 5: Active directory authentication system audit completed by national cyber security commissioned requirement.	January 2025	Executive Team/ Finance & Performance Committee	Full	None identified.					
Corrective Actions Required (include start date)				Action Start Date	Action Status	Action Owner	Forecast Completion Date		
Control 1: Bolster online defences and complete an annual penetration test. Retest on significant infrastructure change.				2020	Ongoing.	ICT Director	The penetration test was completed in May 2025 , the next one is due in May 2026.		
Control 1 and 4. Strategic update report to the Finance and Performance Committee quarterly to manage resources against priorities.				Ongoing	Ongoing	ICT Director			
Control 1: System Vulnerability Test: to be undertaken across the major IT systems within the Trust and ensure the patching regime is fully completed.				2020	Complete	ICT Director	April 2024 – May 2025		
Control 3: Careful and consistent monitoring of systems needs to be in place through start of the day checks and CareCert National Cybersecurity Monitoring.				-2022	Ongoing	ICT Director	Ongoing- Care Certs received monthly		
Control 5: Ensure fully risk-assessed gaps in cybersecurity action plan delivery.				Ongoing	Ongoing	ICT Director			

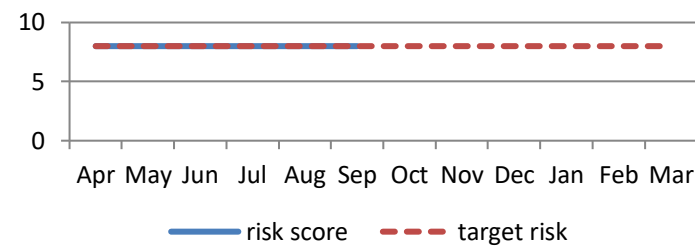
CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Performance	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks	
				The risk score is consequence x likelihood				
Deliver our services in line with our board agreed financial plan during 2025/26 whilst developing plans to return to a recurrent sustainable balanced break even position by 2028/29.	1713	Finance and Performance Committee	Chief Finance Officer	4x5 (20)	4 x 4 (16) 4 x 3 (12)	2x1 (2)	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds	
Risk Description	Risk Score Movement			Interdependencies				
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, (excluding non-recurrent deficit support funding), includes any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.	 — risk score - - - target risk			The activity and demand within the system. The SY ICS financial position. The current financial framework in operation. Covid-19 and recovery pressures.				
				Risk Update/Progress Notes				
				September 2025: There was a discussion at the F&P Committee and BoD where it was recommended that an increase to the risk score. Following review by the Chief Finance Officer, it was recommended to increase the residual risk score to 16 (4 x 4). Decision on continuation of receiving deficit support funding is expected following submission of month 5 actuals.				
Risk Appetite				Risk Tolerance				
Open (Finance / Value for Money)				Treat				
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control				
1. Board owned financial plans.	September 2025	November 2025	Collette Gerraghty	None identified, Board approved final 2024/25 plan in June.				
2. Requirements identified through business planning and budget setting processes and prioritised based on current information.	September 2025	November 2025	Collette Gerraghty	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.				
3. Additional requirements must follow business case process.	September 2025	November 2025	Collette Gerraghty	None identified - well established business case process.				
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings.	September 2025	November 2025	Collette Gerraghty	None identified.				
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans.	September 2025	November 2025	Collette Gerraghty	Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management.				
6. Barnsley Place Efficiency Group established to identify, monitor and support delivery of system opportunities.	September 2025	November 2025	Collette Gerraghty	Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance.				
7. Identification of additional efficiency / spend reduction.	September 2025	November 2025	Collette Gerraghty	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.				
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	September 2025	November 2025	Collette Gerraghty	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.				
9. Tight management of costs, with delegated authority limits, including review of agency usage.	September 2025	November 2025	Collette Gerraghty	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.				
10. Continued discussions with SY ICB.	September 2025	November 2025	Collette Gerraghty	Lack of Trust control over financial performance of external partners. which could have a detrimental impact on the system financial position and ability to receive all available resource allocations, such as non-recurrent deficit support funding.				
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	Received By	Assurance Rating	Gaps in Assurance				
All controls - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P.	September 2025	Finance & Performance Committee	Partial	Pressures arising from recovery, activity increases and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations, and any increased requirements for the system to break-even in the year.				
Corrective Actions Required (include start date)				Action Due Date		Action Status	Action Owner	Forecast Completion Date
Control 2, 6 & 10: Gaps in control are outside the Trust's control.				N/A		N/A	N/A	N/A
Control 7, 9: Urgent identification of additional opportunities required to reduce spend and increase productivity, as well as reviewing what difficult choices the Trust may need to take to improve the financial position.				May 2025		Complete	Chris Thickett	Recovery plan went to the Finance and Performance Committee in June 2025

CURRENT		BOARD ASSURANCE FRAMEWORK 2025/26								
Strategic Objective 2025/26: Best for Performance		Risk Ref:	Oversight Committee		Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks	
						The risk score is consequence x likelihood				
Deliver our services in line with our board agreed financial plan during 2025/26 whilst developing plans to return to a recurrent sustainable balanced break even position by 2028/29.		2845	Finance and Performance Committee		Chief Finance Officer	4x4 (16)	4x4 (16)	4x2 (8)	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability 1791 - Risk regarding insufficient cash funds to meet the operational requirements of the Trust	
Risk Description		Risk Score Movement			Interdependencies					
Inability to improve the financial stability of the Trust over the next two to five years There is a risk that we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit leading to financial instability.					This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability; it is also interdependent with national funding priorities and decisions.					
					Risk Update/Progress Notes					
					September 2025: Following review of the risk, no change has been made to the residual risk score of 16.					
Risk Appetite					Risk Tolerance					
Open (Finance / Value for Money)					Treat					
Controls		Last Review Date	Next Review Date	Reviewed by	Gaps in Control					
1. Board-owned financial plans.		September 2025	November 2025	Collette Gerraghty	None identified.					
2. Achievement of the Trust's in-year financial plan and any control total (see risk 1713).		September 2025	November 2025	Collette Gerraghty	None identified.					
3. Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.		September 2025	November 2025	Collette Gerraghty	None identified.					
4. Delivery of the EPP programme recurrently.		September 2025	November 2025	Collette Gerraghty	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management. The development of a 3 year efficiency programme was included in the financial recovery paper, which was presented to the Finance and Performance Committee in June 2025.					
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.		September 2025	November 2025	Collette Gerraghty	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.					
6. Continued discussions with SY ICB.		September 2025	November 2025	Collette Gerraghty	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.					
7. Potential additional national and/or system resources become available.		September 2025	November 2025	Collette Gerraghty	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process. Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control					
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent		Last Received	Received By	Assurance Rating	Gaps in Assurance					
Control All: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P.		September 2025	Finance & Performance Committee	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations and potential impact on the Trust.					
Corrective Actions Required (include start date)							Action Due Date	Action Status	Action Owner	Forecast Completion Date
Control 6 & 7: Gaps in control are outside the Trust's control.							N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Partners	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks	
				The risk score is consequence x likelihood				
Work with our partners to deliver the Integrated Care Partnership Strategy and Joint Forward Plan across South Yorkshire including an increased collaboration with TRFT in 2025/26.	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3 (12)	4 x 3 (12) 4x2 (8)	4x2 (8)	1693 - adverse reputational damage to the Trust	
Risk Description	Risk Score Movement			Interdependencies				
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.				Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022.				
				Risk Update/Progress Notes				
				September: Following a review of the risk with the Managing team, it is recommended that the residual risk score be increased to 12 (4 x 3), due to the impact on four-hour performance and the non-elective target				
Risk Appetite				Risk Tolerance				
Seek (Partnerships)				Treat				
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control				
1. Trust vision, aims and objectives.	September 2025	November 2025	M Wright	None identified.				
2. Communications and Engagement strategy (Trust approach for collaboration with partners, public, etc.).	September 2025	November 2025	M Wright	None identified.				
3. Membership of partnership forums in Barnsley Place and SYB ICS.	September 2025	November 2025	M Wright	None identified.				
4. Regular meetings with partners, Chair meetings and exec to exec working.	September 2025	November 2025	M Wright	None identified.				
5. Membership of networks and service level agreements.	September 2025	November 2025	M Wright	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance reported to the Finance and Performance Committee in November 2024, with an annual review planned for November 2025.				
6. Review of avoidable attendances in the Emergency Department with partners to agree on alternative models for the front door.	September 2025	November 2025	M Wright	The proposed programme of work across the Barnsley Place Partnership is now underway. ~~has commenced.~~ However, despite its commencement, demand levels have remained high, which has negatively affected Emergency Department four-hour performance.				
7. There is an agreement within the SY AF to do a shared sustainable service review and identify priority service areas that need support or review.	September 2025	November 2025	M Wright	Organisations may not agree to shared solutions once the review is completed. Individual Trusts have shared sustainability reviews with the Acute Federation, Trusts came together in August 2024 to review prioritised opportunities/risks. Sessions have commenced to support collaboration across 6 fragile specialties.				
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance				
Control 1, 3, 4, 6 and 7: regular ET agenda item regarding Barnsley and ICS meetings.	July 2025	Executive Team	Partial	There are concerns regarding Intermediate Care (IMC) Services in the short term due to uncertainty about the future location of the Acorn service. The long-term model for IMC is still yet to be agreed. Concerns alleviated due to short-term relocation of the Acorn Unit into the main hospital, but remains a partial assurance due to the short-term nature of the relocation. Managing Director leading on internal discussions, also capturing Trust Objectives for 2025/26. Two internal meetings have taken place, chaired by Michael Wright, Managing Director.				
Control 1: Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS.	June 2025	Board of Directors	Full	None identified.				
Control 6: There is increased focus on four-hour performance; however, from a Place perspective, no reduction in demand has been observed. This continues to negatively affect both four-hour performance and bed availability.	September	ET/Committees/ Board	Partial	None identified.				
Corrective Actions Required (include start date)					Action Start Date	Action Status	Action Owner	Forecast Completion Date
Control 1: All issues and concerns regarding the Acorn Unit have been escalated to Place Partnership via the Place Board so these issues are understood. The Trust is working as part of a Place Working Group to address these issues, as well as performing an internal Task & Finish Group led by the Managing Director. Regular updates on progress are going to ET and the Board of Directors. All issues and concerns re the intermediate care service – agreed model required during 2025.					1 February 2024	In Progress	M Wright	December 2025
Control 5: Review of unsigned service level agreements and take any necessary actions to address the gap (Control 5). There are no material concerns at the present time Annual review of Service Level Agreement position to F&P.					April 2021	In progress	C Thickett	November 2025, to be reported to the Finance and Performance Committee
Control 6: Working with Place, to support the proposed programme of work across the Barnsley Place Partnership will commence in April 2025. NHS England is now focusing on demand at the Place level, with fortnightly review meetings linked to Tier 2 monitoring of four-hour performance against trajectory					April 2024	In progress	M Wright	March 2027
Control 3: Primary Care Industrial Action: An internal Task and Finish Group-was established to manage this emerging issue. All issues are being raised to Place partners regularly, with the Trust monitoring and taking necessary actions as appropriate. A letter has been sent to the Medical Director for the ICB outlining the Trust's concerns and suggested actions to address them.					September 2024	In progress	M Wright	Unclear how long the industrial action will last

CURRENT		BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Place	Risk Ref:	Oversight Committee	Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks		
				The risk score is consequence x likelihood					
We will continue to work with partners across Place with a commitment to improving population health, reduce health inequalities supporting delivery of key Place priorities in 2025/26.	2605	Quality and Governance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)	2527 - ineffective partnership working 2592 - failure to deliver performance/targets		
Risk Description	Risk Score Movement			Interdependencies					
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes				Wider system pressures, partner organisations' capacity and ability to collaborate, and partners' recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners' priorities and strategies to improve population health. Developing the role of ICS (future ICB) in the management of population health and an emergent strategy for health inequalities.					
There is a risk that we will not take appropriate action to address health inequalities in line with the local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities and improve patient and population health outcomes.				Risk Update/Progress Notes					
				September 2025: Following review of the risk by the Consultant in Public Health, no change has been made to the residual risk score of 12.					
Risk Appetite				Risk Tolerance					
Minimal (Clinical Safety)				Treat					
Controls	Last Review Rate	Next Review Date	Reviewed by	Gaps in Control					
1. Continued engagement with commissioners and ICS developments in clinical service strategies to prioritise, resource and facilitate more action on prevention and health inequalities.	September 2025	November 2025	M Wright Dr S Enright A Snell	Need to improve data quality and sharing to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development. - Financial pressures across the system mean risk to specific investments in reducing inequalities. Approaches to integrating improved data and inequalities into local developments according to the 10 year plan are required.					
2. Partnership working at a more local level, including active participation in the Health Inequalities workstream, which will feed through the Integrated Care Governance (ICDG andup to the ICPG).	September 2025	November 2025	B Kirton Dr S Enright A Snell	Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across Place, to ensure those people at the greatest risk of inequalities are able to access services to the same level as those who do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken. Understanding the primary care's role and capacity to contribute through the alliance continues to be difficult amidst pressures.					
3. All patients on the existing planned care waiting lists and those being booked for new procedures are regularly assessed against the national clinical prioritisation standards (FSSA) as a minimum, taking into consideration individual patient factors pertaining to health inequalities where possible.	September 2025	November 2025	M Wright Dr S Enright A Snell Dr J Bannister	No gaps in clinical prioritisation. Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards was presented to the Clinical Engagement Group and approved. Incorporating inequalities alongside clinical prioritisation remains in the pilot phase through the use of the WHaLES patient treatment list administration tool. Application to other areas, such as outpatients, preassessment and maternity, is only in the exploration phase.					
4. Established population health management team that supports both the Trust and Place, which is also linked to the ICS, led by a Public Health Consultant.	September 2025	November 2025	M Wright A Snell	None identified.					
5. Dedicated population health management team delivering the Healthy Lives Programme covering tobacco and alcohol control.	September 2025	November 2025	M Wright A Snell	None identified.					
6. 35 key actions to influence health inequalities around 3 key factors: establish new services, enhance existing services & develop as an Anchor institution. All within the health Inequalities action plan, including using the vulnerability index to monitor access to care and an information sharing agreement with BMBC	September 2025	November 2025	M Wright A Snell	None identified.					
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	Received By	Assurance Rating	Gaps in Assurance					
L2, Control 1: Updates on the strategy and action plan to improve public health and reduce inequalities including measurement of inequalities in BHNFT services, quarterly reports to Quality & Governance Committee and annually to the Board of Directors.	~~May~~ —July 2025 September 2025	Quality & Governance Committee / Board of Directors / BMBC Public Health DMT	Partial	Progress has been made across all CBUs, but still with specific services and pathways and yet to be Trust-wide. At the July 2025 BoD session, the Executive Directors supported the progress of the strategy and the forward direction.					
L2, L3 Control 2: Integrated Care Delivery Group- understanding of priorities for Barnsley regarding health inequalities assessed by the Barnsley Health Intelligence and Equity Group (meets monthly)	~~April~~ 2025 September 2025	Integrated Care Delivery Group	Full	None Identified					
L1, Control 3: Current working group led by CBU2 and due to report on pilot that will be commencing in April. Currently meeting fortnightly. The group will report to the relevant governance groups.	May 2025	Clinical Business Unit 2	Full	~~None identified-~~ The Trust objective relating to this was marked as amber for Quarter One submission owing to reduced capacity in CBU 2 and a postponement of the expansion of the WHaLES to September/October 2025.					
L1, Control 5: ACT, QUIT and Early Help Team activity and performance reports submitted at Q & G	February 2025	Quality & Governance Committee	Full	~~None identified~~ The community provider for alcohol and drug services has not been able to work onsite in the hospital whilst service agreements and contractual issues have been resolved, CBU 3 are currently working through this.					
L2, L3 Control 6: Programme of work for 2024/25 will be presented to Q&G at the next quarterly update from Public Health National conferences and engagement (next one in May 24)	May 2024	National	Full	Complete.					
Corrective Actions Required (include start date)						Action Start Date	Action Status	Action Owner	Forecast Completion Date
Control 1 & 2: The new proposal for Place health inequalities allocation focuses on community work and engagement, the funding submitted and approved.						June 2024	Complete	A Snell	
Control 6: BMBC and BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education. Whilst there is not currently clear steer from the Place partnership around the health anchors network, a conversation was restarted at the Inclusive Economy Board in April 2025, which will be followed up by Andy Snell.						October 24	In progress	A Snell	Ongoing
Control 5: Contract review for QUIT will be considered once the SY ICS QUIT Business Case has been processed.						Sept/October 2024	Complete	C Harwood	
Control 5: Funding proposal for ACT						July 24	Complete	C Harwood	
Control 6: Programme of work for 2024/25						Marc/Apr 24	Complete	A Snell	
Control 1: Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan, which is aligned to the BHNFT plan. This is facilitating alignment across partners, but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS.						2023	Complete	A Snell	
Control 3: Piloting a waiting fair initiative for people on BHNFT's PTL (using the locally built WHaLES) across T&O, General Surgery, ENT – Phase 1 complete, phase 2 in progress. The expansion of pilot in T&O and General Surgery, planned for July 2025, has now been revised up to a full trial across all CBU 2 surgical waiting lists, to commence in September/October 2025. has been approved by the Business and Governance Groups. Meetings to explore opportunities in Maternity, Outpatients and Preassessment are ongoing.						Q1 24/25	In progress	A Snell	Q3 2025/26
Control 3: There is a clinical prioritisation process in place which aligns with key waiting time thresholds and is due to be complemented by health inequalities measures (as per update from Louise Deakin, CBU2)						2023	Complete	S Enright	
Control 1: Population health analyst recruited and working across CBUs and with operations to standardise and integrate measurement of inequalities						2023	Complete	A Snell	
Control 2. Anna Hartley (DPH) is the new SRO for Place inequalities and intelligence priority and reports regularly in the Place Partnership Delivery Group						Q4 23/24	Complete	A Snell	
Control 2: A pilot waiting fair, waiting well initiative is being trialed across the new Provide Alliance, looking at how partners can collectively to create more equitable care (with an initial focus on MSK/T&O)						May 24	In progress	A Snell	Ongoing

Control 5: Ceryl Harwood (clinical lead for HLP for CBU3 and Corporate) is having regular meetings with Bob Kirton and place partners re sustainable funding model for ACT	July 24	Complete	B Kirton	
Control 6: Action plan is now entering a new cycle of annual refreshes alongside annual revision of trust objectives and informing an annual programme of work	July 24	Complete	A Snell	
Control 6: Capacity of the BHNFT public health team is nearing full re permanent staff and is regularly supported by integration with other key teams and approaches (e.g. QI), PH HSTs and junior docs on PH placement	2023	Complete	A Snell	
Control 1 & 5: BHNFT's public health team is part of the working group carrying out a staff health needs assessment and developing a staff health and wellbeing strategy, this has been approved by the Board of Directors.	Oct 2024	In progress Complete	A Snell	4 June 2025 4 September 2025
Control 1 & 2: BHNFT is working with BMBC and the Place partnership on an engagement and co-development initiative for frequent attenders of A&E from Core20+ communities. BMBC have recruited a programme lead for this An options appraisal for expanding the high-intensity support services is being presented to PPDG on 9 September 2025.	Sep2024	In progress	A Snell	June 2025
Control 5. HLT and CBU3 are developing a business case for the sustainable funding of the Healthy Hospital Programme Lead	Dec 024	Complete	C Harwood	
Control 1. Health and Equality Metrics have now been added to the monthly IPR submitted to ET, Committees and Board. Standard approach to measurement of HI and identifying gaps in service delivery has been established at BHNFT and is being used by other partners (including SWYFT).	Jan 2025	Complete	A Snell	
Control 5: A deep dive on the performance of the services that sit under the Healthy Lives Programme is being prepared for the June 2025 Quality and Governance Committee.	April 2025	Ongoing Complete	A-Snell C Harwood	June 2025
Control 1 & 2: Place Partnership delivery Group has agreed on a health care activity analysis for the Core20+ cohort using linked data across Barnsley, including onboarding GP practices. This is intended to inform Barnsley's approach to delivery of the 10-year plan, including neighbourhood health services.	June 2025	Ongoing	A Snell	
Control 3: Discussions are underway with SY Acute Fed and NHSE NEY regarding BHNFT facilitating a regional application of WHaLES.	June 2025	Ongoing	A Snell	
Control 5: CBU 3 and the Trust's Public Health Team are meeting with the Community provider of drug and alcohol services (BRS), the Commissioner for these services (BMBC) and the relevant clinical teams on 8 September 2025 to plan for the BRS return to the Hospital site. CBU 3 have already approved the necessary documents for this to happen for alcohol services.	September 2025	In progress	C Harwood	1 October 2025

CURRENT	BOARD ASSURANCE FRAMEWORK 2025/26							
Strategic Objective 2025/26: Best for Planet	Risk Ref:	Oversight Committee		Risk Owner	Initial Risk Score	Current Risk Score	Target Risk Score	Linked Risks
					The risk score is consequence x likelihood			
Deliver energy efficiencies and refinement of plans in 2025/26 to enable a platform to make meaningful progress against the ambition for 80% reduction in direct emissions between 2028 and 2032	2827	Finance and Performance Committee		Managing Director of BHNFT	4x4 (16)	4x2 (8)	4x2 (8)	
Risk Description	Risk Score Movement			Interdependencies				
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.				Grant Funding Govt directives/legislation				
				Risk Update/Progress Notes				
				September 2025: Following the review of the risk, no change has been made to the residual risk score of 8.				
Risk Appetite				Risk Tolerance				
Open				Treat				
Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control				
1. Green Plan	September 2025	November 2025	Sustainability Action Group, BFS Board, Finance & Performance Committee, Board of Directors/ M Sajard	COMPLETE: The new Green Plan was presented to the Sustainability Group on 14th July, the BFS Board on 21st July, and the Trust Board on 7th August 2025. A key gap identified is the incomplete measurement of carbon emissions for Scopes 2 and 3, primarily due to the limitations and inaccuracy of current measurement tools. While independent consultants could undertake this task, the estimated cost would be around £25,000, plus an ongoing annual fee. ~~The updated NHS Guidance (2025) no longer requires organisations to measure their carbon footprint. A new draft Green Plan has been developed and is scheduled for presentation at the Sustainability Group meeting on 14 July, followed by presentations at BFS Board on 21 July and Trust Board on 7th August.~~				
2. Sustainability (Green Delivery) Plan	September 2025	November 2025	Finance & Performance Committee	To successfully deliver the Green Plan, the Trust must secure strong commitment and support from all stakeholders. A full launch will be carried out, highlighting key success stories to help communicate the message widely and engage as many people as possible. ~~The Trust must secure strong commitment and support from all stakeholders to successfully deliver.~~				
3. Heat Decarbonisation Plan	September 2025	November 2025	Sustainability Action Group, BFS Board, Finance & Performance Committee/ M Sajard	Delivery of the Trust's Heat Decarbonisation plan is closely linked to the availability of grant and capital funding. Phase 1 of the decarbonisation plan has been successfully implemented across in the Trusts outer buildings. Following our recent successful funding bids for £399k, phase 2 is now underway				
4. The Trust meets local stakeholders through the Barnsley 2030 Group	September 2025	November 2025	Sustainability Group, Chairs Log, Executive Team/ M Sajard	None Identified.				
5. Trust Sustainability Action Group and ICB Sustainability meetings take place every 6 weeks to coordinate the delivery of the Trust's strategic plans, monitor progress and address new and emerging changes.	September 2025	November 2025	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None Identified.				
6. Effective engagement with staff and the public	September 2025	November 2025	Sustainability Action Group/ M Sajard	Ongoing engagement and communication will be required to achieve the Trust's objectives.				
7. Trust has secured funding and continues to seek funding to meet Net Zero targets.	September 2025	November 2025	Sustainability Action Group, Chair Log, Finance & Performance Committee / M Sajard	Achieving the Trust's Net Zero ambition will require sustained and substantial capital investment, with a continued reliance on external grant funding. To date, the Trust has secured £3.72 million for Phase 1 of the Heat Decarbonisation Project. In addition, further funding has been successfully obtained, including: £386,000 for LED lighting upgrades £667,000 for solar panel installations £43,000 for enhanced metering infrastructure £5,800 for nitrous oxide mitigation £399,000 for upgrading and improving the IT building Since the July update we have secured a further £146k to fund solar installation. The Trust remains committed to pursuing additional funding opportunities as they arise. However, recent announcements from the Department for Energy Security and Net Zero confirm that there will be no Low Carbon Skills Fund for FY 2025–26, and no further rounds of the Public Sector Decarbonisation Scheme. This presents a significant challenge to the Trust's decarbonisation efforts and progress toward Net Zero.				
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	Received By	Assurance Rating					
L1 & L3, Control 1: Independent sustainability audit gave an opinion of Significant Assurance.	December 2022	Executive Team	Significant rating	None Identified.				
L1, L2 & L3 Control 1, 2 & 3: Sustainability Green Plan	August 2025	Executive Team Finance & Performance Committee Board of Directors		None Identified.				
L1, L3 Control 4: The Trust meets local stakeholders through the Barnsley 2030 Group	March 2024	Sustainability Group		None Identified.				
L1 Control 5: Trust Sustainability Action Group and ICB Sustainability meetings	May 2025	Executive Team Finance & Performance		None Identified.				

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		Committee Sustainability Group						
Corrective Actions Required (include start date)				Action Start Date	Action Status	Action Owner	Forecast Completion Date	
Control 1, 2 & 3: New communication plan to support and improve understanding of sustainability and the Trust's role with the staff and the public.				June 2024	Complete	Emma Parkes		
Control 1, 2, 3, 4, 5 & 7: The Trust needs to continue to evaluate all sustainable investments to prove our return on investment, connected to national funding programmes and sustainability networks. Develop innovative schemes with partners and keep well networked.				April 2024	Ongoing	M Wright	March 2026	

Risk domain	Risk appetite	Risk level
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	SEEK
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	CAUTIOUS
People	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	OPEN
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	SEEK
Regulatory / Compliance	The Trust has a risk-averse appetite for risks relating to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	MINIMAL
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Planet	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	SEEK



Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER

September 2025

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their lives

Summary Corporate Risk Register – July 2025

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2025/26	Strategic Goals and Aims	Page No.
Risk domain: Regulation / Compliance								
Performance								
2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	May 2021	Chief Operating Officer	20	November 2024	Operational Risk	Best for Patients and the Public Best for Performance	4
Risk domain: Clinical Safety/Clinical Effectiveness/Workforce								
Service Delivery								
3014	Lack of Clinical Leadership and inability to meet service demands within OMFS Services	March 2024	Chief Operating Officer	15	November 2024	Operational Risk	Best for Patients and the Public Best for Performance	5
2557	Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services	March 2021	Chief Operating Officer	16	September 2024	Operational risk	Best for Patients and the Public Best for People	6
Risk domain: Clinical Safety/ Reputation/ Patient Experience/ Finance/Value for Money								
Service Delivery								
2695	Risk of failure to reduce hospital acquired Clostridioides difficile infection	August 2025	Director of Nursing, Midwifery and AHPs	15	New risk	Operational Risk	Best for Performance Best for Patients and the Public	
Risk domain: Finance / Value for Money/ Workforce								
Workforce Costs								
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	November 2021	Director of People/Chief Finance Officer	16	November 2024	Operational Risk	Best for Performance Best for People	9
Risk domain: Finance / Value for Money								
Financial Stability								
2845	Inability to improve the financial stability of the Trust over the next two to five years	January 2023	Chief Finance Officer	16	November 2024	Operational Risk	Best for Patients and the Public Best for Performance Best for Partner Best for Place	10
1713	Risk regarding inability to deliver the in-year financial plan	August 2025	Chief Finance Officer	16	August 2025	Operational Risk	Best for Performance	11

Strategic Objectives 2025/26

- Best for Patients and the Public: Achieve quality of care consistent with a CQC outstanding rating and perform at top quartile in patient experience surveys by 2028/29
- Best for Performance:
 - Operational: Deliver national planning guidance priorities in 2025/26 and develop plans to meet constitutional standards including 92% of patients waiting no longer than 18 weeks for elective treatment, cancer care standards and top 10 performance for Urgent & Emergency Care (UEC) by 2028/2
 - Finance: Deliver our services in line with our board agreed financial plan during 2025/26 whilst developing plans to return to a recurrent sustainable balanced break even position by 2028/29
- Best for People: Achieve a top 5-10% staff survey result and have the necessary workforce in place by reducing staff sickness to 5% and further to 4.5% by 2028/29 and improve our vacancy rate to 2.8% and retention rate to 93% in 2025/26
- Best for Place: We will continue to work with partners across place with a commitment to improving population health, reduce health inequalities supporting delivery of key Place priorities in 2025/26
- Best Partner: Work with our partners to deliver the Integrated Care Partnership Strategy and Joint Forward Plan across South Yorkshire including an increased collaboration with TRFT in 2025/26
- Bes for Planet: Deliver energy efficiencies and refinement of plans in 2025/26 to enable a platform to make meaningful progress against the ambition for 80% reduction in direct emissions between 2028 and 2032

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	SEEK
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	CAUTIOUS
People	OPEN
Reputation	OPEN
Finance / Value for Money	SEEK

Risk domain	Risk Appetite level
Regulatory / Compliance	MINIMAL
Partnerships	SEEK
Innovation	SEEK
Planet	SEEK

Risk 2592: Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	C = 3 L = 5	15	Low risk		Moderate risk			High risk			Extreme risk					
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score							Current score	
Risk Description:																
There is a risk of patient harm due to the Trust not delivering against operational plans, as agreed in April 2025. ~~failure or delay in patient diagnoses and/or treatment due to the Trust's inability to consistently meet planned performance trajectories aligned to regulatory standards and waiting time expectations.~~											Executive lead: Chief Operating Officer					
											Date added to CRR: May 2021					
											Last reviewed date: September 2025					
											Committee reviewed at: Finance and Performance Committee					
Consequence of risk occurring																
The materialisation of this risk will impact patient care potentially resulting in poor outcomes and adverse harm, poor patient experience and breach of standards with associated financial penalties and reputational damage.																
Risk Appetite								Risk Tolerance								
Cautious								Treat								
Controls			Gaps in controls			Further mitigating actions			Action Owner		Target Date					
1.The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting.			Ongoing monitoring			Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly			Michael Wright		Ongoing					
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalate to the ET. Business plans are complete, which are aligned to delivery.			None identified.			capacity gap identified in business planning & additional activity requirements discussed with finance director. Operational planning to maintain safety during periods of industrial action.			Lorraine Burnett Chris Thickett		Ongoing					
3. Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.			Regulatory environmental changes			Development of Acute Federation & Integrated Care Board.			Lorraine Burnett		Ongoing					
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.			Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes.			Working to include health inequality data alongside waiting list management as per health inequalities action plan.			Lorraine Burnett		Ongoing					
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.			None identified.			Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes.			Simon Enright Sarah Moppet		Ongoing					
6. Improved communication at ICS meetings and contributions to the development of the system position.			Information flow			Attendance at ICS meetings and contributions to the development of the system position.			Lorraine Burnett		31.03.26					
7. Regional Tier 2 oversight meeting – fortnightly			Several actions sit external to the Trust and therefore not under direct control, ie, Yorkshire Ambulance Service conveyance, Primary Care Access and Community Support.			None identified.			Lorraine Burnett		Ongoing					
Risk Update/Progress Notes																

September 2025: Following review of the risk with the Chief Operating Officer, no change has been made to the residual risk score of 20. The Trust has been placed in tier 2 for Urgent and Emergency Care performance.

Risk 3014: Risk regarding lack of clinical leadership and inability to meet services demands within Oral Maxillo-facial Services (OMFS)	C = 3 L = 5	15	Low risk			Moderate risk			High risk				Extreme risk					
			1	2	3	4	5	6	8	9	10	12	15	16	20	25		
					Target score								Current/ initial score					
Risk Description:																		
The OMFS Department does not have the required capacity to meet the demands of the service, there is no clinical leadership across the Consultant body which subsequently impacts the ability to develop the service, address the capacity issues and support the existing workforce as well as the overall quality of care. The Cancer pathway sits with a sole consultant without any cover for annual leave or other absence. This Consultant has three weeks in October 2025. The Cancer Lead withdraws from Barnsley Hospital NHS Foundation Trust (BHNFT) service on 31 March 2025, no replacement has been identified by Sheffield Teaching Hospital (STH), therefore there will be no cover for cancer referrals as of 1 April 2025.															Executive lead: Chief Operating Officer			
															Date added to CRR: March 2024			
															Last reviewed date: September 2025			
															Committee reviewed at: Quality & Governance Committee			
Consequence of risk occurring																		
Mismanagement of patient care/ delayed treatment/ loss of finance/poor patient experience/ waiting list backlogs																		
Risk Appetite												Risk Tolerance						
Avoid												Treat						
Controls						Gaps in controls				Further mitigating actions				Action Owner		Target Date		
Working with STH colleagues to seek sustainable solutions to workforce planning and leadership.						Dependant on the availability of Sheffield Teaching Hospital staff for meetings				Issue taken to South Yorkshire Integrated Care Board Sustainable Clinical Services Meeting, awaiting further action. Meeting scheduled with CEO, MD, Chief Operating officer and consultants meeting in November to discuss the service				Lorraine Burnett		31.08.2025 31.03.2026		
										Paper was presented to the Executive Team on 17 January 2025, recommending service failure and referral to Acute Federation, for mutual support.								
										OMFS part of services sustainability programme, ongoing workshops to consider future service delivery across the ICB Weekly updates to the executive team								
The service Management team works closely with the SAS workforce to manage patient backlogs as much as possible.						SAS Doctors are unable to complete all activity.				Rota review by STH to increase allocation of core dental trainees to BHNFT				Lorraine Burnett		31.08.2025 Complete		
										Ongoing discussions regarding independent practice.								
										Oral Surgeon commenced in post. Out to advert for oral surgeon. Recruited 2 oral surgeons								
Outsourcing to the private sector for orthodontics						None identified.				Agreed locum cover for ongoing follow-ups and complex pts.				Lorraine Burnett		Ongoing Complete		
										All routine referrals are sent to the independent sector.								

Improved Business and Governance Communication	Sheffield Teaching Hospital (STH) Consultants are unable to deliver administrative time to attend meetings; Business and Governance meetings require loss of activity.	Regular Business and Governance Meetings to be held. BHNFT managers liaising with ENT to review cancer pathways. Meeting STH leads and managers w/c 10 March 2025 to understand residual risk and agree on mitigation. All cancer patients are being transferred to STH. Ongoing clinical sustainability work ongoing with SY ICB	Lorraine Burnett	Ongoing
Risk Update/Progress Notes				
September 2025: Following review of the risk by the Chief Operating Officer, no change has been made to the residual risk score of 15. The Oral Surgery provision is resolved, however there are ongoing issues with cancer pathways and oral maxillofacial surgery.				

Risk 2557: Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services	C = 4 L =4	16	Low risk			Moderate risk			High risk				Extreme risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
				target										Initial/ current score		
Risk Description:																
There is a risk that future configuration of services will not be achieved due to the level of estate work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impacts on clinical care and patient experience.												Executive lead: Chief Operating Officer				
												Date added to CRR: March 2021				
												Last reviewed date: September 2025				
												Committee reviewed at: Quality & Governance Committee				
Consequence of risk occurring																
The materialisation of this risk will impact the Trust's ability to deliver business-as-usual services, leading to potential delays and impacts on clinical safety and patient experience. It may also negatively impact working conditions and reduce staff morale.																
Risk Appetite						Risk Tolerance										
Cautious						Treat										
Controls				Gaps in controls			Further mitigating actions				Action Owner		Target Date			
1. Improved Communication Strategy.				Communication with Staff			The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes				Lorraine Burnett		31.04.2026			
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff				None identified.							Robert McCubbin		31.04.2026			
3. Home working is being promoted at all levels via departmental managers to enable shared desks and the release of space				No current plan for Hilder House.							Lorraine Burnett		31.04.2026			
4. Space Utilisation Group				None identified							Lorraine Burnett		31.04.2026			
5. Contracts and SLAs between the Trust and BFS				None identified							Lorraine Burnett		31.04.2026			
6. EDMS Project (reduce paper in the Trust and in turn, release space)				Contracts and SLA			Review of outpatient pharmacy SLA				Robert McCubbin		31.04.2026			
7. Trust 5-year strategy				Green policy			Awaiting completion of project & space release; No space released.				Tom Davidson		31.04.2026			
8. Development of a frailty same day emergency care unit.				None identified							Michael Wright		31.04.2026			
Urgent care improvement plan.				Increased demand for urgent and emergency care against previous year			Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce need for inpatient beds				Lorraine Burnett		31.04.2026			
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery				None identified							Lorraine Burnett		31.04.2026			
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)				None identified. Suspended until October 2025 due to Senior Management development							Lorraine Burnett		31.04.2026			
11. Bed reconfiguration programme to increase medical bed capacity				None identified							Lorraine Burnett		31.04.2026			
12. Health on the High Street: development off-site facilities for out-patient services				None identified							Michael Wright		31.04.2026			
Risk Update/Progress Notes																
September 2025: Following review of the risk with the Chief Operating Officer, no change has been made to the residual risk score of 16.																

Risk 2695: Risk of failure to reduce hospital acquired C.difficile infection	C = 5 L = 3	15	Low risk			Moderate risk			High risk			Extreme risk				
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		Initial score	Current Score			
Risk Description:																
There is a risk of patient safety, reputational damage to the Trust and potential financial implications caused by a breach in the hospital acquired C.difficile infection threshold (avoidable and unavoidable), set by NHSEI												Executive lead:				
												Director of Nursing, Midwifery and AHPs				
												Date added to CRR:				
												August 2025				
												Last reviewed date:				
												September 2025				
												Committee reviewed at: Quality and Governance Committee				
Consequence of risk occurring																
There is a potential risk of not achieving CDI to threshold levels set by NHSEI, a risk to patient safety, potential adverse publicity and potential financial consequences.																
Risk Appetite						Risk Tolerance										
Cautious						Treat										
Controls				Gaps in controls			Further mitigating actions						Action Owner		Target Date	
1. IPCN's have oversight of all patients with CDI and GDH positive				No gaps in control			IPCN reviews all patients with CDI/GDH positive Patients with a previous history of CDI/GDH are alerted on Careflow, ICE and EPMA. CDI reduction part of Trust IPC annual plan. AMS action plan in place. Monitored and managed by the IPCG and by exception to the Q&G Committee.						Christine Fisher		Completed	
2. Microbiologist input				No gaps in control			Consultant microbiologist clinical lead for AMS action plan. Daily ITU ward round, Weekly antimicrobial review of antibiotic prescriptions via EPMA. Antimicrobial prescribing feedback is provided to the healthcare profession via face-to-face, note entry in EPMA and EPR. Antibiotic review of patients with a positive blood culture.						Dr Y M Pang		Completed	
3. CBU's provided with data relating to CDI				No gaps in control			CDI specific report provided to each CBU by IPCT. Detailing number of patients, improvements in management, areas for improvement and trends.						Christine Fisher		Completed	
4. CDI and AMS action plans				No gaps in control			Both action plans are reviewed bi-monthly at IPCG and form part of the IPCG exception report to Q&G. AMS action plan presented at Medicines Management Group. Executive and clinical lead for both action plans						Christine Fisher/ Dr Y M Pang		Completed	
5. Patient and GP Information				No gaps in control			GP letter updated to provide additional safety netting advice and link to antibiotic prescribing guidelines. The patient information leaflet for CDI was updated to include advice when leaving the hospital and taking medications. Documentation issued with CDI treatment to help remind patients to take medication – particularly useful if on reducing doses of vancomycin or prescribed fidaxomicin.						Christine Fisher		Completed	
6. Audit				No gaps in control			Diarrhoea audit completed by ward staff Environment, equipment and hand hygiene audits are undertaken when the patient is diagnosed with CDI.						Christine Fisher		Completed	

		Routine annual audits are undertaken in all clinical areas by IPCN. Significant lessons via the Patient Safety Bulletin. Annual Trust-wide antibiotic prescribing audit via point prevalence study as part of the Infection Control Accreditation. The results from these audits feeds back to IPC, MMC and Departmental Governance meeting to improve antimicrobial prescribing		
7.Hand hygiene policy, signage, training,	Hand hygiene compliance not consistently above 90%	Hand hygiene policy review in line with the National Infection Prevention and Control Manual for England. Hand hygiene signage displayed near all hand wash basins and in staff toilet areas. Hand hygiene champions provide practical hand hygiene training. Hand hygiene audits undertaken by matrons and lead nurses. IPCN's undertake ad-hoc hand hygiene audits. IPC escalation process when poor compliance to hand hygiene identified.	Christine Fisher	Completed
8.Hand hygiene champions	No gaps in control	Hand hygiene champion programme led by IPCT. Regular review by IPCT to ensure each clinical area has a champion. Terms of reference for champion programme. Champions are given yearly updates with additional study events. Regular newsletters. WhatsApp group set up for Hand Hygiene champions Hand hygiene Champion training updated.	Christine Fisher	Completed
9. Thematic reviews of AAR's	No gaps in control	AS of September 2025, initially a temporary hold on completing AAR in current format. MDT review to take place on completed AAR's. Clinical teams continue to investigate as part of Datix reporting. Datix to be shared within the CBU as part of CBU governance. MDR review results to be presented at IPCG and any actions incorporated into CDI action plan - risk register.	Christine Fisher	January 2026
10. High-level decontamination utilised - Tristel, HPV and Ultra V	Deep Cleaning wards not possible year round	24 hour/7 day per week service. High-risk cleans (using HPV) monitored by IPCT. Escalation when appropriate clean is not possible within 24 hours. Deep cleaning of sluices completed Deep cleaning of 5 wards commenced June 2025	Christine Fisher	October 2025
11. AMS strengthened	No gaps in control	AMS/RCA review is now part of the consultant appraisal process. AMS action plan in place. Executive lead Dr Enright, clinical lead Dr Pang. AMS Group with medical representation. Exception report and AMS action plan reviewed bi-monthly at IPCG. AMS training delivered by microbiologist and antimicrobial pharmacist. Pharmacy dashboard. AMS training for registered nurses as part of targeted CDI support on identified wards planned for September 2025. Targeted AMS training for medical staff planned for September 2025	Dr Y M Pang	October 2025
12. Training	Training on-going. Reliant on IPCN's delivering training with support from CBU practice educators	Ward-based bitesize training to supplement IPC mandatory training. Sessions include assessing patients for infectious diarrhoea, completion of stool chart and diarrhoea assessment tool; and nurses' responsibility for cleaning. Further promotional events as part of SIGHT SY improvement plan – hand hygiene commenced August 2025 and further events planned re gloves in September 2025	Christine Fisher	October 2025

13. Achieve compliance with National Cleaning Standards and IPC Audits	Training for lead nurses to use medical audits software	Audit in line with recommendations set out in the national standards for cleanliness. IPC Audit Programme to be agreed annually. Domestic services and IPC to audit using medical audits software Lead nurses and department leads to rectify actions through medical audits software. Domestic Services and IPC to support clinical teams in achieving high standards.	Christine Fisher Dawn Pickering	Ongoing
14. Early identification and isolation of patients with diarrhoea	Lack of automated alerting system for patients with loose stools.	Lead nurses to complete diarrhoea audit results to be fed back to the IPC Group via exception report. IPC Group to undertake an annual diarrhoea audit. To explore and utilise digital programme to identify ways of alerting IPC to patients with loose stools. To review datix relating to delays in isolation.	Christine Fisher	Ongoing
15. Annual Programme of Deep Cleaning	Lack of Resources	Liase with BFS regarding the annual Programme of deep cleaning. CDI surveillance to assist in identifying priority areas for deep cleaning. IPC Group to have oversight of the Programme.	Christine Fisher Rob McCubbin	Ongoing
Risk Update/Progress Notes				
September 2025 following review by Director of Nursing and Assistant Director of Infection Prevention and Control, an increase in C. diff cases in quarter one compared to the previous quarter was noted, though there were two fewer cases than the same quarter last year. The risk was presented and approved at QRP on 05.08.25 where the score was approved at 15, with agreement that this reflects the seriousness and political sensitivity of the issue, especially following a recent community-acquired C. diff death.				

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 4	16	Low risk		Moderate risk		High risk			Extreme risk						
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		Initial score		Current score		
Risk Description:																
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, industrial action, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.										Executive lead: Director of People						
										Date added to CRR: November 2021						
										Last reviewed date: September 2025						
										Committee reviewed at: People Committee/ Finance & Performance Committee						
Consequence of risk occurring																
The materialisation of this risk could result in financial over-spend impacting on quality of services and compromising patient care.																
Risk Appetite					Risk Tolerance											
Open					Treat											
Controls			Gaps in controls			Further mitigating actions					Action Owner		Target Date			
1.Sickness absence reduction plan (sickness absence target 4.5%), including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group and the Improvement Programme Board			None identified.													
2.Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend.			£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors’ rosters needed to be delivered by March 2022 and this has been completed.			1. Junior Doctors: The Allocate system was implemented, and all areas under the control of Medical Staffing are now fully rostered on the system. The responsibility for rostering ED, Anaesthetics, and higher surgical resident doctors remains with these specialities. 2. Consultants/SAS: We have moved Job Planning to the L2P system and improved processes with monitoring and sign-off of Job Plans. This applies to all Senior Doctors. In line with agreements made as part of discussions with ET and at the Improvement Board, we are setting up a project group in the new year to set future plans for rostering across all services and grades. This will be done collaboratively with our partners in Rotherham. As a result, we will keep the existing medical rostering system (Allocate) for the next two years to allow time to plan and align procurement timelines. The previously identified risk associated with the Allocate system has not materialised and while the consequence remains high, the likelihood of this occurring is very low.					Andrew Wiles		December 2026			

3.National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel.	Governance Process	ICB provide oversight and approves agency usage		
4.Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information.	None identified			
5.Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified			
6.Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified			
7.Risks relating to shortages of specialist medical staff (Dermatologists and Breast radiologists) are managed through CBU governance arrangements.	None identified			
8.Reporting of agency spend/medical staff is provided monthly to the Executive Team and Quality and Governance Committee.	None identified.			
9.Efficiency and Productivity Programme; regular reporting to the Executive Team, Finance and Performance Committee and Board of Directors. Strengthened controls around vacancies and regular reporting to the Executive Team Improvement Board.	None identified			
10.Regular monitoring of workforce costs undertaken through revised performance management meetings.	None identified			
Risk Update/Progress Notes				
September 2025: Following review of the risk by the Deputy Director of People, no change has been made to the residual risk score of 16. The Trust decided not to implement backpay for NHSP shifts between April – September 2024. The Executive Team decided not to uplift extra contractual rates for medical staff. Deputy Director of Finance have updated risk description to incorporate industrial action.				

Risk 2845: Inability to improve the financial stability of the Trust over the next two to five years	C = 4 L = 4	16	Low risk			Moderate risk			High risk				Extreme risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score						Initial score Current score	
Risk Description:																
There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve its financial sustainability and return to a breakeven position.													Executive lead: Chief Finance Officer			
													Date added to CRR: January 2023			
													Last reviewed date: September 2025			
													Committee reviewed at: Finance & Performance Committee			
Consequence of risk occurring																
The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back-to-balance position, without external funding.																
Risk Appetite								Risk Tolerance								
Open								Treat								
Controls		Gaps in controls					Further mitigating actions					Action Owner		Target Date		
1.Board-owned financial plans.		None identified.														
2.Achievement of the Trust's in-year financial plan and any control total (see risk 1713).		None identified.														
3.Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.		None identified.														
4.Delivery of the EPP programme recurrently.		None identified.														
5.Continued work on opportunities arising from PLICS / Benchmarking and RightCare.		None identified.														
6.Continued discussions with SY ICB.		Lack of Trust control over the financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.														
7.Potential additional national and/or system resources become available.		The long-term revenue funding available remains unclear. Allocations are now received and controlled via the ICB with some national funding available through a bidding process.														
Risk Update/Progress Notes																
September 2025: Following review of the risk, no change has been made to the residual risk score of 16.																

Risk 1713: Risk regarding inability to deliver the in-year financial plan	C = 4 L = 4	16	Low risk			Moderate risk			High risk				Extreme risk					
			1	2	3	4	5	6	8	9	10	12	15	16	20	25		
				Target score										Current score	Initial score			
Risk Description:																		
There is a risk of failing to deliver the in-year financial plan, (excluding non-recurrent deficit support funding), includes any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.															Executive lead:			
															Chief Finance Officer			
															Date added to CRR:			
															August 2025			
															Last reviewed date:			
															September 2025			
															Committee reviewed at:			
															Finance & Performance Committee			
Consequence of risk occurring																		
The materialisation of this risk would adversely impact on the financial stability of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage.																		
Risk Appetite									Risk Tolerance									
Open									Treat									
Controls			Gaps in controls						Further mitigating actions					Action Owner		Target Date		
1. Board owned financial plans.			None identified, Board approved final 2024/25 plan in June.															
2. Requirements identified through business planning and budget setting processes and prioritised based on current information.			Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.															
3. Additional requirements must follow business case process.			None identified - well established business case process.															
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance & Performance Committee meetings.			None identified.															
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans.			Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management.															
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities.			Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance.															
7. Identification of additional efficiency / spend reduction.			Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.															
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.			Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.															
9. Tight management of costs, with delegated authority limits, including review of agency usage.			Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.															
10. Continued discussions with SY ICB.			Lack of Trust control over financial performance of external partners. which could have a detrimental impact on the system financial position and ability to receive all available resource allocations, such as non-recurrent deficit support funding.															
Risk Update/Progress Notes																		

September 2025: There was a discussion at the F&P Committee and BoD where it was recommended that an increase to the risk score. Following review by the Chief Finance Officer, it was recommended to increase the residual risk score to 16 (4 x 4).
Decision on continuation of receiving deficit support funding is expected following submission of month 5 actuals.

Risk domain	Risk appetite	Risk level
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	SEEK
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	CAUTIOUS
People	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	OPEN
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	SEEK
Regulatory /	The Trust has a risk-averse appetite for risks relating to compliance and regulatory requirements.	MINIMAL

Risk domain	Risk appetite	Risk level
Compliance	Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Planet	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	SEEK

4. Assurance

4.1. Quality and Governance Committee Chair's Log: 27 August/24 September 2025

For Assurance

Presented by Gary Francis



REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/10/02/4.2

SUBJECT:	QUALITY AND GOVERNANCE CHAIR'S LOG

DATE:	2 October 2025

PURPOSE:		<i>Tick as applicable</i>		<i>Tick as applicable</i>
	<i>For decision/approval</i>	✓	Assurance	✓
	<i>For review</i>		Governance	✓
	<i>For information</i>	✓	Strategy	

PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair

SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair

PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board in obtaining assurance about the quality of care and rigour of governance. The Committee met on Wednesday 27 August 2025 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance.

Q&G's agenda included consideration of the following items:

- Nursing, Midwifery & Medical Safe Staffing Report
- Antimicrobial Stewardship update
- Mental Health Annual Report
- Learning from Experience Quarter One Report
- Fire Statement
- Violence & Aggression Update
- Integrated Performance Report- by exclusion
- Temporary Escalation Space Report
- Chair's Logs and minutes: CBU Performance; Executive Team; Patient Safety and Harm Group; Health and Safety Group; Medicines Optimisation Group

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to note and receive the chair's log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 25/10/02/xx

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	Date: 27 August 2025	Chair: Gary Francis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Nursing, Midwifery & Medical Safe Staffing Report	Nursing, Midwifery, Therapy, and Radiography: Safe Staffing: - Sickness rates have increased across the CBUs (6.8-7.8%). - Maternity Leave has increased in month with mitigations in place. - Special Leave has increased (700 hours) - Winter Planning has commenced. - Action Log feedback regarding the availability of apprenticeships in hard-to-appoint AHP specialities has been referred to the People Committee for follow-up. NHSE Safer Staffing: - Budget establishment numbers are now available and reported. - In relation to 'entrustability', there are gaps in certain departments (Paediatrics and Obstetrics) which are being addressed via utilisation of NHSP pending workforce review. - Consultant vacancies have been mostly addressed, with vacancies in AED and Anaesthesia. - Fill rate remains high (92%). - Going forward, focus on middle grade recruitment and the impending impact of the Leng report recommendations.	Board	Assurance

2	Antimicrobial Stewardship update	The Committee noted and received the updates, with the following key points: • 4 themes: Leadership, Digitisation, Data and Education & Training. • Overall, antibiotic consumption is reducing (not pre-Covid levels yet), with the trust benchmarking well against peer organisations. • Broad spectrum antibiotic prescribing target (10%) just missed. Focus on the target to reduce narrow spectrum antibiotics. • Community prescribing remains an issue.	Board	Assurance
3	Mental Health Annual Report Improve	The Committee noted and received the updates, with the following key points: • 4th Annual Report presented. Despite limited resources, the trust has achieved the majority of its objectives in 2024. • Much work has been conducted to support suicide in children and develop partnerships across a wide range of providers. • External audits have been commissioned. • Notable achievements include: working with a charity (Papyrus) as an online resource for trust staff; and development of an all-age mental health liaison service which aims to reduce the time for mental health referral; this has resulted in a marked reduction in the number of children who avoid in-patient admission. • The trust has outlined an ambitious set of objectives for 2025-2026. • The Mental Health Annual Report is appended for information	Board	Assurance/Information

4	Learning from Experience Quarter One Report	The Committee noted and received the updates, with the following key points: • Trust-wide 84% response within 40- and 60-day targets for complaints. • Introduced a weekly CBU complaints performance meeting • Low-lying themes (telephone response times, communications and appointment cancellations) with actions in development to improve performance.	Board	Information
5	Fire Statement	With some nationally required amendments, the Committee approved the annual Fire Statement.	Board	Assurance
6	Violence & Aggression Update, including annual effectiveness review	The Committee noted that engagement has improved, but ongoing issues relating to violent and aggressive incidents. Targeted work to look to improve the approach and liaison with South Yorkshire Police to explore wider learning.	Board	Information
7	Integrated Performance Report-	The Committee noted sustained improvement in falls, pressure ulcers, sepsis management and VTE assessment. Ongoing issues with: CDT rates, 4-hour AED, RTT and financial sustainability delivery.	Board	Assurance
8	Temporary Escalation Space (TES) Report	The Committee that TES Beds required for 24 days during the month, resulting in 161 bed days (both increased from the previous month). One Datix reported - inappropriate acuity and dependency. No harms or complaints in the month.	Board	Information/Assurance

9	Chair's Logs and minutes: CBU Performance; Executive Team; Patient Safety and Harm Group; Health and Safety Group; Medicines Optimisation Group	CBU: Meetings stood down in the month owing to Resident Doctors' Industrial Action Executive Team: Attention to Paid Breaks; 4-hour improvement programme, and consolidating the Efficiency Programme projects Patient Safety and Harm Group: Two of the three quality targets have been met again (Lying/Standing Blood Pressure measurements and Pressure Ulcers). Falls have been higher than the target. Health & Safety Group: Violence and Aggression trainer appointment (12-month appointment) has commenced work at the trust. Medicines Operational Group: Penicillamine allergy mapping remains problematic; targeted training for locum and locally employed doctors. Patient Group Directive compliance audit conducted, and an action plan has been agreed	Board	Information/Assurance



REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/10/02/xx

SUBJECT:	MENTAL HEALTH ANNUAL REPORT			
DATE:	2 October 2025			
PURPOSE:		<i>Tick as applicable</i>		<i>Tick as applicable</i>
	<i>For decision/approval</i>	✓	<i>Assurance</i>	✓
	<i>For review</i>		<i>Governance</i>	✓
	<i>For information</i>		<i>Strategy</i>	
PREPARED BY:	Dawn Gibbon, Head of Safeguarding, Natasha Geldart – Quality, Safety and Governance Lead Becky Hoskins, Deputy Director of Nursing & Quality			
SPONSORED BY:	Becky Hoskins, Deputy Director of Nursing & Quality			
PRESENTED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHPs			

STRATEGIC CONTEXT

The Trust has a Mental Health Strategy which describes how we work with mental health partners, patients, and our staff to deliver our aim that all patients' physical and mental health care needs are met.

The Strategy aims to ensure that the mental health needs of our staff are met and that measures are taken to support staff at work. The Strategy recognises the need for our staff to have the skills and confidence to provide mental health support to our patients, as there is no health without mental health, and we want the best health outcomes for everyone who uses our services. Progress on staff-related mental health support is not included in this report.

The detail of this report is aligned with the Trust's Strategic Objectives and Best for Patients and the Public.

EXECUTIVE SUMMARY

This is the Trust's Fourth Mental Health Annual Report.

The report provides key achievements during 2024 and outlines the ambitions for 2025 in the provision of patient-related mental health services.

RECOMMENDATIONS

The Board of Directors is asked to note and receive the Mental Health Annual Report, noting it was approved by the Quality and Governance Committee on 27 August 2025.



MENTAL HEALTH ANNUAL REPORT

January – December 2024

Authors

Becky Hoskins – Deputy Director of Nursing & Quality

Dawn Gibbon - Head of Safeguarding

Natasha Geldart – Quality, Safety and Governance Lead

Becky Slaytor – Named Nurse for Safeguarding Adults

Kim Walsh – Named Midwife for Safeguarding children

Katie Madej – Named Nurse for Safeguarding Childrens



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11.0 Conclusion

Appendix 1 – Mental Health Activity

Appendix 2 – Dentition data



1.0 INTRODUCTION/EXECUTIVE SUMMARY

Barnsley Hospital NHS Foundation Trust (BHNFT) vision is to provide outstanding integrated care. In delivering this we aim to ensure that mental health care is integrated with physical health care. This will ensure we care and treat the whole person.

This is the Trust's fourth Mental Health Annual Report. The report provides key achievements during 2024 and outlines the ambitions for 2025 in the provision of patient related mental health services.

The Trust continues to work with the Mental Health Strategy which describes how we support mental health partners, patients and our staff to deliver our aim that all patients' physical and mental health care needs are met.

The Strategy aims to ensure that the mental health needs of our staff are met and measures are taken to ensure that staff are supported at work. The Strategy recognises the need for our staff to have the skills and confidence to provide mental health support to our patients as there is no health without mental health and we want the best health outcomes for everyone who uses our services. Progress on staff-related mental health support is not included in this report.

1.1 Governance arrangements

At BHNFT, mental health governance is anchored in a multi-tiered framework:

Mental Health steering Group: This multi-agency, multi-professional group meets every quarter to oversee the delivery of the Trust's Mental Health Strategy and support with the Barnsley Place multi-agency Mental Health and Wellbeing strategy 2022-2026 delivery action plan. It reports into the Safeguarding Steering Group, Patient Safety & Harm Group, and the Quality and Governance Committee of the Trust Board.

The Mental Health Operational Group (MHOG) is a key component of mental health governance structure. It operates as a multidisciplinary team, multi-professional forum that meets to:

- review and coordinate operational mental health activity across the Trust and partner organisations.
- Monitor progress against the Mental Health Strategy.
- Escalate issues and learning to the Mental Health Strategy Implementation Group

Structured Judgement reviews (SJR) are shared at the Mental Health Operational group from the Mortality Overview Group (MOG) if there has been an in-patient death where they may have been identified as having a serious mental health concern. This allows the operational group to screen the SJR to identify any learning or gaps. Any actions identified is fed back to MOG and monitored on the operational group action plan.



The Trust is represented at the Barnsley Mental Health Learning Disability, Dementia & Autism Partnership by the Deputy Director of Nursing and Quality; This is a place-based meeting focussed on developing an all age mental health strategy that ensures high quality support and compassionate services for the residents of Barnsley. The Partnership also includes ICB South Yorkshire, third sector organisations, Healthwatch and South West Yorkshire Partnership NHS Foundation Trust (SWYPT).

The Partnership brings together the partners to support across service delivery of mental health care.

Representatives from BHNFT also attend the Barnsley Mental Health Partnership Delivery Group, Learning Disability & Autism delivery groups, Mental Health Crisis Delivery Group and South Yorkshire ICB Suicide Prevention group, which in turn report to the Barnsley Partnership.

2.0 MENTAL HEALTH PROVISION

Specialist mental health services are provided by SWYPFT. The Trust has access to a Mental Health Liaison Team (MHLT) based on site which provide a 24-hour service supporting staff and assessing patients requiring mental health assessment in the Emergency Department and inpatient wards. The MHLT have access to the BHNFT EPR system to assist in recording assessments and provide clear action plans for all staff to have oversight.

The MHLT also assesses children presenting with any mental health presentation and undertake initial assessments and refer onwards to the Children and Adolescent Mental Health Services (CAMHS).

Between January – December 2024, there were 4641 adults and 670 paediatric attendances in the Emergency Department due to presenting with a mental health concern. Appendix 1 provides comparison data from the previous years. There has been an increase in attendance regarding Mental health with more patients attending in crisis. This is reflected in the increase of detention under the Mental Health Act.

There is an All Age Mental Health Pathway in place for patients attending the Emergency Department with a mental health problem. This is supported by the 16-18-year-old pathway to ensure that the staff support a child when presenting within the adult ED setting.

There is a Maternal Mental Health Pathway in place that supports staff to understand the process for the identification of women with mental health problems in the antenatal and post-natal periods of pregnancy.

The Trust employs staff in specialist roles that can further support people with their mental health needs such as the Learning Disability Liaison Nurse, Admiral Nurse, Specialist Midwife for Mental Health and The Children's Neurodisability nursing Team.

There is a Frequent Attenders User Group, which is chaired by an ED consultant. This group provides a collaborative approach to the care of patients who attend ED frequency involving a variety of services across South Yorkshire and the more specifically the Barnsley area. Agencies represented include South Yorkshire Police, Adult Social Care, YAS, Mental Health services and social prescribers. Evidence indicates that this collaborative approach improves the outcomes and decreases hospital attendances in frequent ED attenders.

3.0 MENTAL HEALTH CARE IN ACUTE HOSPITALS

Department of Health and Social Care, Rapid review into Mental Health Inpatient Settings (2024), The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2017, 'Treat as One' report into mental health care in general hospitals and the Care Quality Commission (CQC) 'How are people's mental health needs met in acute hospitals, how can this be improved?' Including Health Service Safety Investigations Body (HSSIB) investigation reports, has supported in a progression in the trust improvement plan from the benchmarking of these reports. Barnsley Local Authority, ICB, and SWYFT have supported the traction of the action plan.

The findings from these reports emphasised the need to have integrated mental and physical care provided in parallel to ensure holistic care for patients and improvements have been identified following the completion of a gap analysis against these documents.

This was replicated within the research paper "Mental health policy and services in England" 2023.

3.1 Key Achievements in 2024

- Continued work with Barnsley Mental Health Forum to ensure that the voice of the patient is represented within the trust.
-
- A formal Service Level Agreement with SWYFT has commenced to assist with confirmation regarding support of MH activity within the trust. We have been working on the improvement plan and including new recommendations from the Health Service Safety Investigation Body (HSSIB)
- Chilypep attended the children's assessment unit and A+E department in April to complete a young health commissioner's You're welcome assessment.
- The free digital Kooth services was launched within South Yorkshire for 10-25.

3.2 Key ambitions for 2025

- We will continue to work with partners on the delivery of the Mental Health Improvement Plan
- We will work in collaboration with our mental healthcare providers to support mental and physical healthcare being provided in parallel with each other

- Engage with patients who have received care for their mental health condition whilst in BHNFT to inform improvements in relation to the environment and access to services.
- To consider and embed the recommendations from the Chilypep assessment.
- Chilypep are invited to complete the “Young Health Commissioners You’re Welcome Assessment” within adult A&E department regarding the young persons' experience.
- Build on the work with partners to prioritise and deliver improvements to the experience and care patients with mental illness receive, ensuring Mental Health service support is in a place where needed and the patient’s voice is heard in delivery and design.
- To review and consider the Barnsley Service User and Carer Mental Health Service Quality Standards that have been produced by Barnsley Mental Health Forum.
- To conclude the formal service specification with SWYFT
- To update the Mental Health trust strategy
- To review and incorporate any actions from NHS England staying safe from Suicide report.
- To review recommendations from HSSIB mental health inpatient settings: overarching report of investigations directed by the secretary of state for health and social care,
- To review NHS England , Inpatient mental health: improvement guide.
- To share updates following the Government proposal around the reforming of the Mental Health Act 1983 once confirmed within Parliament.

4.0 HM CORONER REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

There has been no Regulation 28 Report against the trust in 2024.

In 2022 The Trust was issued a Regulation 28 Report to Prevent Future Deaths by HM Coroner regarding a patient who had a delay in having a NG tube inserted. The Trust and SWYFT are reviewing the protocol for managing temporary transfers of care from SWYPFT to BHNFT for physical health treatment whilst under the care of mental health services. This was following an action after a Patient Safety Incident Investigation (PSII) regarding a delay again regarding NG tube insertion.

5.0 MENTAL HEALTH ACT DETENTIONS

Under the Trust’s CQC registration, the Trust is registered to provide assessment or medical treatment for persons detained under the 1983 Mental Health Act (1983).

The number of patients detained under the Mental Health Act (MHA) whilst in the care of the Trust is small in comparison to other trusts covered by SWYPFT . However, all legal requirements must be met to ensure patients’ rights and safeguards are maintained and the Trust protects itself from litigation and reputational damage.

In 2024 85 patients have been detained under the MHA. The majority of these are patients detained under section 2 of the MHA.



Within 2024, there has been 1 patient that have filed a right to appeal against the Mental Health detention. This is the 1st time this has occurred, as patients have previously been transferred to a mental health setting before the appeal has been submitted.

Patients who attend the trust under a section 136 with the police are reviewed within the safeguarding team on a daily basis. The time the patients are detained within the trust is monitored and the data is shared with Barnsley Crisis delivery group.

MHA office has stated that from 2025 service fees for admin and other support are going to be generated on a monthly basis as in accordance to the joint SLA.

5.1 Key Achievements in 2024

- 100% of staff identified in the training needs analysis have received training on the receipt and scrutiny of detention papers.
- A quarterly report is provided to the Patient Safety and Harm Quality and Governance Committee for the ongoing monitoring of compliance against the detainment of patients under the Mental Health Act. The report assures that systems and processes for monitoring compliance are in place and that any gaps or weaknesses in practice are identified to support staff where required;
- Authorised signatories have been monitored to ensure the Trust is compliant with the Nominated Deputy agreement which states that the nominated deputy will be the most senior trainee doctor based on the ward, where the patient is located at the time the section is applied; The Service Level Agreement for the detention of patients has been reviewed and updated in partnership with the MH Office at Kendray Hospital. The Trust commissions SWYPT to support MHA detentions in a Service Level Agreement (SLA).
- The Trust's Head of Safeguarding attends the Mental Health Act Committee meeting hosted by SWYPT. Attendance at the Committee ensures the Trust is aware of changes to the Mental Health Act and its implications for the Trust.
- A joint monthly training session with the Mental Health Act office, Calderdale and Huddersfield NHS Foundation Trust, and Mid-Yorkshire Hospitals NHS Trust are available for staff to attend regarding receipt and scrutiny

5.2 Key Ambitions for 2025



- To continue to capture the number of S136 brought to ED and liaise with partner agencies to confirm if the trust was the most appropriate place of safety. Ongoing consultation with Barnsley Place to scope if there is no medical need for a person on s 136 to attend BHNFT if they can be taken directly to Kendray to sit and wait rather than sitting in ED.
- We will ensure the Trust responds to any MHA amendments as required.
- To keep accurate details of any amendments that are required with the section papers due to SWYPT invoking an administrative charge stated within the SLA.
- To collate the bed days for medically fit patients who are awaiting a transfer to a mental health bed.

6.0 Right Care Right Person (RCRP)

RCRP is a national model which has been created to ensure partners in the health, social care, and the Police work collaboratively to support and protect members of the communities, by providing the most appropriate responses to incidents linked to welfare, medical, and social care issues. The initiative is designed to protect vulnerable people and ensure members of our communities are receiving the right care and support from the right agency.

6.1 Key Ambition for 2025

- To continue to liaise with partners around cases that have been challenged under the RCRP.
- To continue to be an active agency at any RCRP meetings.

7.0 MATERNAL MENTAL HEALTH

In 2024, the Trust continued to prioritise maternal mental health through the dedicated role of the Specialist Mental Health Midwife and Lead consultant, Specialist Birth in Mind Midwife and Specialist Clinical Psychologist. These roles are crucial in providing

support, assistance, and advice to women at risk of or experiencing perinatal mental illness, as well as their families.

7.1 The Specialist Mental Health Midwife role includes:



- Supporting, assisting, and advising women with, or at risk of perinatal mental illness and their families. The role supplements the care provided by the community midwives where necessary. i.e. Working with women in partnership with their midwives developing individual care plans, and referring for additional specialist support where required.
- Acting as an advocate for women ensuring they get the specialist mental health care they need such as attending consultations with obstetric leads about the choice of birth and writing a birth plan.
- Liaising with mental health services, other services and partner agencies ensuring women with severe mental illness are receiving active and effective care. Communication pathways have been strengthened to ensure that care is streamlined and communication between all agencies is effective.
- Working in partnership with the Obstetric Consultant Lead for perinatal mental health, undertaking a joint weekly antenatal clinic. The clinic offers all Antenatal women the opportunity to discuss previous birth experiences, anxieties in their current pregnancy, birth options or require support with complex choices.

7.2 Advice and Training

The Specialist Mental Health Midwife is a contact for all agencies including all staff within the maternity unit who is involved with the care of women who are pregnant or who have recently given birth and who are struggling with mental illness.

Training for Maternity and Neonatal services are incorporated into the joint training.

7.3 Service Development/Quality Assurance

- Source varied family feedback regarding the service offered at BDGH to support service developments
- Update local policies inline with national best practice
- Ensure an equitable and accessible service is available to all that need it

7.4 Partnership working and development of pathways

- Continued working and development with care partners such as the 0-19 services, Perinatal mental health services and GP's to improve the



communications and support offered between services ensuring they are streamlined.

- Update local policies to support transparency within the service

7.5 Knowledge and development

- Improve access for all staff to the medicines catalogue available online to support maternal choice of medication.
- Employ a trained bereavement counsellor to support mothers and their families after a loss at more the 20 weeks gestation.

7.6 Ambitions for 2025

- Moving into 2025 the service aims to be more transparent by providing at least quarterly updated to Women's Business and Governance meeting around the services offered, the numbers accessing these and any theme to support any ongoing improvement work.
- Continue evaluation via surveys are to be expanded to review the service offer.

8.0 PATIENT SAFETY

It is recognised that some patients experiencing mental health concerns can present a risk of deliberate self-harm and the environment needs to be appropriately risk assessed to reduce the risk of harm.

Children who have presented at ED department with Mental Health concerns are discussed at the daily briefing, a multi-agency Child exploitation meeting where a representative from social care, education, health and police are able to identify and determine robust support plans around potentially vulnerable children.

8.1 Key Achievements in 2024

- Incidents relating to ligature risk are presented at the mental health steering group;
- Annual environmental ligature risk assessments have been completed in all clinical areas across the Trust.
- A revised Enhanced Care risk assessment to identify the need for continues supervision for patients who have been identified as high risk is in place following a trial period in 2023.



- Agreement was obtained for a non-deliberate, violence and aggression trainer to be employed for 12 months to upskill staff around clinical holding and de-escalation techniques.
- Restraint policy was updated.

8.2 Key Ambitions for 2025

- We will continue to provide patients with a safe therapeutic environment that is appropriate to their needs and minimises the potential for them to injure themselves
- The ligature policy is to be updated.
- Mandatory training for conflict resolution to be monitored.
- To roll out additional training around non-deliberate violence and aggression.
- To scope audit of ligature risk assessments for assurance of quality.

9.0 TRAINING

The Trust recognises the need to ensure our staff have the confidence and skills required for the needs of their service regarding mental health.

9.1 Key achievements in 2024

- A brief overview of the Mental Health Act is now included in the level 3 Think Family safeguarding training
- Maudsley training for Mental health awareness for acute trusts and Mental health crisis in the emergency department has been obtained
- Specific training for staff in acute Trusts caring for patients with mental health concerns has been identified.

9.2 Key ambitions for 2025

- To support staff that have been identified that require receipt and scrutiny
- To have training options from SWYFT that is within the SLA

10.0 RISK AND VULNERABILITIES

There continues to be a number of children and young people requiring Tier 4 specialist mental health care facilities. This has resulted in children and young people accommodated at the Trust waiting a specialist placement. These children and young



people are medically well and are often not admitted with a physical health need. In effect, the Trust is providing Tier 3 accommodation whilst a bed becomes available. At the Trust the children are cared for by health care support staff provided by SWYPT's Child and Adolescent Mental Health Services (CAMHS). There is no on site (CAMHS) Registered Mental Health Nurse to provide supervision and support for the unregistered support staff.

There has been an increase of Adult patients been detained under the Mental Health Act that are cared for at the Trust until a suitable bed becomes available. Every attempt is made to provide supervision whilst the patient is detained to BHNFT.

The contract and commissioning arrangements in relation to the provision of mental health care at the Trust is unclear in terms of the service specification, key performance indicators and expectations. There is no Service Level Agreement in place to support service delivery. Currently there is joint working between SWTPT and BHNFT to create a new service level agreement. This currently has been shared with members of the organisation for comments.

The risk to patients who may not be assessed, referred and treated in a timely and appropriate manner due to an increase in patients presenting to the hospital with a mental health condition, and lack of assurance on current service provision and capacity is detailed in the Trusts risk register. The risk score is moderate (6) due to the possible impact on patient's safety and poor patient experience.

10. 1 Key ambitions for 2025

- We will continue to work with SWYPT and ICB South Yorkshire on the contractual arrangements to ensure the Trust can deliver the same high-quality care for patient's mental health needs as for their physical health needs;
- We will ensure that all services being provided to the Trust via partners have a robust Service Level Agreement and policy that underpins the SLA so everybody is aware of what is being delivered and expectations from the service;
- We will continue to work with NHS England and local commissioners around capacity for Tier 4 beds and collaborate with CAHMS to provide care for children and young people; and
- We will work with SWYPT to ensure adults detained at BHNFT awaiting placement to a mental health facility are fully supported by the Mental Health Liaison Team.

11.0 CONCLUSION



This Annual Report demonstrates the Trust's commitment to improve outcomes for people experiencing a mental health issue. The annual report offers assurance of the mental health work programme delivered in 2024 and presents the ambitions for 2025 in the delivery of high quality integrated mental and physical health care.

Appendix 1

Attendances within ED where Mental health was the main presentation at attendance

Date	Adults	Children
2021	4522	1168
2022	4699	950
2023	4356	561
2024	4641	670

Appendix 2

Detentions within the trust.

Date	Section 5(2)	Section 2	Section 3	Section 4	Section 17 leave
2021	20	17	4	1	29
2022	27	31	2	0	15
2023	35	54	7	0	55
2024	42	86	3	0	36



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02/4.1

SUBJECT:	QUALITY AND GOVERNANCE CHAIR'S LOG				
DATE:	2 October 2025				
PURPOSE:		<i>Tick as applicable</i>			<i>Tick as applicable</i>
	<i>For decision/approval</i>	✓		<i>Assurance</i>	✓
	<i>For review</i>			<i>Governance</i>	✓
	<i>For information</i>	✓		<i>Strategy</i>	
PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair				
SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on Wednesday 24 September 2025 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance.

Q&G's agenda included consideration of the following items:

- Health Inequalities Action Plan
- Nursing, Midwifery and Allied Health Professionals Safe Staffing Report
- Six monthly Nursing Establishment Review
- Perinatal Quality Assurance Scorecard
- Corporate Performance Reports: By Exception
- Mortality and Learning from Deaths Report
- Peripherally Inserted Central Catheterisation update
- National Major Trauma Network: Negative Outlier deep dive
- Integrated Performance Report: By exception
- Temporary Escalation Space Report
- Board Assurance Framework and Corporate Performance Review
- Chair's Logs and minutes: IPC; CEG and Medicines Optimisation Group (MOG)

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Quality and Governance Committee is asked to receive and review the attached Log; and approve the Reports as noted in the Log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 25/10/02/4.1

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	Date: 24 September 2025	Chair: Gary Francis

	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Health Inequalities Action Plan	The Committee received the quarterly update and noted: - Recent Trust Board presentation. - Targeting Healthcare Inequalities. - Trust will host the soon to be appointed Associate Director of South Yorkshire Tobacco Control Alliance.	Board of Directors	Information/ Assurance
2	Nursing, Midwifery and Allied Health Professionals Safe Staffing Report	The Committee noted and received the updates, with the following key points: - Overall staffing metrics remain stable - Pockets of high maternity and sickness leave, together with vacancies in Clinical Business Unit (CBU) 3. Mitigations have prevented harm. - Flourish DX is in use and has highlighted issues in certain areas (e.g. Dietetics). - Extensive work is being done in AHP (budgeting and commissioning pathways)	Board of Directors	Assurance
3	Six-monthly Nursing Establishment Review	The Committee noted and received the updates, with the following key points: - On the whole Safer Nursing Care Tool scoring of patient acuity and dependency was in line with expectation and follows trends seen in previous data collections. - Recommendation to adjust rotas to improve overall skill mix over a period of time were supported.	Board of Directors	Assurance

4	Perinatal Quality Assurance Scorecard	The Committee noted and received the updates, with the following key points: • Positive trainee doctor survey. • Two of the in-year perinatal mortality deaths were in women from Asian/Black minorities. • More deaths in a younger cohort of patients (30-34 years). • Update on management of MRSA outbreak on the neonatal unit. • Staff attitude and behaviours are part of an action plan to address patient feedback. • Smoking at Time of Delivery (SATOD) 3.2% • Breastfeeding rates increased.	Board	Assurance
5	Mortality and Learning from Deaths Report	The Committee noted and received the updates, with the following key points: • SHMI 95.02; HSMR 73.69. • Five Learning Bulletins issued • Medical Examiner service continues to deliver	Board	Assurance
6	Peripherally Inserted Central Catheterisation update	The Committee received a proposal regarding a change in service provision that would reduce the requirement for radiological confirmation when placing peripherally inserted catheters. This proposal was approved.	Board of Directors	Assurance

7	National Major Trauma Network: Negative Outlier deep dive	The Committee received an update covering three years of outlier data, which indicated that mortality rates are higher in older patients managed at the Trust compared to those referred to a major trauma centre. A total of 74 cases were reviewed. Several challenges were identified, including issues with diagnosis, coordination of care by non-trauma trained clinicians, patient cohorting, a gap in rehabilitation coordinator provision, and the management of pain, delirium, sepsis, and respiratory care. A trauma coordinator post has been approved, but there has been a delay in appointing a trauma rehabilitation coordinator. The Executive Team has agreed in principle to the development of a 'silver trauma' ward or area. The Quality and Governance Committee will receive a further update on progress in due course.	Board of Directors	Assurance												
8	Integrated Performance Report: By exception	The Committee noted and received the updates, noting the positive metrics (falls, pressure ulcers, MRSA); CDT numbers of concern and that the Hospital Flow metrics have improved.	Board of Directors	Assurance												
9	Temporary Escalation Space Report	<table><tr><td></td><td>June</td><td>July</td><td>August</td></tr><tr><td>Days TES in use</td><td>24</td><td>29</td><td>27</td></tr><tr><td>Bed Days</td><td>128</td><td>161</td><td>125</td></tr></table> One Datix, no harms; ongoing audit of risk assessments		June	July	August	Days TES in use	24	29	27	Bed Days	128	161	125	Board of Directors	Assurance
	June	July	August													
Days TES in use	24	29	27													
Bed Days	128	161	125													
10	Board Assurance Framework (BAF) and Corporate Performance Review (CRR)	The Committee received the reports noting that CRR Risk 2695 was added with an amended residual risk of 15 (joint project with public health), which previously had a residual risk score of 12. The Committee approved the proposed increase in score, with a recommendation to the Board of Directors for approval.	Board of Directors	Assurance/ Approval												

11	Chair's Logs and minutes: Infection Prevention and Control (ICP) Clinical Effectiveness Group (CEG) Medicines Optimisation Group (MOG)	IPC: • Blood contamination rates have reduced (3.4%) • Deep clean programme as part of the CDT Action Plan, included ward sluice areas. Trial of a new Hydrogen Peroxide Vapour (HPV) machine - not able to implement following trial. • Rabies report confirmed all actions complete. • Zero MRSA • CDT: 21/51 • E. Coli 17/57 CEG: • QI project has reduced inappropriate cardiology referrals in AED/AMU by 47% • National Hip Fracture mortality outlier. • 8 clinical audits completed, with 7 providing significant assurance. The limited assurance audit relates to the provision of services for homeless people who present to AED. This is subject to a joint project with Public Health colleagues MOG: • Opioid prescribing gaps have been identified, which have been subject to an action plan to address the training shortfall. • The committee also received a six-month update on the action plan arising from several reviews within pharmacy over the past year.	Board of Directors	Assurance

4.2. Finance & Performance Committee Chair's Log: 28 August /25 September 2025

For Assurance

Presented by Alison Knowles



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02.4.2

SUBJECT: FINANCE AND PERFORMANCE CHAIR'S LOG - PUBLIC

DATE: 2 October 2025

PURPOSE:		Tick as applicable		Tick as applicable
	For decision/approval		Assurance	✓
	For review	✓	Governance	✓
	For information	✓	Strategy	

PREPARED BY: Alison Knowles, Non-Executive Director, Chair Finance & Performance Committee

SPONSORED BY: Alison Knowles, Non-Executive Director, Chair Finance & Performance Committee

PRESENTED BY: Alison Knowles, Non-Executive Director, Chair Finance & Performance Committee

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns (if appropriate) and make recommendations on people, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY: £k = thousands
£m = millions

This report provides information to assist the Committee and Board to obtain assurance regarding the finance and operational performance of the Trust and the appropriate rigour of governance. The meeting was held on 28 August 2025.

The following topics were the focus of discussion:

- Finance Report including ICS Financial Position
- Efficiency & Productivity Programme
- IPR
- Performance Exception Report – RTT
- ED Improvement Project
- ICS Quarter 2 Update
- Premises Assurance Model

RECOMMENDATIONS

The Board of Directors is asked to receive and review the attached log.

Subject:	Finance and Performance Committee Chair's Log - Public	Ref:	BoD: 25/10/02.4.2

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	Date 28 August 2025	Chair:
Finance and Performance Committee		Alison Knowles, Non-Executive Director

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
1	Finance Report The Committee received and discussed the Trust's Finance Report for Month 4, which reported a consolidated deficit of £51k against a planned deficit of £53k. The Committee discussed the key drivers for the financial position: • Total activity is 3.5% below plan in month. • ERF performance has improved in-month and is now £59k favourable, with Advice & guidance £95k favourable for the year-to-date. • CDC delivered below plan in month and is now £0.104m adverse. • Agency costs are 2.5% of pay costs for the month and 2.3% for the year-to-date. • Bank costs are 6.7% of pay costs for the month and 6.9% for the year-to-date. The Committee noted that Bank and Agency spend have both improved year on year, with agency controls having delivered a 37% decrease over the last year. The Trust is currently calculating the financial impact of the resident doctors' industrial action, which it estimates to be ca £0.4m for the action in July. Capital expenditure is below plan year to date, but will recover by year-end as individual projects are realised. The month 5 report to the Committee will include a forecast year-end position.	Board of Directors	Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	All Trusts and the ICB are reporting that they will deliver their financial plan for month 4, and all Trusts are making good progress on the NHSE requirement to have their full EPP identified from month 5.		
2	Efficiency and Productivity Programme The Committee discussed the month 4 report on the Efficiency and Productivity Programme. Significant progress has been made on identifying and signing off on individual projects in each of the CBUs and at a corporate level. The full year effect of these schemes in 2025/26 is now £11.7m, which will result in £16.4m FYE for 2026/27. This is a much-improved position from month 3 and a better position than at month 4 in prior years. In month 4, the Trust delivered £.0718m savings against a plan of £1.08m. Year to date, the Trust has delivered £2.73m against a plan of £4.05m. The Trust is aiming to recover this under-delivery by end of month 6. The focus of work is now moving to the delivery of individual schemes. The highest risk schemes remain those related to reducing non-contracted pay (agency and bank spend). The EPP report for month 5 will cover: • Final sign-off of all schemes • Identification of recurrent and non-recurrent schemes • Delivery profile for the remainder of 2025/26, and • Update on Quality Impact Assessment process and outcomes.	Board of Directors	Assurance
3	Integrated Performance Report The Committee discussed the month 4 IPR and noted that it will be updated to reflect the new NHS Oversight Framework from month 6 onwards. The focus of the discussion on delivery covered: • ED performance was 72.3% for Type 1 performance with bed occupancy remaining high at 94% • RTT performance has dropped slightly to 70.8% and diagnostic waiting times are now 4% of patients waiting more than 6 weeks.	Board of Directors	Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	There were 3 breaches of the 62-week target at month end and 122 patients waiting more than 52 weeks. The Trust has achieved the 28-day Faster Diagnosis Standard for cancer but did not achieve either the 31-day or the 62-day ambitions. The Committee discussed the RTT performance in detail, including the growth in the waiting list since December 2024 and the increase in cancer referrals, which is putting pressure on routine capacity. The Committee received assurance that there will be one breach of 65 weeks at the end of August, but then no further breaches in the remainder of 2025/26.		
4	Exception Report: RTT The Committee received a report on the work underway to recover the RTT position. The Trust remains ahead of England in terms of overall waiting times but needs to deliver its plan of 80% of patients waiting less than 18 weeks by end March 2026. A recovery trajectory is being developed, which will be reported to the Committee in month 5 and will be driven by improvements in: - Referrals and clock starts - Capacity and delivery of planned care - Validation of the waiting list - Diagnostic waiting times - Reduction in patients waiting over 52 weeks	Board of Directors	Assurance
5	ED Improvement Programme The Committee received the first of monthly reports into the ED Improvement Programme, which has been set up in the Trust. The programme is led by an externally commissioned clinical lead, Tom Nield, and will focus on five workstreams: - Improving the flow for non-admitted patients - Improving admission and discharge processes for inpatients - Strengthening professional standards - Improving capacity and demand management including work with primary care	Board of Directors	Assurance Page 98 of 380

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Delivering our ambition and a high-performance culture.		
6	ICT Update The Committee received the quarterly update on the Trust's ICT programme, including an update on the Cyber Security Action Plan. Significant progress has been made on IT systems to support the Health on the High Street project, support to paediatrics, the roll-out of updated discharge summaries and the new E-consent. Work continues to support the roll-out of CareTrack, including strengthening the Trust's wifi system to enable tracking of patients. CareTrack remains on track to be delivered from end of September. The Pharmacy Stock Control system, which had previously been delayed, will now go live on 9 September. On Cybersecurity, the IT team have closed one high-risk system, which had been identified and are on track to deliver all the other required improvements.	Board of Directors	Assurance
7	Premises Assurance Model The Committee received and approved the Premises Assurance Model for submission to NHSE by 30 September. The PAM is now mandatory for all NHS providers and is delivered through a series of self-assessment, structured questions. The NHS PAM self-assessment questions (SAQs) are grouped into five 'domains', with a separate section for helipads, FM Standard Maturity Framework and contacts. The five reported domains for 2025 cover Safety (Hard and Soft), Patient Experience, Efficiency, Effectiveness, Governance and FM Maturity Standards. The PAM review for Barnsley Hospital NHS Foundation Trust (BHNFT) and Barnsley Facilities Services (BFS) is good, with some areas requiring Minimal Improvement and no areas requiring Moderate Improvement or rated as Inadequate. Areas of outstanding practice were also identified.	Board of Directors	Assurance



REPORT TO THE BOARD OF Directors		REF:	BoD: 25/10/02/4.2	
SUBJECT:	FINANCE AND PERFORMANCE CHAIR'S LOG - PUBLIC			
DATE:	02 October 2025			
PURPOSE:		<i>Tick as applicable</i>		<i>Tick as applicable</i>
	<i>For decision/approval</i>		<i>Assurance</i>	✓
	<i>For review</i>	✓	<i>Governance</i>	✓
	<i>For information</i>	✓	<i>Strategy</i>	
PREPARED BY:	Nicky Clarke, Non-Executive Director, Chair Finance & Performance Committee			
SPONSORED BY:	Alison Knowles, Non-Executive Director, Chair Finance & Performance Committee			
PRESENTED BY:	Alison Knowles, Non-Executive Director, Chair Finance & Performance Committee			
STRATEGIC CONTEXT				
The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns (if appropriate) and make recommendations on people, financial and performance matters to the Board of Directors.				
EXECUTIVE SUMMARY			KEY: £k = thousands £m = millions	
This report provides information to assist the Committee and Board to obtain assurance regarding the finance and operational performance of the Trust and the appropriate rigour of governance. The meeting was held on 25 September 2025. The following topics were the focus of discussion: • ED improvement plans and outcomes • Integrated Performance Report • Performance Exception Reports • Health on the High Street update • Finance Report • ICS Finance Report • Efficiency and Productivity Programme update • System Working updates • Board Assurance Framework / Corporate Risk Register • Sub Group Chairs' Logs				
RECOMMENDATIONS				
The Board of Directors is asked to receive and note the attached log.				

Subject:	Finance and Performance Committee Chair's Log - Public	Ref:	F&P: 25/09/25/1.6

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	Date 25 September 2025	Chair:
Finance and Performance Committee		Nicky Clarke, Non-Executive Director

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
1	ED Improvement Plans The Committee was updated on the plans in place as part of the 'Be The Best' programme as well as the actions as a result of being in the Tiering programme with NHS England. Positive progress being made on overall 4 hour performance and 62% of discharges now being achieved prior to 5pm (was 49%). Teletracking is helping to understand flow and enable speedier actions to be taken to maintain performance. System support being sought to reduce attendances. The increased oversight of ED performance is strengthening and accelerating the understanding of what is impacting performance so corrective action can be taken more quickly.	Board of Directors	Assurance
2	Integrated Performance Report Highlights from the IPR: - Emergency Department performance strong nationally with performance at 78.3%. - Referral To Treatment times are struggling at 68.8% with action plans in place for underperforming specialities. - Cancer metrics are improving with the Trust close to achieving all the targets. - Diagnostics is showing an increase in delays due to a nationally mandated change in reporting in audiology related to hearing aid checks. - Theatres productivity is at 79% with challenges in a small number of specialities. - DNA rates are a concern and work is underway to address this.	Board of Directors	Assurance
3	Performance Exception Reports The Committee received the detailed exception reports. Key area of focus is the growth in the waiting list with a 6% rise in cancer referrals and a 14% increase in the diagnosis of cancer, which is inevitably displacing routine work. Discussions are underway in the system to minimise unnecessary referrals. Waiting lists are also being validated.	Board of Directors	Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
4	Health on the High Street update Programme is on track for Phase 1 teams to move in on 27 th October following issues with water being resolved. A small number of other issues are being resolved with the Council. Phase 2 is on track as well.	Board of Directors	Assurance
5	Finance Report The Trust is on plan at Month 5 with a consolidated deficit of £64k against a plan of £66k. Surge funding has been released as planned with work to do to ensure efficiency plans deliver as intended to hit the year end forecast as they are slightly behind plan at Month 5. Activity income is also behind plan. Non contractual pay has seen an uplift in the month consistent with the holiday period and it is anticipated the run rate will reduce in Month 6. The full year forecast is heavily dependent on activity being recovered in a cost efficient way with all efficiencies being delivered to plan.	Board of Directors	Assurance
6	ICS Finance Report ICS finance report demonstrates the ICB is moving in the right direction to get to plan. The decision on Q3 deficit funding will be made this week, with all providers reporting an on plan forecast at Month 5.	Board of Directors	Assurance
7	Efficiency & Productivity Programme Encouraging progress was presented to the Committee in terms of schemes to hit the efficiency target with schemes now totalling £11.7m in place, which if achieved will be the first significant step in getting the Trust back to balance.	Board of Directors	Assurance
8	System Working Barnsley Place - It was reported to the Committee that Barnsley had not been successful in being included in the neighbourhood scheme being run nationally. Intermediate care provision would be discussed at the Place Board later in the day. South Yorkshire ICS - It was noted that the ICB Chief Executive had made the decision to retire and that the plans for reconfiguring the ICB were on hold.	Board of Directors	Assurance
9	Board Assurance Framework / Corporate Risk Register The BAF was presented to the Committee and a recommendation to increase two risk scores was approved for onward agreement at Board.	Board of Directors	Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
10	Sub Group Chairs' Logs Highlights from the sub groups: - Capital Monitoring – behind plan by £4.3m, but all schemes forecasting to be on plan by year end. - Trust Operations group has restarted with a focus on operations and finance. - Digital Steering – updated on changes needed to the Electronic Patient Record system to facilitate the Emergency Care Data Set. - Positive reports from both Data Quality and IG groups.	Board of Directors	Assurance

4.3. Audit Committee: Nil return

For Assurance

Presented by Stephen Radford

4.4. People Committee Chair's Log: 23 September 2025

For Assurance

Presented by Kevin Clifford



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02/4.4

SUBJECT:	PEOPLE COMMITTEE ASSURANCE REPORT				
DATE:	2 October 2025				
PURPOSE:		<i>Tick as applicable</i>			<i>Tick as applicable</i>
	<i>For decision/approval</i>	✓		<i>Assurance</i>	✓
	<i>For review</i>			<i>Governance</i>	✓
	<i>For information</i>	✓		<i>Strategy</i>	
PREPARED BY:	Nicky Clarke, Non-Executive Director / Committee Deputy Chair				
SPONSORED BY:	Nicky Clarke, Non-Executive Director / Committee Deputy Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director / Committee Chair Nicky Clarke, Non-Executive Director / Committee Deputy Chair				

STRATEGIC CONTEXT

The People Committee is a committee of the Board responsible for oversight and scrutiny of the Trust's development and delivery of workforce, organisational development and cultural change strategies supporting the Trust's strategic priorities. Its purpose is to provide detailed scrutiny, to provide assurance and to raise concerns (if appropriate) to the Board of Directors in relation to matters within its remit.

EXECUTIVE SUMMARY

The Committee met on Tuesday 23 September 2025 considered the following items:

- Workforce Insight Report
- Workforce Disability Equality Standard Annual Report
- Workforce Race Equality Standard Annual Report
- Consultant Job planning
- Getting the Basics Right for Resident Doctors
- Medical Appraisal and Revalidation Annual Report
- Director of People Monthly update
- Medical & Dental Exclusions / Restrictions update
- Trust Communications Strategy
- Proud to Care Cultural Leadership Steering Group – Chair's log
- CBU updates
- Board Assurance Framework

For assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached Log.

Subject:	PEOPLE COMMITTEE ASSURANCE REPORT	Ref:	BoD: 25/10/02/4.4

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee (Q&G)	Date: 23 September 2025	Chair: Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Workforce Insight Report	The Committee received the latest people data. There were positive trends in mandatory training and appraisal completion, as well as return to work interviews. Sickness absence continues to be a cause for concern, with the level at 5.5%, with significant increases in mental health-related absences. Work is underway to address this.	Board of Directors	Assurance
2	Workforce Disability Equality Standard Annual Report	The annual report was presented. Some positive improvements were noted, including increased reporting of disabilities and long-term conditions, although concerns were raised about bullying and harassment and the likelihood of being appointed to roles. No board representation is a persistent issue. Detailed plans to address the concerns were discussed.	Board of Directors	Assurance
3	Workforce Race Equality Standard Annual Report	The annual report was presented. Positive trends in representation across many bands, although still poor representation in senior roles. Of particular concern is the likelihood of BME candidates being appointed, where white colleagues are 4.36 times more likely to be successful. Detailed plans for addressing this were discussed.	Board of Directors	Assurance
4	Consultant Job Planning update	A comprehensive update was provided showing positive progress in job plans being signed off – now at 95% of consultants having signed them off. The action plan, in	Board of Directors	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		response to the 360 audit, is being progressed with all actions on track.		
5	NHSE Ten Point Plan – Getting the Basics Right for Resident Doctors	The action plan to address the 10 points linked to improving working lives for resident doctors was presented. A further update will be received in November, given the short timescale on the requirements. A Board representative is still to be identified and will be discussed at the Board.	Board of Directors	Assurance
6	Medical Appraisal and Revalidation Annual Report	The annual report was presented with 98.9% of doctors successfully managed for appraisal and 65 of 71 doctors successfully revalidated. The new online system has been well received.	Board of Directors	Assurance
7	CBU updates	CBU 2 gave an update covering a range of people issues. The Committee noted the positive work on sickness absence, performance management and team building.	Board of Directors	Assurance
8	Director of People update	The Committee received an update on national issues, including the current employee relations climate and local issues – paid breaks and the work on nursing and midwifery job descriptions.	Board of Directors	Assurance
9	Trust Communications Strategy	The Committee received and approved the new strategy for onward presentation to the Board.	Board of Directors	Assurance
10	People Engagement Steering Group – Chair’s update	The Committee received a verbal update from the meeting held the previous week.	Board of Directors	Information
11	Proud to Care Cultural Leadership Steering Group – Chair’s Log	The Committee received the most recent Chair’s log.	Board of Directors	Information

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
12	Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	The Committee received and discussed the BAF and the CRR, with discussion around people-related risks. A small number of minor amendments were discussed.	Board of Directors	Assurance

4.5. To be the best Plan

For Assurance

Presented by Lorraine Burnett



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02/4.5

SUBJECT: CONSTITUTIONAL STANDARD - ACUTE AND EMERGENCY CARE - HOUR STANDARD

DATE: 02 October 2025

PURPOSE:		Tick as applicable			Tick as applicable
	For decision/approval			Assurance	✓
	For review			Governance	✓
	For information	✓		Strategy	

PREPARED BY: Tom Nield, Associate Chief Operating Officer

SPONSORED BY: Lorraine Burnett, Chief Operating Officer

PRESENTED BY: Lorraine Burnett, Chief Operating Officer

STRATEGIC CONTEXT

The Trust 4-hour standard is an NHS constitutional standard which is a key National performance indicator for all acute NHS providers.

EXECUTIVE SUMMARY

Situation

Despite significant investment over recent years, the Trust has seen a gradual decline in performance against the four-hour constitutional standard.

Since 2022 the Trust has seen a continual rise in ED attendances. For the years 22/23 this was slightly below plan albeit an annual rise of 2%. However, in 24/25 attendances, exceeded plan by 3.1%. For 25/26 the plan was once again set as forecast out turn from the previous year but year to date has shown another 3% increase. In summary attendances since 19/20 to forecast out turn for 25/26 have increased by 6.5%. Non elective admissions have seen a steeper rise in demand against plan with 5% over plan in 23/24 and 7% in 24/25. Year to date for 25/26 we are on plan, but this is during the summer months when admissions are seasonably lower giving minimal confidence that the trust will not see demand exceeding plan again over the winter months. There are several caveats to the data as coding changes have been made over the years, including the introduction of the Emergency Care Data Set.

The rise in ED attendance is not easily attributable to any specific pathway, acuity or demographic. There has been an increase in GP attendances and those with lower acuity minor illness, but the data is not easily compared over multiple years. The split against age groups has remained static although admissions for >90 years has increased the most. A key factor in attendances has been deprivation with the latest national data showing 40.2% of the catchment area population attending ED each year, against an English mean of 29.5%.

Background

BHNFT has recently, August 2025, been formally notified of its placement in tier 2 of the NHS oversight framework for Urgent and Emergency care performance. This is largely due to a change in national performance management, with performance now measured against the submitted 25/26 operational plan, as opposed to absolute performance.

Actual performance YTD benchmarks' second quartile nationally at 71%, however performance against plan is 9-14% under plan. This is against a 78% plan for August 25, rising to 80% by March 26. Subsequently NHSE has formally recognised that the Trust is off plan.

Since submission of the 25/26 operational plan in March 2025, when the Trust also achieved 80.4%, the Trust has seen fluctuating performance against the Trust 4-hour standard.

2025	2025	2025	2025	2025
March Cumulative Position	April Cumulative Position	May Cumulative Position	June Cumulative Position	July Cumulative Position
80.4%	68.5%	73.5%	64.8%	72.9%

Actions

In response to inconsistencies in performance, in June 2025, the Chief Executive commissioned an independent review from a respected colleague from Rotherham NHS FT with both, previous BHNFT experience and an acute and emergency care clinical background. The Senior Nurse has agreed to support the organisation to undertake a quality improvement programme aimed at ensuring consistent and sustained delivery against the Trust's four hour emergency care standard.

Following an initial four week diagnostic phase that included data analysis, stakeholder engagement and direct clinical observations. A subsequent quality improvement programme was developed and agreed by the Trust's Executive Team.

The 'Be the Best' (BTB) quality improvement programme is a CEO led quality improvement programme with 5 strategic executives led workstreams:

1. Optimising our Acute and Emergency Care areas – Lorraine Burnett
2. Quality Flow – Steve Ned
3. Professional Standards – Simon Enright
4. Capacity, Demand and Strategy – Lorraine Burnett
5. Ambition and High Performance Culture – Michael Wright

In addition to the 5 longer term workstreams, the independent review identified 7 immediate recovery actions that would facilitate immediate improved performance. These immediate actions were implemented in early August 2025 with good effect.

RECOMMENDATION

The Board of Directors is asked to note the placement of BHNFT in Tier 2 for Urgent and Emergency Care performance.

The Board of Directors is asked to note the independent review slide deck and associated quality improvement plan.

“Be The Best” (BTB)

Quality Improvement Programme





1. Process



2. Priorities

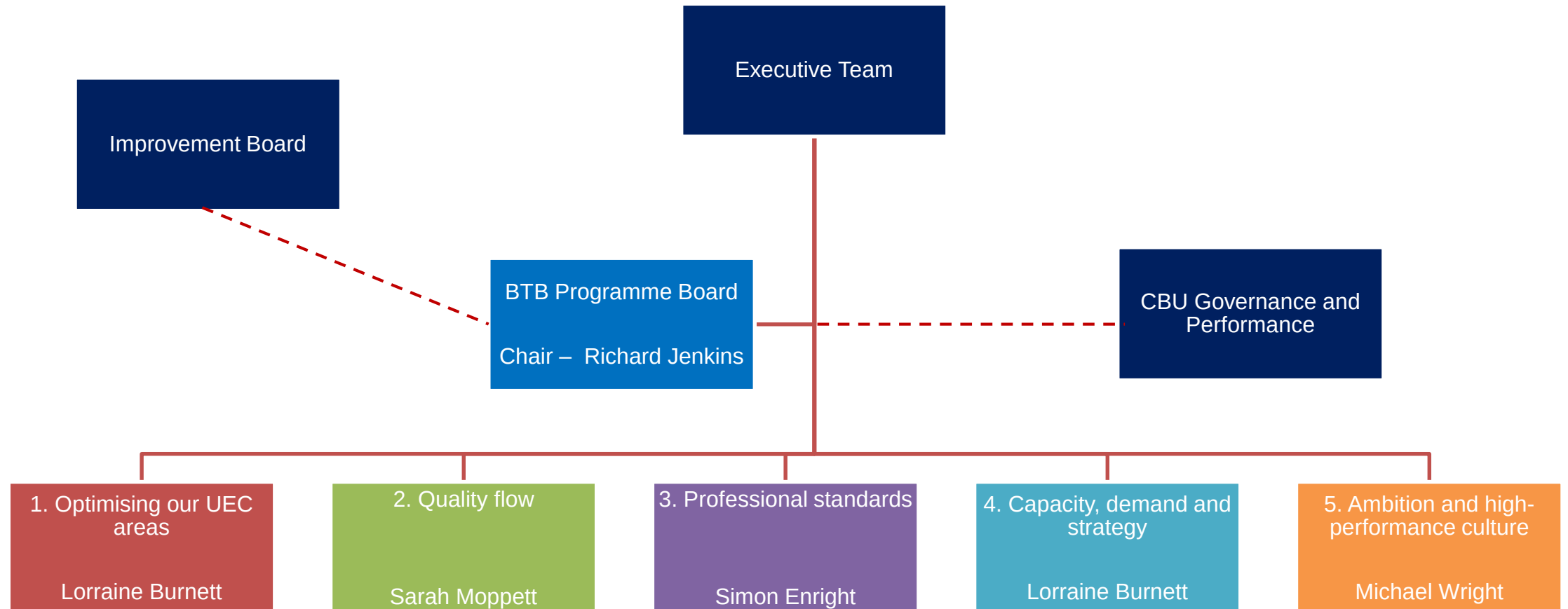


3. People

Programme Development Phases

- [?] Programme planning (2nd–4th July)
Site walk-round, comms and meeting setup with Triumvirates. Request for data to expedite and triangulate improvement plan development
- [?] Engagement (14th July–1st August)
Stakeholder engagement, ward-board, listening and direct clinical observations
- [?] Analysis (4th–9th August)
Literature review, stakeholder meeting feedback and overall recommendation sharing
- [?] Implementation (11th–18th August)
Agree improvement plan and launch

Be The Best - Programme Governance Structure





Be The Best – Achieving the Trust 4-hour Standard

1. Optimising our Urgent and Emergency Care areas

Lorraine Burnett

•SRO's:

- Non admitted adults
- Non admitted paed's
- Ambulance handover (YAS 45 - Aug 25)
- 12 hour in department
- Triage
- Clinical Decision Maker <90 mins
- DTA to Assessment units <45 mins
- SDEC, CDU, CAU utilisation and pathways
- Workforce and efficiencies

2. Quality flow

Sarah Moppett

• SRO's:

- Admitted performance CG 1,2, 3
- Length of Stay (7,14,21 days)
- No Criteria to Reside
- Discharge <17:00
- Out of hours transfers <2200
- Board rounds
- Infection control – rapid turnaround
- Teletracking preparedness
- Mental Health delays
- Discharge unit utilisation
- Pharmacy and print D1 process

3. Internal professional standards

Simon Enright

• SRO's:

- ED - speciality reviews
- Length of Stay
- Medical reviews (SHOP) principles
- Proforma and audit
- 10 steps comms
- Intr review in AMU

4. Capacity, demand and strategy

Lorraine Burnett

• SRO's:

- Site management – actions and response
- Home First principles
- Winter plan
- UEC Plan 25/26
- Teletracking preparedness
- Estates and capital

5. Ambition and High-Performance Culture

Michael Wright

•SRO's:

- Stakeholder engagement
- Culture of care survey
- Compassionate Leadership
- Responsiveness and accountability
- Escalations and actions
- Violence and Aggression
- Digital efficiency

Immediate recovery actions, 01 Aug 25

	Action	Rationale	Date	Owner	Progress (RAG)
1.	AOB to ETM - to reintroduce D1 doctor in Discharge lounge for period of 3 months whilst BTB programme benefits are realised	To improve utilisation of discharge lounge back to 2024 levels	23.07.25	Lorraine Burnett	CBU 1 asked to develop a rota of LED SHO's to cover the role
2.a	CBU1 Matron of the Day to take ownership of early patient flow. Consider 'golden patient' principles. Ensure development of clear KPI's to support oversight and delivery. Monitor dashboard for out of hours and time of day transfers	Nursing engagement and ownership of flow is a critical factor to site management and patient flow	28.07.25	ADON's	Daily 8.30 ADN chaired am huddle – Matrons/lead nurses – to identify discharges/ early moves / staffing Matrons then spend until 10.30 am site meeting supporting wards Metrics being discussed at ADN away day 31/7 Matron focus on support with internal delays to facilitate earlier discharges
3.	Review bed meeting structure and ensure actions from bed meetings are clear with documented actions and responses from accountable teams, with follow up at subsequent meetings. Consider triangulation, responsiveness and learning from ED, AMU and site logs	Ensure appropriate escalations and actions to emerging risk around patient flow, capacity and demand	28.07.25	Sue Spencer	Site Team reminded to ensure clear actions are asked and documented at Bed Meetings. Bed Meeting template being reviewed with a

Immediate Recovery Actions, 08 Aug 25

	Action	Rationale	Date	Owner	Progress (RAG)
1.	AOB to ETM - to reintroduce D1 doctor in Discharge lounge for period of 3 months whilst BTB programme benefits are realised	To improve utilisation of discharge lounge back to 2024 levels	23.07.25	Lorraine Burnett	Implemented
2.a	CBU1 Matron of the Day to take ownership of early patient flow. Consider 'golden patient' principles. Ensure development of clear KPI's to support oversight and delivery. Monitor dashboard for out of hours and time of day transfers	Nursing engagement and ownership of flow is a critical factor to site management and patient flow	28.07.25	ADON's	CH to confirm interim and longer-term plans verbally at 08.08.25 meeting
3.	Review bed meeting structure and ensure actions from bed meetings are clear with documented actions and responses from accountable teams, with follow up at subsequent meetings. Consider triangulation, responsiveness and learning from ED, AMU and site logs	Ensure appropriate escalations and actions to emerging risk around patient flow, capacity and demand	28.07.25	Sue Spencer	Bed Meeting template circulated 07.08.25 for feedback and comments
4.	Review AMU domestic provision to mitigate change in flow and reduce delays relating to IPC cleans. Review IPC practice around previous infection status	There are currently long delays due to bed cleans on AMU. The provision of 2 domestics 0800-1945 does not match current flow requirements	28.07.25	Rob McCubbin & Sarah Moppett	Review undertaken by DoN and IPC
					RMc updated on an interim AMU plan
5.	Review organisational readiness for YAS 45 handover. August 2025 implementation date	There has been limited engagement from key stakeholders that may impact implementation	04.08.25	Lorraine Burnett	YAS have confirmed that they will be attending site to work with us on W45 readiness. ED walk round has established 1 additional handover space. Reviewed the risk assessments from last winter to establish cant have the trollies on corridor near ambulance entrance. Past week had 6 >45 min handovers. Meeting on Thurs PM to consider role of an additional

Immediate Recovery Actions, 14 Aug 25

	Action	Rationale	Date	Owner	Progress (RAG)
1.	AOB to ETM - to reintroduce D1 doctor in Discharge lounge for period of 3 months whilst BTB programme benefits are realised	To improve utilisation of discharge lounge back to 2024 levels	23.07.25	Lorraine Burnett	Implemented
2.a	CBU1 Matron of the Day to take ownership of early patient flow. Consider 'golden patient' principles. Ensure development of clear KPI's to support oversight and delivery. Monitor dashboard for out of hours and time of day transfers	Nursing engagement and ownership of flow is a critical factor to site management and patient flow	28.07.25	ADON's	1 st Sep – Matron of the Day Implementation
3.	Review bed meeting structure and ensure actions from bed meetings are clear with documented actions and responses from accountable teams, with follow up at subsequent meetings. Consider triangulation, responsiveness and learning from ED, AMU and site logs	Ensure appropriate escalations and actions to emerging risk around patient flow, capacity and demand	28.07.25	Sue Spencer	Go live 18 August 2025
4.	Review AMU domestic provision to mitigate change in flow and reduce delays relating to IPC cleans. Review IPC practice around previous infection status	There are currently long delays due to bed cleans on AMU. The provision of 2 domestics 0800-1945 does not match current flow requirements	28.07.25	Rob McCubbin & Sarah Moppett	Review undertaken by DoN and IPC RMc updated on an interim AMU plan
5.	Review organisational readiness for YAS 45 handover. August 2025 implementation date	There has been limited engagement from key stakeholders that may impact implementation	04.08.25	Lorraine Burnett	SOP for Friday meeting approval
6,	Develop and agree programme structure with CBU's for Be The Best Quality improvement programme. Meetings to start WC 04 August.	Create a multi-stream quality improvement programme that ensures sustained improvement and delivery	04.08.25	Tom Nield, PMO and QI	PMO support secured. BTB Metrics dashboard – 18 Aug due to annual leave
7.	Meet with CBU 2&3 triumvirate and continue deep dive into services and pathways relevant to Acute and Emergency Care performance.	In limited time, initial data suggested focus and starting point of ED and as	Ongoing	Tom Nield	CBU3 completed CBU 2 completed

4.6. Fire Code Statement

For Assurance/Approval

Presented by Michael Wright



**REPORT TO THE
BOARD OF DIRECTORS**

REF:

BoD: 25/10/02/4.6

SUBJECT: ANNUAL FIRE STATEMENT

DATE: 2 October 2025

PURPOSE:		Tick as applicable		Tick as applicable
	For decision/approval		Assurance	✓
	For review		Governance	✓
	For information	✓	Strategy	

PREPARED BY: Gill Lammas; Head of Operations and Compliance

SPONSORED BY: Michael Wright; Managing Director

PRESENTED BY: Michael Wright; Managing Director

STRATEGIC CONTEXT

The Technical Memorandum 05-01 refers to the management of Fire Safety within Healthcare premises.

This guidance states that this fire code statement must be completed annually for governance and signed by the Chief Executive.

EXECUTIVE SUMMARY

The Annual Fire Statement is for the 1st April 2024 to the 31st March 2025. The Trust has not had any intervention from the Fire Service. The Fire Risk Assessments are all up to date and reviewed appropriately.

Each year a capital budget of £300,000.00 is designated for Fire Safety. Last financial year this was spent on replacing some fire doors, installing the fire suppression system in WH Smiths and work on fire dampers and damper infrastructure.

The Fire Code was noted and approved at the Quality and Governance Committee in August 2025, with a recommendation for endorsement by the Board of Directors.

RECOMMENDATIONS

The Board of Directors is requested to approve the Fire Statement for Governance and to delegate authority for final sign-off to the Chief Executive.

Annual Statement of Fire Safety 2024/2025

NHS organisation: Barnsley Hospital NHS Foundation Trust		
I confirm that for the period 1 st April 2024 to the 31 st March 2025, all premises which the organisation owns, occupies or manages have fire risk assessments undertaken, and under review, in compliance with the regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):		
1.	There are no significant risks arising from the fire risk assessments.	
2.	The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment.	☒
3.	The organisation has identified significant risks, but does not have a programme of work to mitigate those significant risks.	
4.	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	
5.	During the period covered by this statement, the organisation ~~has~~ /has not* been subject to any enforcement action by the fire and rescue authority. Please outline details of enforcement action in Annex A Part 1.	☒
6.	The organisation ~~has~~ /has not* got any on-going enforcement action pre-dating this Statement. Please outline details of on-going enforcement action in Annex A Part 2	☒
7.	The organisation achieves compliance with the Department of Health's fire safety policy by the application of Firecode or some other suitable method.	☒
Chief Executive:	Dr. Richard Jenkins	
Head of Operations & Compliance	Gillian Lammas	
Contact Details:	E-mail: gillian.lammas@nhs.net	
	Telephone: 01226 436402	
	Mobile: n/a	
Signature of Chief Executive:		
Date:		
Completed statement to be retained for future audit		

*Delete as appropriate

ANNEX A

Part 1 – Outline any enforcement action taken during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the costs to comply.

None for the period 1st April 2024 to the 31st March 2025.

Part 2 – Outline any enforcement action on-going from previous years and the action the organisation has taken so far. Include any proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.

No ongoing enforcement action from previous years.

NHS Organisation:	Barnsley Hospital NHS Foundation Trust
Date:	11/07/2025

Programme of Fire Related Works:

In 2023/24: -

Capital Work were completed on replacing damaged beyond repair fire doors, fire stopping O-Block, replacing the old fire alarm system and some access work to enable fire dampers in ventilation systems to be tested, expansion joints replaced with fire rated material.

In 2024/25: -

Capital Work was completed on replacing fire doors that were beyond repair, remedial works on fire dampers that failed their inspection, and remedial works on dampers that were deemed as not accessible due to access hatches not being in situ. Fire damper panel infrastructure was put into the AB tower block in preparation for installation of automatic dampers during refurbishments. Fire stopping works was undertaken in all the tower blocks, the fire suppression system was installed into WH Smiths, and there was some work on the fire alarm system upgrading to an L1 system. Work was started on the Theatre extension, which will create an extra theatre, and staff facilities for the area.

In 2025/26: -

Capital works have been planned for the relocation of the Theatre Arrivals Unit, into the main Theatre complex. This work is subject to a Building Safety Regulator (BSR) application to the Health & Safety Executive (HSE), and therefore capital works are currently focused on the subsequent works required prior to submitting the application. Actions from fire risk assessments are still being collated and there is a focus to complete these actions as budgets allow.

Break

5. Performance

5.1. Maternity - Perinatal Quality

Assurance Scorecard : Tracy Taylor and
Sarah Petty in attendance

For Assurance

Presented by Sarah Moppett



**REPORT TO THE
BOARD OF DIRECTORS**

REF:

BoD: 25/10/02/5.1

SUBJECT: PERINATAL QUALITY OVERSIGHT SCORECARD

DATE: 2 October 2025

PURPOSE:		Tick as applicable		Tick as applicable
	For decision/approval		Assurance	√
	For review	√	Governance	√
	For information	√	Strategy	

PREPARED BY: Maternity and Neonatal teams

SPONSORED BY: Sarah Moppett, Director of Nursing, Midwifery and AHP's

PRESENTED BY: Sarah Petty, Joint Director of Midwifery
Tracy Taylor, Associate Director of Nursing

STRATEGIC CONTEXT

This report contains details and assurance relating to the national minimum perinatal clinical quality data set for maternity services.

Trust Boards are responsible for perinatal oversight under the Perinatal Quality Oversight Model (NHS England, 2025), with duties that include ensuring safety of care, providing necessary resources for staff, and addressing health inequalities. These responsibilities correspond with the Trust's ambitions and strategic objectives.

EXECUTIVE SUMMARY

This report provides the Trust Board with an analysis of bimonthly perinatal clinical quality oversight information:

The key messages contained within the paper refer to July and August 2025 data are as follows:

•**Perinatal Activity and Outcomes Overview:** Barnsley Hospital NHS Foundation Trust recorded 2,919 bookings and 2,874 births from September 2024 to August 2025, with 20 home births and 21 born before arrival. Continuity of care was provided to 666 women, with 1,108 inductions of labour and 1,328 caesarean sections (857 emergency, 471 elective). Unassisted births numbered 1,236, assisted births 289, and preterm births under 37 weeks were 210. Term admissions to neonatal unit totalled 91, with a 99.9% right place of birth rate. The birth rate remained stable with a sharp increase in August 2025, and smoking at birth fell to 3.6%.

•**Safety, Incident Reporting, and Perinatal Mortality Reviews:** Perinatal mortality reviews (PMRT) were completed for four cases in July and August 2025, with learning actions including debrief checklist implementation and improved communication. There were no Coroner Regulation 28 reports or term hypoxic ischemic encephalopathy (HIE) cases since December 2021. One patient safety incident investigation was underway for a term transfer with fractured skull. Maternity and Neonatal Safety Incident (MNSI) referrals and serious incidents have decreased since 2023. The MRSA outbreak on NNU was reopened on 6 July 2025 after another baby tested positive. UKHSA is supporting the management of the outbreak.

Workforce, Training, and Staffing: Staffing gaps reduced from 15.04 WTE in July to 12.74 WTE in August 2025, with one obstetric consultant vacancy and another expected due to retirement. Training compliance for PROMPT, fetal monitoring, and neonatal life support remained above 90%.

though a small reduction occurred due to staff rotation. Safeguarding Level 3 training compliance met the 90% Trust target for maternity establishment and obstetrics staff, with ongoing monitoring and allocation for non-compliant staff. Overall training compliance across subjects remains above 90%, supporting safe service delivery.

Qualified in Specialty (QIS) training for registered nurses was at 65%, which is just below BAPM standards, with an action plan to increase compliance. Sickness absence was 7.6% in July, reduced to 4.8% in August.

•Patient Experience and Engagement: The Maternity and Neonatal Voice Partnership (MNVP) holds monthly meetings with the Matron team to incorporate service user feedback. Progress includes sharing patient stories and embedding co-production with service users. Areas for improvement include inclusive language, staff attitudes, feeding support post-caesarean, induction of labour information, neonatal unit communication, and bereavement support. The service aims to increase positive feedback, improve National Maternity Survey results, and reduce complaints and concerns, with particular focus on the ANPN ward.

•Clinical Performance Metrics and Trends: Induction of labour and caesarean section rates increased in line with best practice guidance, with unassisted vaginal births averaging 48%, slightly above the national average. Assisted births averaged 7%, just below the national average. Third-degree tears show an upward trend and are under thematic review. Breastfeeding initiation rates and preterm breastmilk provision continue to improve.

National Data Reporting: The service submitted the Maternity Services Data Set (MSDS) and is on track with all Maternity Incentive Scheme safety actions. The three-year delivery plan is underway, with improvement plan actions based on the 2024 Maternity inpatient surveys targeting antenatal and postnatal care.

RECOMMENDATION(S)

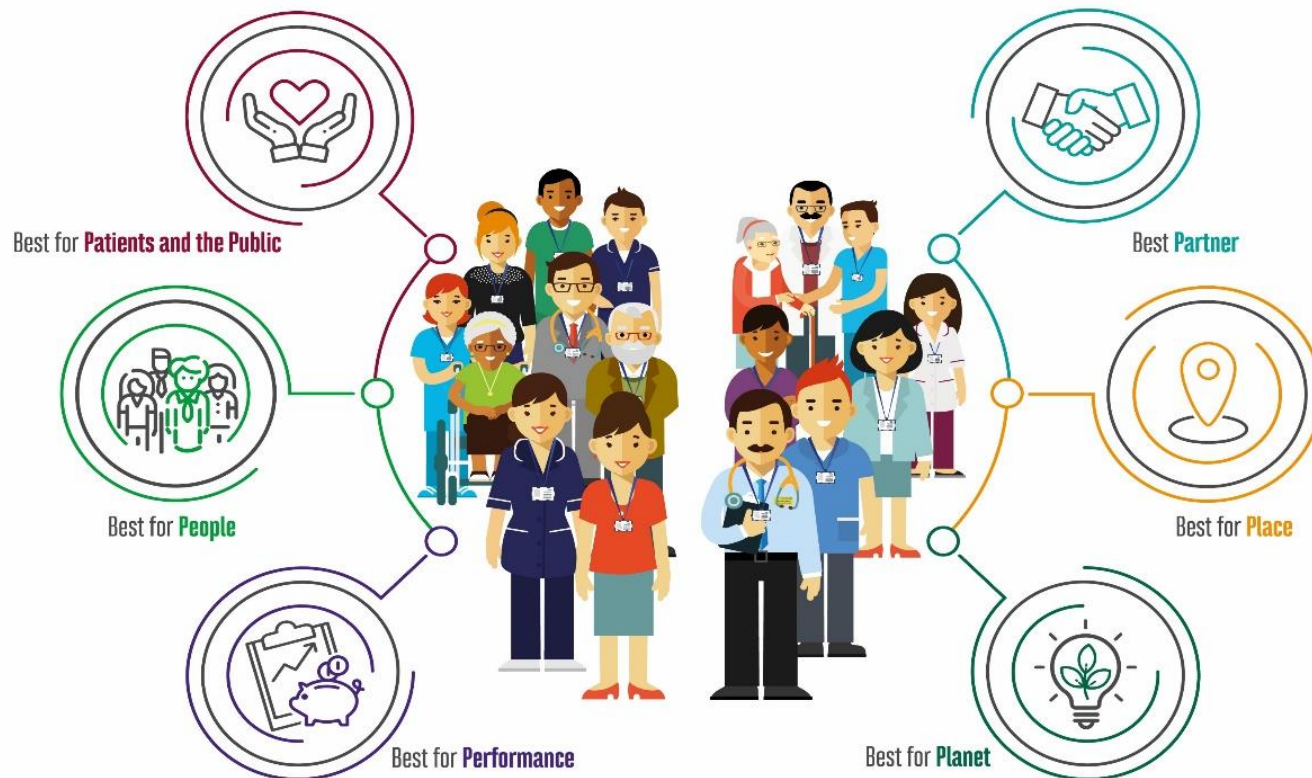
The Board of Directors is asked to receive the report and acknowledge receipt of the bi-monthly Perinatal Quality oversight Scorecard for maternity and Neonatal services.

PROUD

to
care

July and Aug 2025

Our Strategy 2022-2026



Contents



Best for People



PRETERM



SAVING BABIES'
LIVES
V3



THREE YEAR
DELIVERY
PLAN



AVOIDING TERM
ADMISSIONS
IN NEWBORNS



OVERALL
SUMMARY



Best for Patients
and Public



Best for
Performance



Best for Place



PERINATAL
MORTALITY

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MATERNITY
INCENTIVE
SCHEME

Month at a Glance

 Best for Patients and Public		July	Aug	 Best for People		July	Aug
	Perinatal patient safety incidents reported	95	128		BBC co-ordinator not supernumerary – awaiting midwife during escalation	0	2
	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	 AVOIDING TERM ADMISSIONS IN NEWBORNS	RCOG roles and responsibilities audit	100%	100%
	Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0		Term neonatal admission	14	12
	Incidents confirmed as moderate physical harm or above and statutory duty of candour completed	2	3	 Best for Performance	Compliance for fetal monitoring training	100%	99%
	Finalised internal SI/PSII reports	0	0		Compliance for PROMPT Training	96%	90%
	Finalised reports received from MNSI	0	0	 PERINATAL MORTALITY	Compliance for MAST training	94%	92%
	Cases referred to MNSI and families informed of their role	0	0		Perinatal deaths completed using Perinatal Mortality Review Tool	4	0

Perinatal Scorecard Summary



On the 26th August the Perinatal Quality Oversight Model was updated therefore further changes have taken place to include this data within this report.

As part of a national effort to improve how qualifying perinatal events are notified, NHS England is launching the *Submit a Perinatal Event Notification* (SPEN) portal, a unified system that will replace the separate reporting portals currently used by MNSI, MBRRACE-UK, and NHS Resolution.

The SPEN portal is a single point of entry, which allows information submitted for one organisation to be automatically shared with others, significantly reducing duplication. It also ensures that headline data feeds directly into the new Maternity Outcomes Signal System (MOSS), helping to identify safety concerns earlier and support national maternity and neonatal safety efforts. It is anticipated this will launch in November 2025 for South Yorkshire.

Celebrations: Maria Tidball visited to discuss how the service can lead in improving maternity care for disabled women and patients



Quality & Safety

- No Coroner Regulation 28 cases or Never Events.
- Stillbirth rate stabilised; 1 case in July, none in August.
- Maternity Incentive Scheme (MIS) Year 7 Safety Action 2 complete with confirmed submission to Maternity Services Data Set (MSDS) received.
- There was one divert in July to Rotherham Maternity service due to capacity and high acuity, with five triage patients diverted. Elective caesarean sections were delayed and reallocated.

Experience

- The Stillbirth and Neonatal Death Charity SANDS undertook a bereavement care review of the Trusts in South Yorkshire. Benchmarking of the findings is currently underway

Outcomes

- 40 more babies born in August compared to July
- Smoking at time of birth fell to its lowest point in August at 3.6%
- The number of women offered Induction of Labour (IOLs) has seen an increase from June 2024, this aligns with national guidance and recommendations based on risk for conditions such as reduced fetal movements, small for gestational age babies

Training & Learning

- Training is on track to meet Maternity Incentive Scheme (MIS) requirements by the end of November 2025.
- Learning from thematic reviews continues to be informative and is shared via the safety champions meetings along with action plans.

Workforce

- Anaesthetic cover 100%.
- Royal College of Obstetricians and Gynaecologist (RCOG) roles and responsibilities 100% compliance
- Consultant gaps persist; locum cover in place.

Current Issues and Summary



CQC Maternity Ratings April 2023	Safe	Caring	Responsive	Effective	Well Led
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually – from 2022)	Proportion of midwives who would recommend as a place to work 2022: 60%			2023 figure: 68.4%	2024: 65%
	Proportion of midwives who would recommend as a place to receive treatment 2022: 75.3%			2023 figure: 81.6%	2024: 72%
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	92.3% reported they received good clinical supervision out of hours				

In Summary

What is the data telling us?

- There has been one service suspension including home births within maternity in the last two months, this was due to high acuity and bed capacity in the service.
- There have been two occasions out of hours whilst awaiting on call to arrive when the labour suite coordinator did not maintain supernumerary status. This does not impact the MIS compliance as the escalation policy was enacted.
- 1:1 care was not achieved on one occasion whilst waiting for the continuity midwife to arrive

What do we need to focus on?

- Compliance with the Year 7 MIS standards (see slide 27)
- Continued engagement with service users, to support improvements in patient experience resulting in national maternity survey satisfaction
- Staff Survey improvement work/ engagement with teams remain ongoing.
- Increase the number of safeguarding supervisors to support improved staff compliance

What areas are showing improvement?

- Sustained compliance with all maternity and Neonatal training requirements
- Despite high acuity a sustained reporting of patient safety incidents is maintained demonstrating the services commitment to good governance.
- No moderate harm incidents related to the unit closure.

Where do we want to be?

- An outstanding Maternity Service offering compassionate, personalised care to all women and families who use our services.
- 100% compliant in Saving Babies Lives Version 3.2 (SBLV3.2) and MIS year 7

PERINATAL MORTALITY

In Summary

What is the data telling us?

Local stillbirth rates (stabilised and adjusted) have seen an increase from 2022 to 2024:

- 2021: 3.32/1000 births MBRRACE data
- 2022: 2.69/1000 births MBRRACE data
- 2023: 2.90/1000 births MBRRACE data
- 2024: 3.45/1000 births BHNFT data (adjusted with the removal of MTOP and abnormalities)

ONS data indicated a 25% decrease in stillbirths in 2020, followed by a 20% rise in 2021 due to the COVID-19 pandemic.

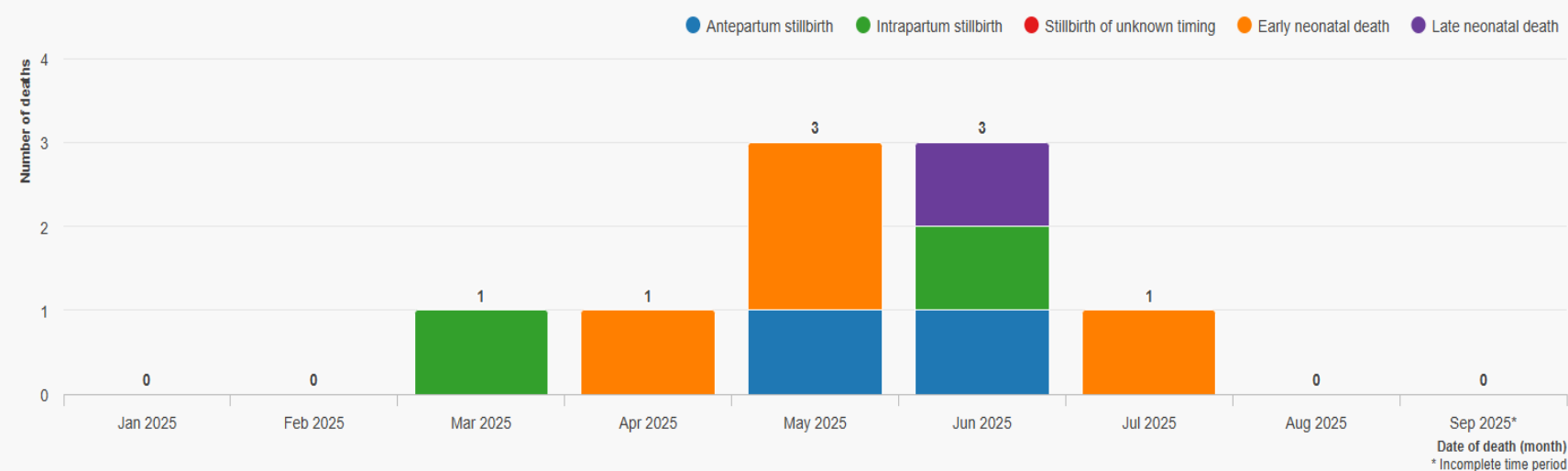
National rates were:

- 2021: 3.52/1000 births
- 2022: 3.33/1000 births
- 2023: 3.9/1000 births
- 2024: data not yet available

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Perinatal Mortality Summary

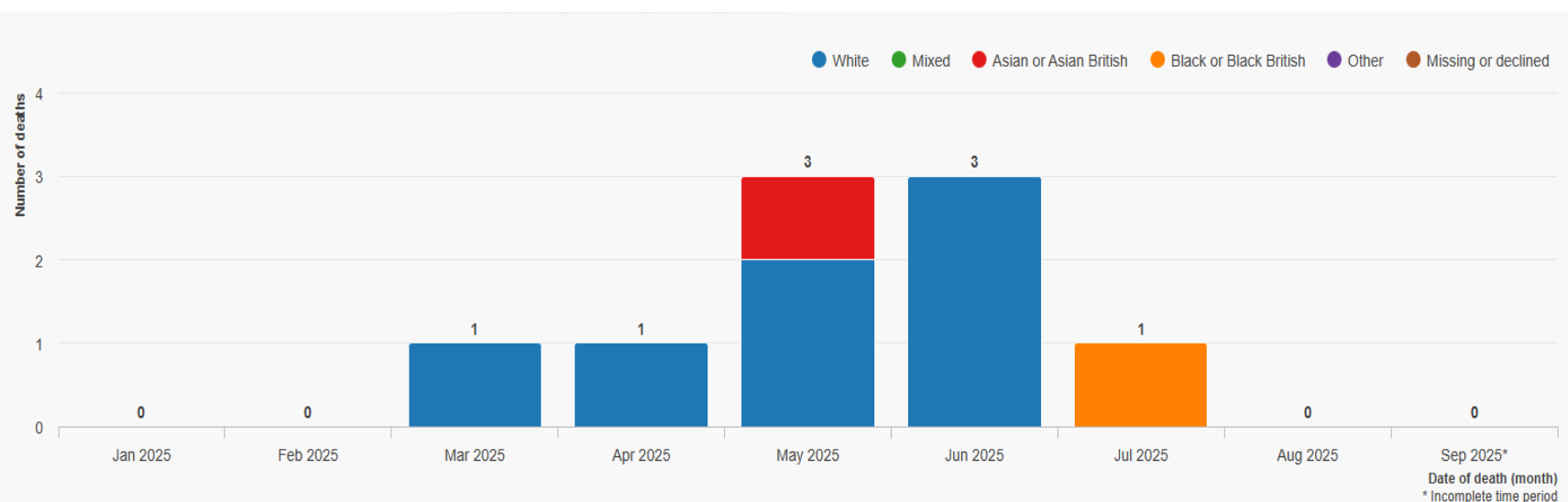
Year to date Summary



What is the data telling us?

- Two of the perinatal deaths were women from Asian and Black heritage. The National Maternity Dashboard data reflects the number of women who book to birth at Barnsley with Asian or Asian British, Black or Black British origin is around 6 %
- Three of the five NNDs were babies that care with BNHFT but died at another Trust

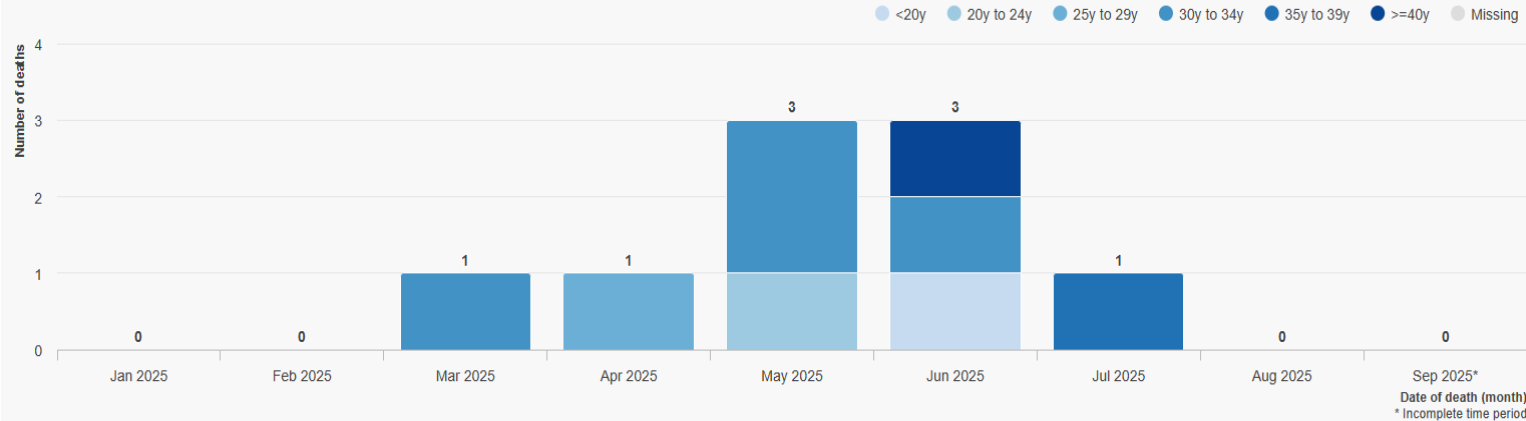
NB: Further analysis will be available once all reviews are completed



What objectives are we aiming for?

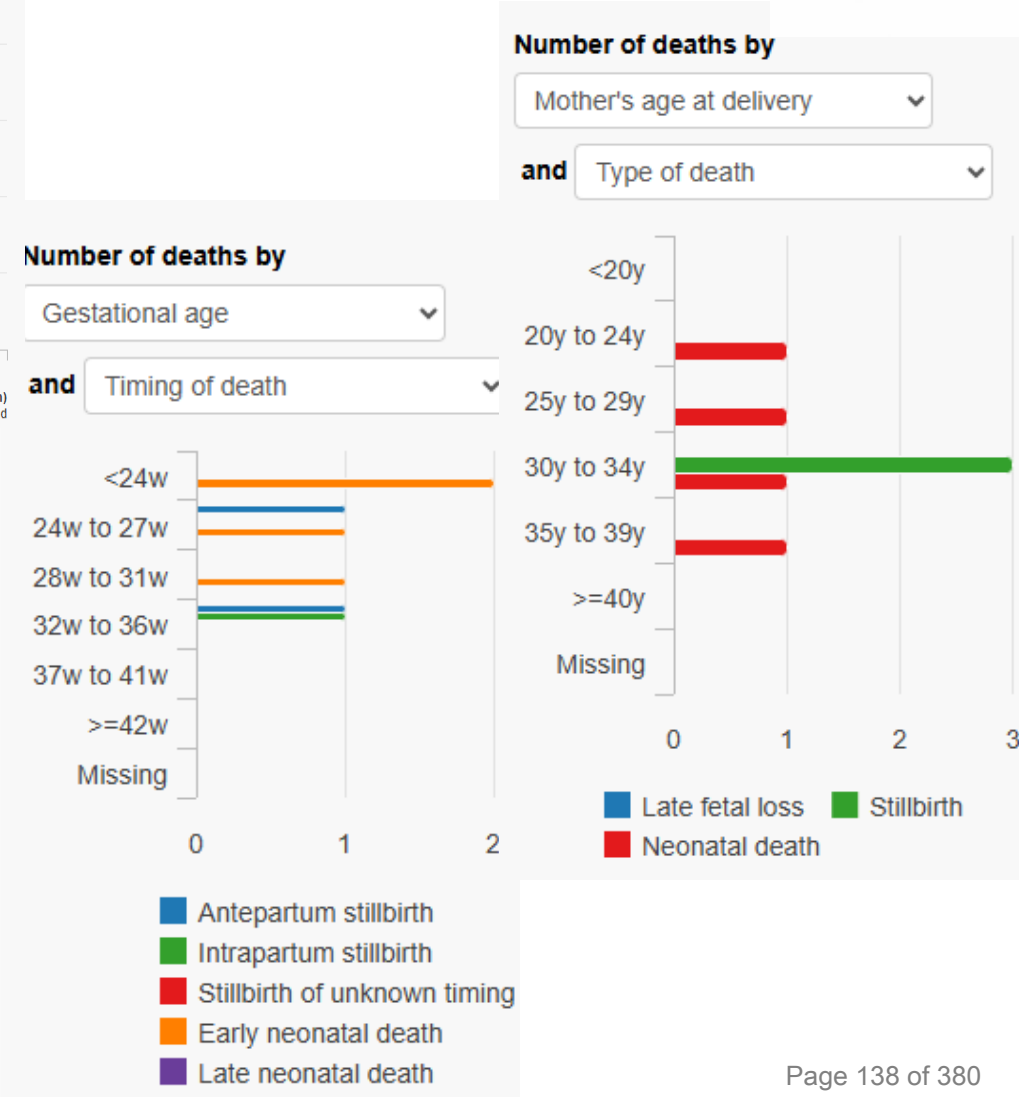
- Providing safe care that meets national best practice guidelines
- Introducing and maintaining improved continuity of care for all women from ethnic minority backgrounds booking at Barnsley
- Reducing stillbirth and perinatal mortality rates in line with national goals

Perinatal Mortality Summary



What insights does the data provide?

- From January to the end of August 2025, there have been 9 perinatal losses, compared to 10 during the same period in 2024.
- Excluding fetal abnormalities, there are 7 perinatal losses in 2025, whereas in 2024 there were 8 for the same timeframe.
- Over half of the losses involved mothers aged 30-34, which is younger than the age group noted in the 2024 annual review. According to the National Maternity Dashboard, this age group represents approximately 32% of women giving birth at Barnsley.
- Half of the neonatal deaths occurred before 24 weeks of gestation.
- These cases have not yet completed the full Perinatal Mortality Review Tool (PMRT) process and will be detailed on slide 7 once findings and recommendations are finalized.



Perinatal Mortality Data



Maternity (Perinatal) Incentive Scheme Year 7 – 01/12/2024 – 30/11/2025

MIS Standard 1	Dec 24	Jan 25	Feb	Mar	Apr	May	Jun	July	Aug
Percentage of eligible perinatal deaths notified to MBRRACE-UK with 7 working days (100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of parents that have had their perspective of care and any questions sought following baby's death (95%)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of PMRT reviews started within 2 months (95%)	100%	100%	100%	100%	100%	100%	100%	100%	100%
An external member should be present at PMM and documented on PMRT (50%)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of PMRT reports published within 6 months (75%)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of completed reviews included in board paper	100%	100%	100%	100%	100%	100%	100%	100%	100%

In Summary

What is the data telling us?

- PMRT cases continue to be reported and reviewed within the required timeframes, with consistent involvement from families to ensure their views are included in the PMRT review.

What is going well?

- Continued compliance with MIS year 7

What do we need to focus on?

- Work towards lowering the stillbirth rate as part of national goals.
- Continue to closely review the real time data to support any early themes and actions needed.

Where do we want to be?

- Maintain MIS Year 7 Standard 1 and identify modifiable factors to improve care for BHNFT patients



Best for Patients and Public

Best for Patients and the Public

We will provide the best possible care for our patients and service users

- We will treat people with compassion, dignity and respect at all times, make our services as accessible as possible and our communications clear, timely and simple to understand.
- We will listen to our patients and involve them in decisions about their care.
- We will focus on continuous improvement, patient engagement, best evidence and research to improve patient safety, transform services and introduce new ways of working.
- We will invest in research and development and adopt new innovations as soon as practicable and appropriate to do so.
- We will continue to use digital transformation to support new ways of working and will build on solutions that enable our team to work fully electronically and remotely.
- We will develop our estate to provide the best experience for patients and service users.

Perinatal Patient Experience

The Maternity and Neonatal Voice Partnership (MNVP) have scheduled monthly meetings with the Matron team to share service user voice and collaborate on focused workstreams from feedback and those that align with the MNVP's annual workplan. The Maternity Safety Champions meetings are scheduled with bimonthly walk abouts ensuring visibility across all areas of Maternity, with plans to attend community midwifery venues.

What is the data telling us?

- Lots of good progress in reaching families and hearing their voices
- A recent patient story from a disability lens shared wider through mandatory training demonstrates progress in reaching some of the most vulnerable people.
- Engagement with the Trust patient experience team is well embedded

What is going well?

- Co-production between service user representatives, maternity and neonatal services

What do we need to focus on?

- Further work needed on inclusive language and night staff attitudes on ANPN ward
- Better support with feeding post LSCS and improve the process for colostrum storage
- Improve choice and information regarding the Induction of labour (IOL) process
- More information for about if baby is admitted to Neonatal unit
- Improve rainbow room and communication between teams for bereaved families

Where do we want to be?

- Increase positive feedback and improve National Maternity survey position.
- Reduce complaints and concerns



Best for patients and the public

Key Performance Indicator (KPI'S) (fiscal year)	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	April 25 to date
MNSI Referrals (eligible cases)	3	6	5	4	1	0	1
MNSI Referrals (Referred & Accepted)	3	6	4	2	1	0	1
MNSI Referrals (Declined by MNSI)	0	0	1	2	0	0	0
MNSI Referrals (Declined/consent withdrawn)	0	0	0	0	0	0	0
MNSI Total Safety Recommendations	3	29	10	7	5	0	0
PSII declared	4	2	1	6	1	1	1
PSII reported	-	-	-	-	-	1	1
AAR completed	-	-	-	-	4	3	1
SWARM completed	-	-	-	-	0	3	0

July and Aug 2025
Best for Patients and Public • One PSII has been declared in July and August 2025 - term transfer to NNU with a fractured skull. The investigation is underway and no immediate safety actions have been identified. • No new MNSI referrals, one ongoing MNSI investigation. • No never events. • No Coroner Regulation 28. • No term HIE since December 2021. • No preterm HIE since February 2024.

What is the data telling us?
• Safety Kpi's demonstrate that eligible MNSI referrals and PSII'S have reduced from 2023, The transition to Patient Safety Incident Response Framework (PSIRF) methodology has supported a system based learning approach, focusing on compassionate engagement and a trauma informed approach to investigating safety incidents
What do we need to focus on?
• Continue to listen to families and staff to improve perinatal safety outcomes • Consistent documentation within the EPR.

What is going well?
• Listening to the family voice and experience in all investigation processes. • Ongoing work to improve oversight of community care and visits.
Where do we want to be?
• Continued family engagement for all investigation processes. • improve outcome data for all women and babies.

Best for patients and the public



Best for **Patients**
and **Public**

Perinatal Key Performance Indicator (fiscal year)	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	April 25 to date
Complaints reported	12	14	21	23	13	18	7
Concerns reported	43	36	28	32	38	45	39
Complaints closed	15	14	20	22	15	13	6
FFT – positivity (runs one month behind)	-	-	95%	87%	92%	97%	96%

What is the data telling us?	What is going well?
There is no statistical significant change in the number of concerns and complaints for perinatal services	FFT positivity has remained above 90%
What do we need to focus on?	Where do we want to be?
- Improving FFT response rate - Care experience on the ANPN ward	All women and families receive the best care in the best environment.

July and Aug 2025
- July data highlighted an increase in concerns due to a temporary pause on the MuMs group for three weeks, this is now running again. This is supported through the 0 -19 service. - August data demonstrated half the concerns relate to care experience on the ANPN ward, this triangulates with the high acuity seen in this department. The service is planning walkthroughs and care observations from peers to further support improvements.

Best for Place

Best for
Patients
and the Public

Best for
People

Best for
Performance

Best
Partner

Best for
Place

Best for
Planet

Best for Place

We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health:

- We will continue to play a key role in the delivery of Barnsley Place priorities including emergency and planned care.
- We will act as an Anchor Institution to increase local employment and spend, reduce environmental impact and work as part of place to reduce health inequalities and improve population health.
- We will work with our partners in Barnsley to deliver the vision set out in the Barnsley 2030 plan to make Barnsley the home and place of possibilities.

What is the data telling us?

Patients in IMD 1-3 are more likely to DNA appointments

What do we need to focus on?

Enhanced care models and collaborative approaches with key partners to enable targeted intervention's that prioritise Barnsley most vulnerable people from IMD 1&2

What is going well?

Plans to ensure women from ethnic minority origin, Moderate to severe perinatal mental health, disability, Teenagers, Safeguarding on plans, English not a first language will be offered an Enhanced Continuity of Carer model with a planned launch in Q3 2025.

Where do we want to be?

Providing equitable care with a lower threshold for review for the most vulnerable pregnant people.

Patients seen in the last full month

	0	1	2	3	4	5	6	7	8	9	10	Total
Number of Unique Patients	184	180	165	166	114	47	20	5	4	1	1	887
Total Patients with HI Characteristics	0	56	127	158	114	47	20	5	4	1	1	533
Teen Pregnancies	0	0	1	8	2	7	5	0	0	1	0	24
Patients in IMD 1	0	0	0	71	68	35	15	2	2	1	0	194
Patients in IMD 2	0	0	53	46	29	7	3	1	2	0	0	141
BAME Patients	0	2	5	3	9	1	1	0	0	0	0	21
LD Patients	0	0	0	0	1	0	0	0	0	0	0	1
Safeguarding	0	0	1	0	0	0	0	0	0	0	0	1
Comorbidities	0	54	69	58	82	34	17	5	4	0	1	324
<u>Chronic Condition</u>	0	43	46	44	64	22	12	4	2	0	1	238
<u>Mental Health</u>	0	21	33	26	42	26	13	4	3	0	1	169
<u>Substance Use</u>	0	1	6	3	8	3	4	1	2	0	1	29

DNA Rates by IMD for Obstetric Appointments

Appointments between 01/01/2025 and 31/08/2025

	1	2	3	4	5	6	7-10	Obs Rate
Jan-25	10.7	10.6	9.6	7.7	10.9	4.4	4.5	9.1
Feb-25	13.0	7.6	10.3	5.7	9.9	4.3	5.7	8.9
Mar-25	10.2	7.6	9.1	9.0	9.5	6.2	1.3	8.0
Apr-25	8.0	11.4	8.8	5.7	9.0	10.4	8.0	8.9
May-25	11.6	8.6	10.2	4.9	4.5	7.9	4.7	8.3
Jun-25	11.7	5.7	7.4	15.0	5.5	2.7	3.9	8.0
Jul-25	9.3	7.3	12.3	4.6	8.2	3.0	4.3	7.9
Aug-25	9.0	16.7	10.9	4.2	10.3	0.0	6.1	8.9
2025	10.6	8.5	9.8	7.5	8.4	5.5	4.7	8.5

Maternity Workforce



Best for **People**

The labour ward demand vs capacity in July was met 76% of the time and August 80% of the time. When staffing levels fell short of the required acuity, the shift leader took action to reassign staff within the unit to ensure 100% one-to-one care for all women in labour. (It's important to note that a shortfall in staffing does not always mean rosters were incomplete; it could be due to a temporary rise in service users.) The recruitment of Early Career Midwives, to address turnover and fill gaps in the rota due to maternity leave, which aren't covered by the 25% uplift at BHNFT, is underway.

Planned vs actual cover midwifery cover

	ANPN	ANDS	BBC	Becketts team	Emerald team	Sapphire team	St Helens team
July	87%	88%	86%	69%	66%	88%	85%
Aug	92%	93%	87%	60%	81%	67%	90%

What is the data telling us?

- There continues to be delays in commencing and continuing induction of labour. In July there were three reports for delays in women starting the induction procedure and four in August for delays in acceleration of labour. A review has highlighted these are linked to high acuity and ensuring 1:1 care on the Birthing Centre.
- August plan vs actual cover was noted to be improved due to staff returning from LTS and no mandatory training in the service.
- In August there were 2 occasions where the labour ward coordinator was not supernumery the escalation policy was implemented, requesting a community midwife to support the acute service.

What do we need to focus on?

- Birthrate+ is set to be recommissioned in 2026 to meet Year 7 MIS standards.
- In July, the assessed service gaps were at 15.04 WTE, reducing to 12.74 WTE in August, attributed to maternity leave and long-term illness. NHS professional shifts are utilised to address these gaps, with roster challenge meetings managing Bank usage.
- There is currently one vacancy for an obstetric consultant, with an additional vacancy expected due to retirement in August 2025; both positions are actively being recruited to. There is a focus on the upcoming high level of maternity leave towards the end of the calendar year. The commencement of new career midwives will help with this workforce gap.

What is going well?

- Consultant labour ward attendance is in line with the RCOG guidance for all required and requested care and all rota gaps were covered
- The consultant led ward round took place twice daily on the Birthing Centre.
- Anesthetic labour ward was covered in 100% of the time in both months.
- The supernumerary labour ward co-ordinator status was maintained 100% in July.
- The unit did not close in July and there was a temporary divert to TRFT in August for 3 hours.
- The General Medical Council (GMC) survey results are the best in South Yorkshire
- RCOG roles and responsibilities audit 100% compliance

Where do we want to be?

- To cover all gaps via substantive staff with minimal Bank usage to cover last minutes sickness.
- Maintain low sickness and absence levels.
- Continue to have 100% compliance for all MIS year 7 staffing requirements.

Neonatal Workforce



Best for People

Qualified in Speciality (QIS) Training Status

As of August, 65% of the Registered Nurse nursing workforce were QIS trained. This remains below the BAPM QIS standard and MIS Year 7 requirements for safe care.

► *The QIS risk was reintroduced in April 2025 and is being actively managed.*

Risk Mitigation

To ensure safe staffing, two QIS-trained nurses are scheduled on every shift to cover the two ITU cots.

► *An action plan is in place to increase QIS compliance above 70%.*

- Shift Coverage In July, 88.7% of shifts met the QIS toolkit requirements. In August, 80.6% of shifts were compliant.
- Medical Staffing is covered by rota adjustments and a full review is underway in line with CNST

In Summary

What is the data telling us?

- **Not Yet Meeting BAPM QIS Standard**
The service is currently not aligned with the BAPM QIS standard. This is expected to continue until September 2026.
► *An action plan is in place to support improvement.*
- **Band 6 Vacancy**
There is a 0.6 WTE Band 6 vacancy currently open which we are hoping to convert to Educator role.

What do we need to focus on?

- **Training for New Starters:** Ongoing support and education for newly joined staff.
- **Planning for ANNP Trainees:** Preparing for when Advanced Neonatal Nurse Practitioner trainees qualify in 2026.
- **Educator & Coordinator Roles:** Developing a business case for a supernumerary Coordinator roles. Also exploring options to make Educator a permanent role.
- **OPEL Scoring Policy Update:** Reviewing and updating the policy to ensure consistent use of OPEL scoring—on the agenda for September's Children's Governance meeting.
- **Staffing Review:** Nurse staffing workforce review of current staffing levels

What is going well?

- Risk around QIS coverage is being well managed, with over 90% of shifts covered in July and August.
- Continued detailed monitoring and review of MIS Safety Action 4 to ensure safe neonatal staffing levels.

Where do we want to be?

- **Permanent Educator in Post**
Educator role to be secured as a permanent position.
- **7-Day ANNP Team**
Neonatal Advanced Nurse Practitioner coverage to be available seven days a week.
- **Supernumerary Coordinator in Post**
Coordinator role in place with protected supernumerary status.
- **QIS Compliance Above 70%**
Over 70% of staff to hold Qualified in Specialty (QIS), to support safe and skilled care delivery.

Best for People

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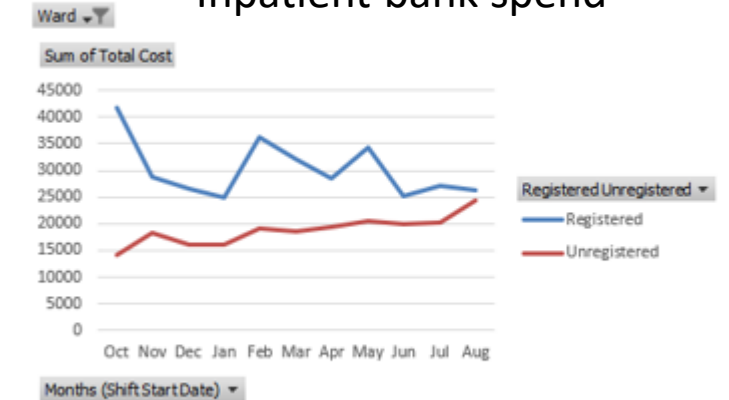
We will make our Trust the best place to work by:

- Ensuring a caring, supportive, fair and equitable culture for all.
- Creating an organisational climate that supports Equality, Diversity and Inclusion.
- Ensuring we recruit and retain staff to achieve future workforce sustainability and to ensure our organisation is correctly resourced.
- Supporting our staff's health and wellbeing.
- Trusting our staff to care for our patients to a high standard.
- Supporting our staff to continuously improve their own work and the work of others.

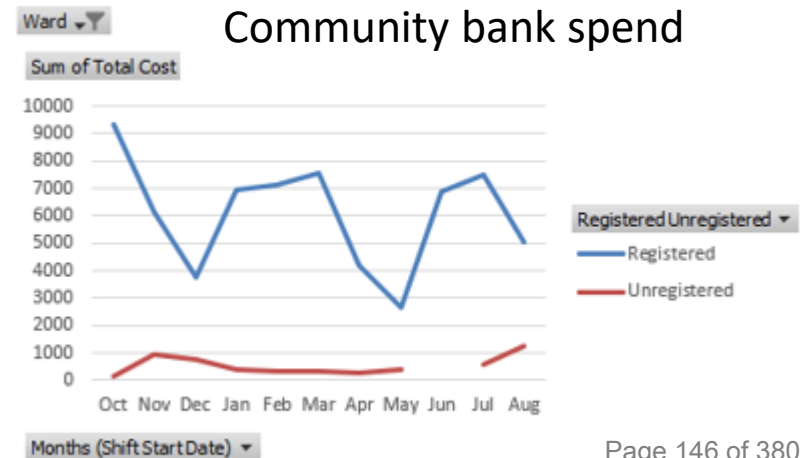
Metric	Trust Target	July	Aug	Achieved in Month
Sickness Absence	4.5%	7.6%	4.8%	✗
Return to Work interviews	70%	70%	-	✓
Appraisals	90%	74%	-	✗
Staff turn over	-	1	0	-
Vacancy rate	-	1.13	0.77	-
Bank/agency spend		↓	↓	-

Further appraisals have been undertaken as staff return to work
The service has reduced staff sickness in August 2025

Inpatient bank spend



Community bank spend





Best for People

Perinatal Staff Experience

In June the service undertook a "pulse check" survey to review the impact of the cultural work via "Even Better Together". There were 43 responses as seen in the table.

In Summary

What is the data telling us?

Some progress is demonstrated in relation to team meetings, speaking up and psychological safety, and communication across teams.

What do we need to focus on?

Work is **still required** to ensure staff feel involved in decision making and to avoid communication breakdowns.

What is going well?

In 7 of the ten questions improvement can be seen. **Significant progress** is highlighted in relation to leadership and line management.

Where do we want to be?

Be in the top 10% of maternity services for staff satisfaction at work

Question	SCORE April 24	Pulse check June 25
Local leadership is available at all times	59%	72%
My line manager regularly makes time to provide positive feedback to me about how I am doing	28%	49%
Where appropriate, I have an opportunity to be involved in decisions that affect my work	55%	52%
My line manager provides meaningful feedback to me about my performance	29%	47%
Our suggestions are listened to and utilized	56%	54%
We meet regularly as a team to discuss our work	47%	56%
I feel I can speak up if I perceive a problem with patient care	60%	88%
It is easy for people to ask questions here if they do not understand	77%	79%
Communication breakdowns are not common here	29%	21%
On the whole, communication across different teams works well here	19%	37%

Best for People

Barnsley Maternity Services: July Safety champion Feedback

Admin Support

You Said: Admin support is needed for community

We Did: Admin support across maternity currently being reviewed to cover 7-day service including community.

IT Equipment

You Said: IT equipment and offline working is an issue

We Did: Leads and matrons are working with IT to look at replacement plan and explore procuring ICE printers. A trouble shooting guide is to be recirculated to improve offline working.

Continuity Implementation

You Said: Enhanced continuity implementation is needed

We Did: Review is underway to look at 100% inclusion for BAME, under 18's, women with disabilities and learning difficulties. The team is looking at the data to make sure continuity capacity can cover this.

Homebirth Bag Checks

You Said: Homebirth bag checks.

We Did: Assurance that home birth bags are checked and contain the right equipment. KPI's reported in the community midwifery matrons report.

Culture

You Said: Culture was a concern.

We Did: Culture work to continue to ensure that teams are inclusive, working together.



Safety Action 9:
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

You Raised

The lifestart™ trolley is not being used as staff are not trained on its use.



We Responded

- The lead doctor for this equipment is arranging with the company to train some key staff to disseminate the training.
- The trolley will be retested to ensure fit for use.
- The SOP is on the [trust intranet](#).

See this short video about this equipment here



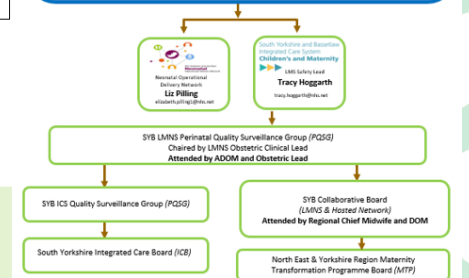
PROUD to care

Maternity Incentive Scheme : Year 7

Neonatal walk round May 2025

Safer Maternity Care

Safety Champion Information for Staff
Our process for raising concerns, sharing learning & changing practice



Safety Champion feedback is circulated to all maternity and neonatal staff following staff engagement via drop-in and walk round sessions in line with MIS Safety Action 9.

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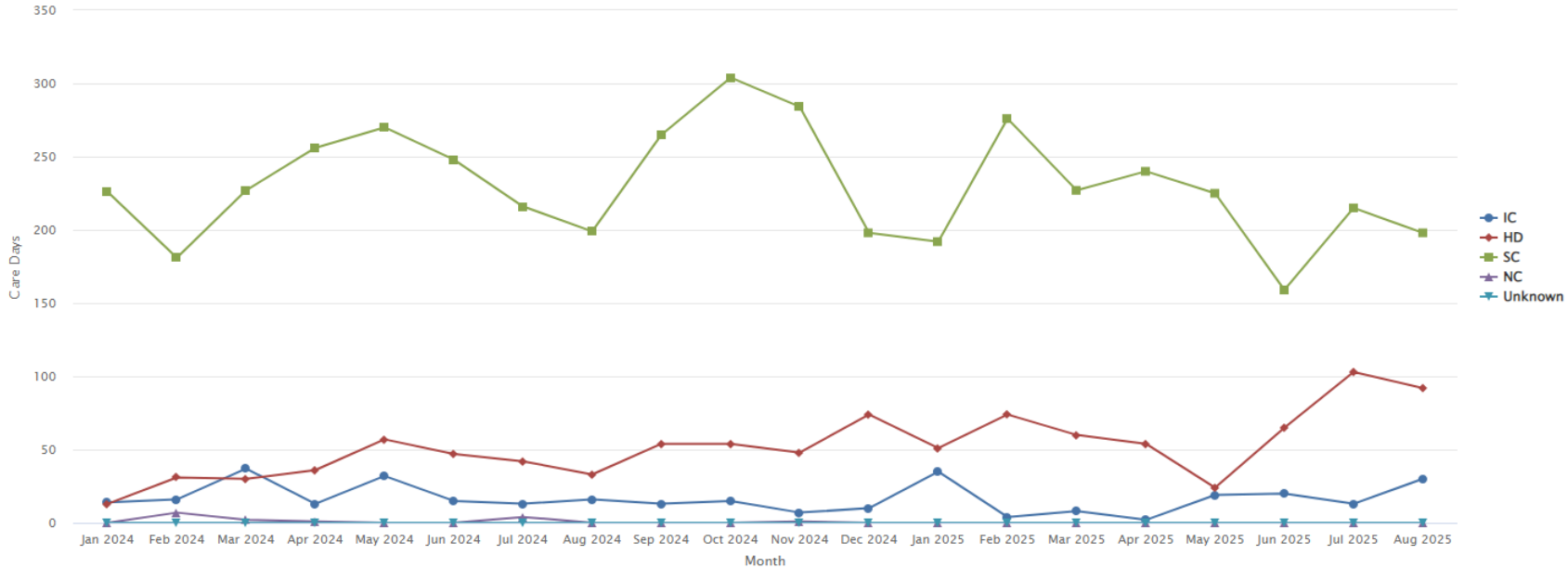
Month/Year	July	Aug
Bookings (number)	246	219
Breastmilk Initiation (%)	71	72
Unassisted Births (%)	38.3	39.4
Induction of Labour (%)	38.2	39.8
Assisted Births (%)	10.4	10
Caesarean Births (%)	50.2	50.2

What is the data telling us?	What is going well?
Increasing IOL and cesarean section rate inline with best practice guidance	- Only one MNSI reportable birth - The birthrate is remaining stable annually
What do we need to focus on?	Where do we want to be?
Review IOL process as some births by caesarean section are birthing people on the IOL pathway, requesting a caesarean section.	Ensure women are fully informed to decide on place and mode of birth

Best for Performance

NNU activity BAPM 2011

BAPM 2011 Monthly Activity



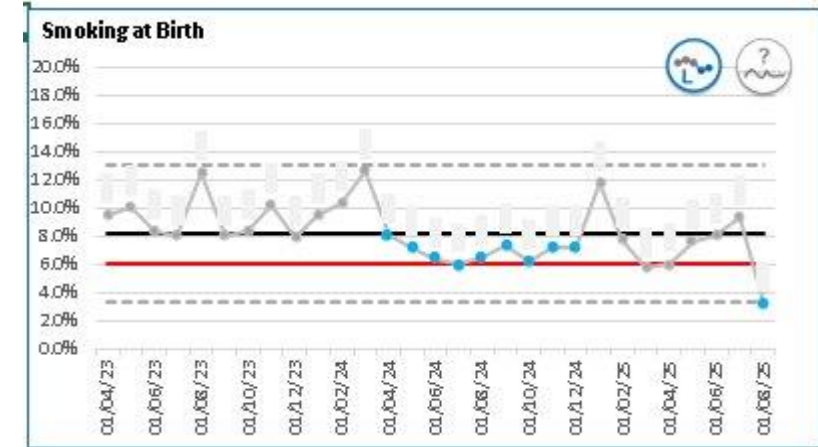
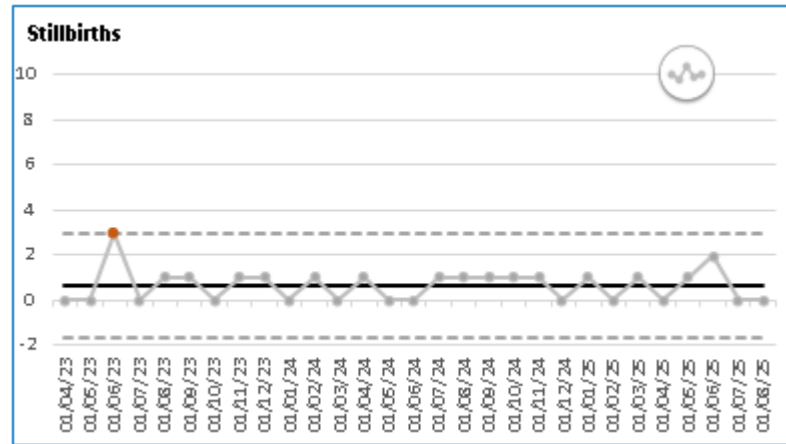
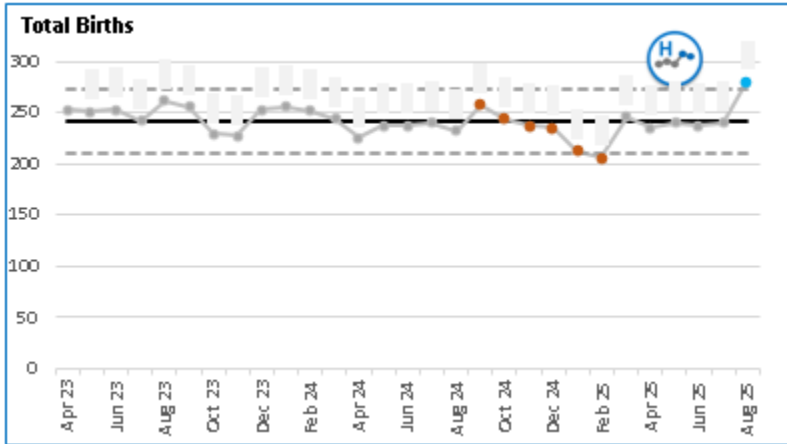
What is the data telling us?	What is going well?
There has been an increase in the high dependency care days (HD) which correlates with an increase in overall birth, admissions.	The training compliance has been maintained above the trust target >90%
What do we need to focus on?	Where do we want to be?
- Recruit QIS staff to improve compliance whilst continuing to train current workforce - Review of establishment underway to ensure BAPM supernumerary is achieved (risk ID 3119)	- A supernumerary coordinator on every shift >70% nursing workforce QIS

	April	May	June	July
BAPM for RN QIS staff	65%	65%	65%	65%
% shifts QIS to tool kit	100%	91%	91%	100%
BAPM supernumerary shift co-ordinator per shift	0%	0%	0%	0%

SPC Charts



Best for
Performance



What is the data telling us?

- The birth rate decreased up to February 2025.
- In August 25 there was a sharp increase in births from anything seen previously with 279 women birthing their babies. Despite this the unit did not close.
- There have been no stillbirths for the months of July and August.

What is going well?

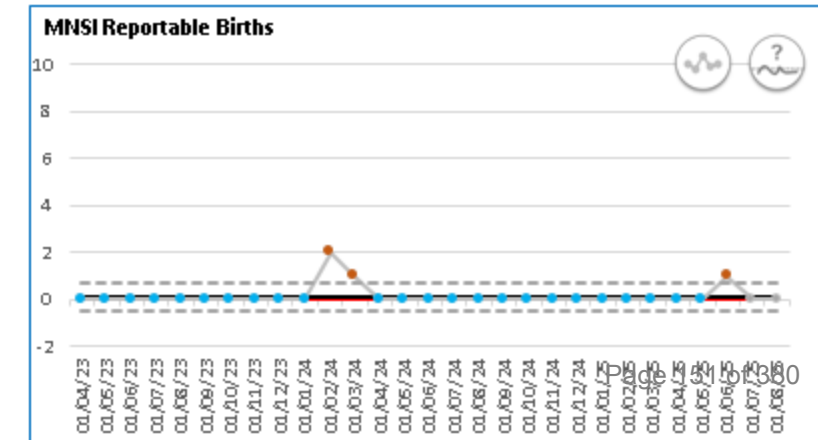
- Women are choosing to birth at BHNFT
- Smoking at birth fell to its lowest point in August at 3.6%

What do we need to focus on?

- Maintaining safe care for all even during times of high activity.
- Continue to gain feedback from the service users to support service improvements.

Where do we want to be?

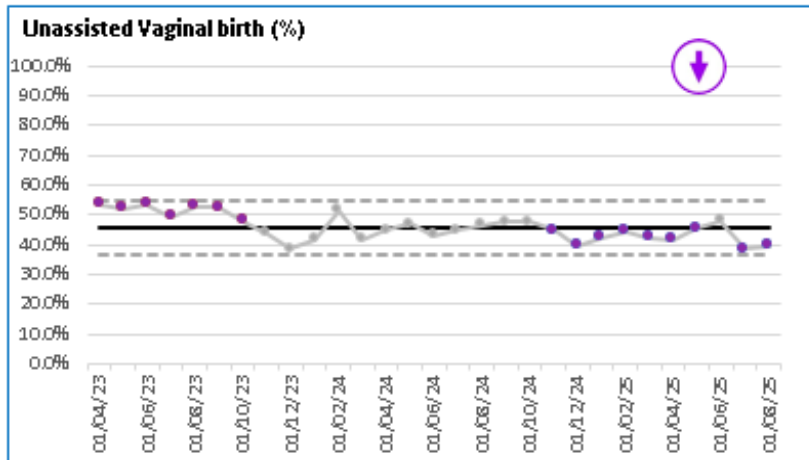
- In the top 10% of England for patient feedback via the CQC annual maternity survey



SPC Charts



Best for
Performance



Select organisation

Barnsley Hospital NHS Foundation Trust (RFF)

Percentage breakdown of Method of delivery in June 2025

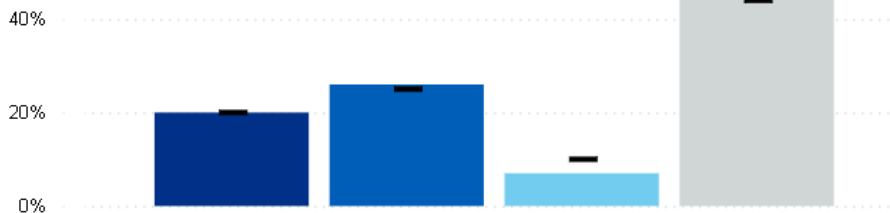


Chart legend

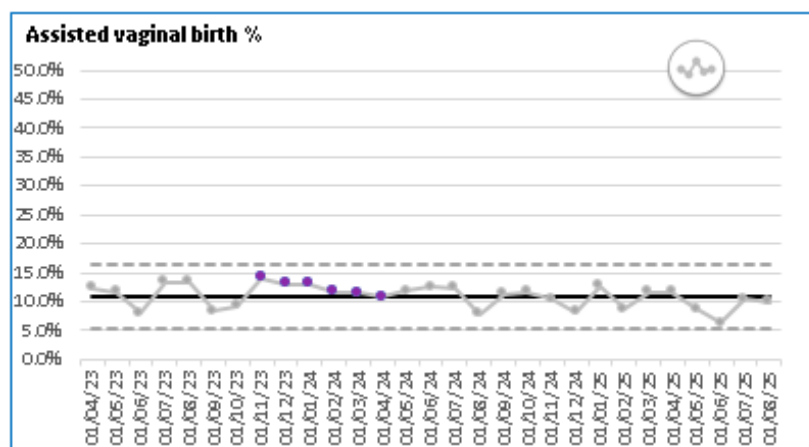
- ◆ Provisional data
- National
- Elective c-section
- Emergency c-section
- Instrumental
- Other
- Spontaneous

What is the data telling us?

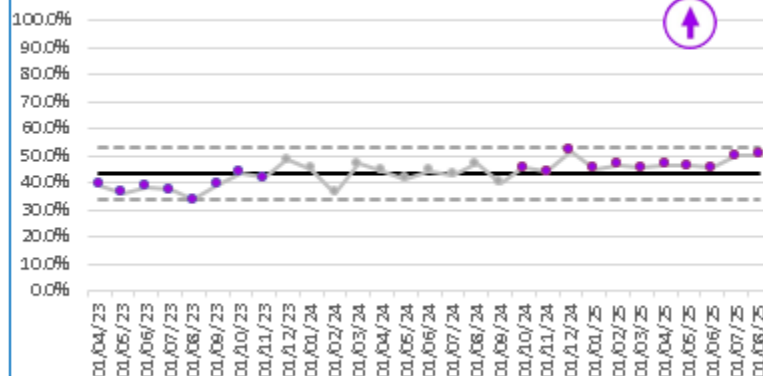
- MSDS data above highlights an average of 48% of women having an unassisted Vaginal birth since May 2022. Just above national average
- Assisted births show an average of 7%. Just below national average.
- Even though our total Caesarean rates are increasing, they are in line with the national average.

Where do we want to be?

- We want to support women to make informed choices about their birth options



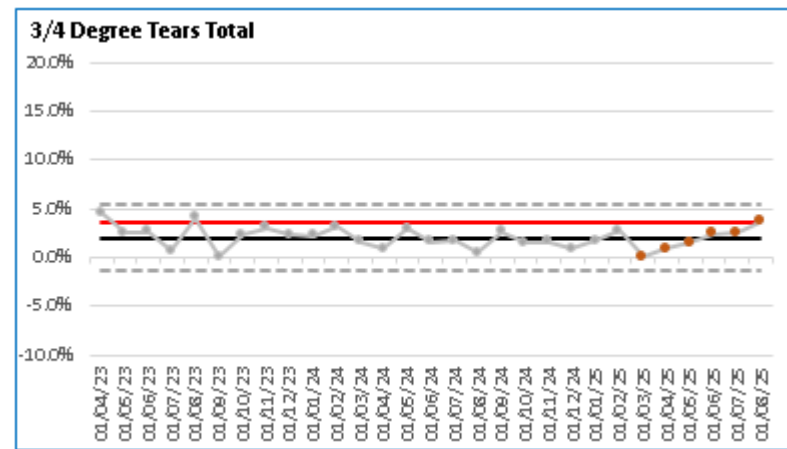
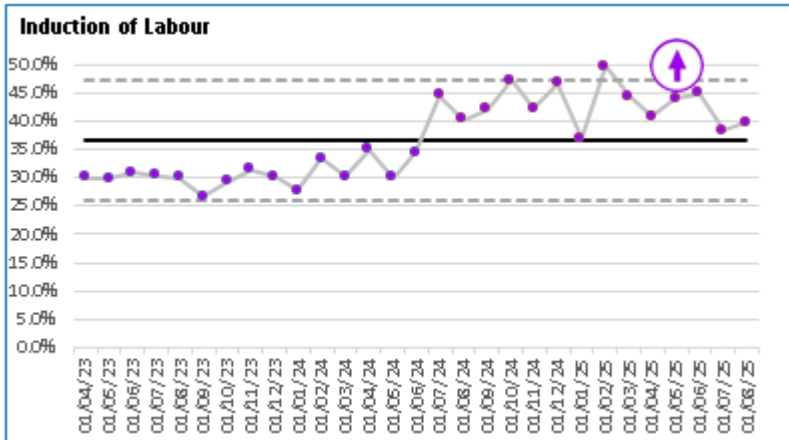
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SPC Charts



Best for
Performance



What is the data telling us?

- Induction rates show an increase but are aligned with national guidance and recommendations.
- 3rd degree tears appear to be on an upward trend, this is under thematic review with no immediate actions identified

What is going well?

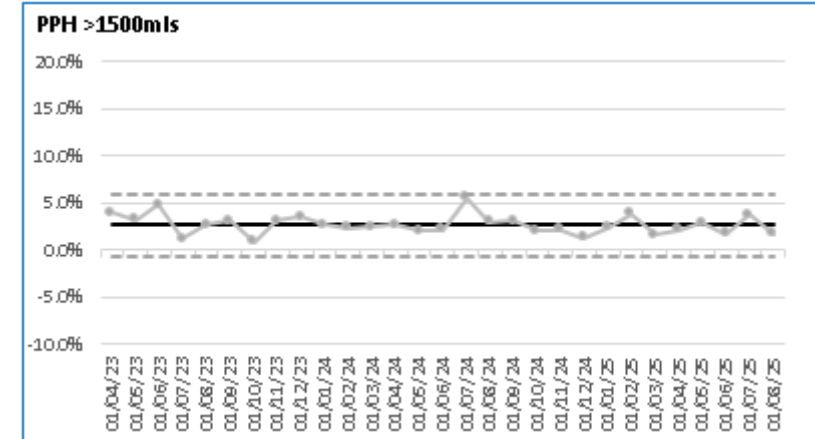
- The service is in the lower percental for PPHs

What do we need to focus on?

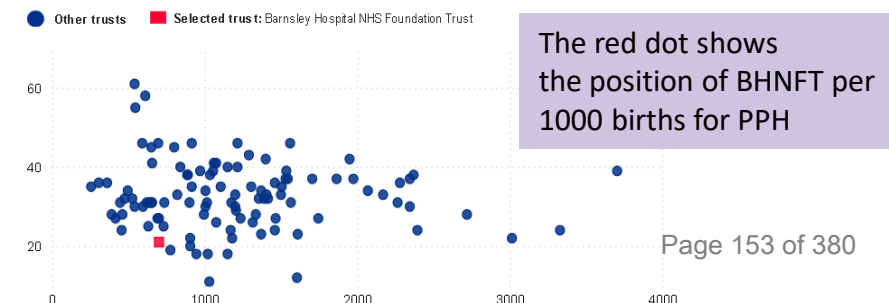
- Completing the 3rd degree tear thematic review and undertaking any learning actions

Where do we want to be?

- We want to support women to make informed choices about their birth options
- Remain in the lower percentile for PPH
- Ensure care is in line with best practice for 3rd degree tears



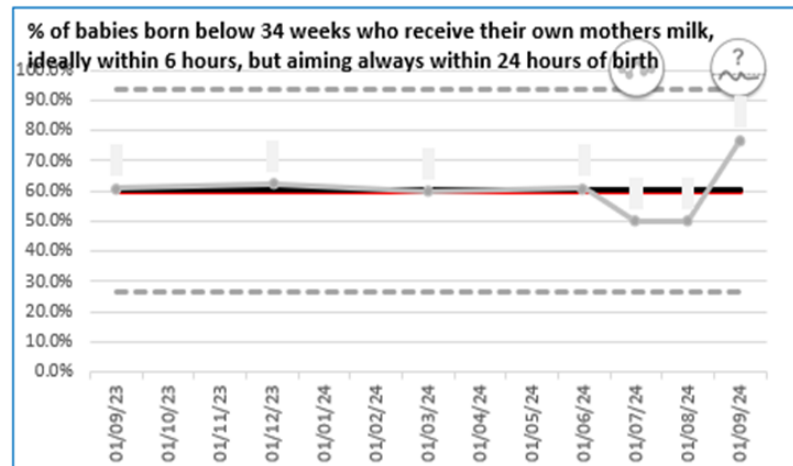
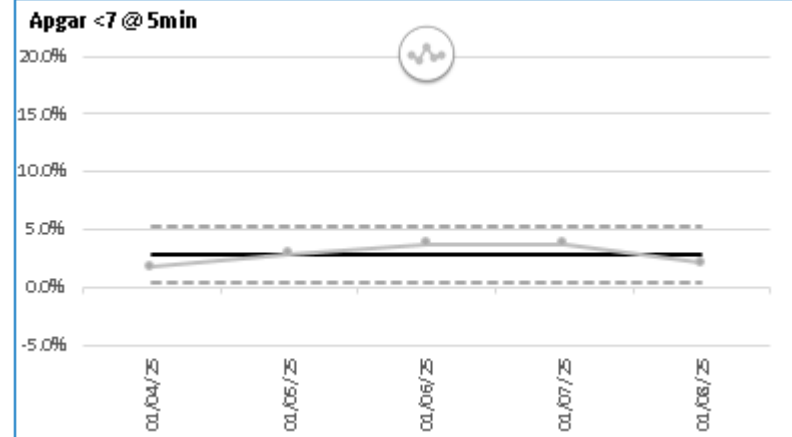
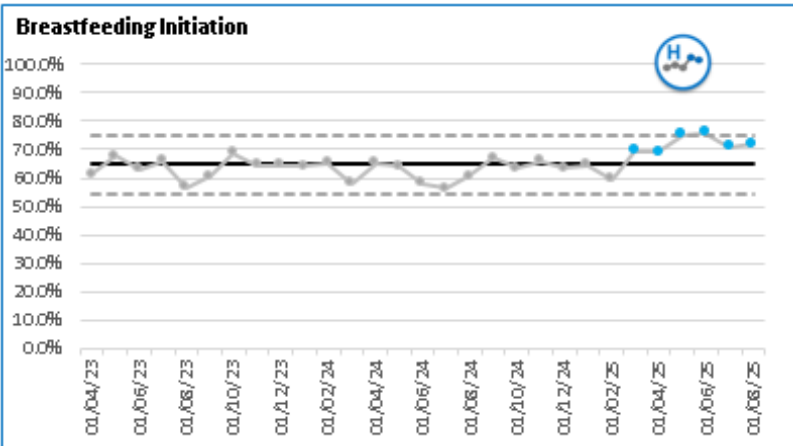
Trust level CQIM values comparison with peers (Rate per 1,000)



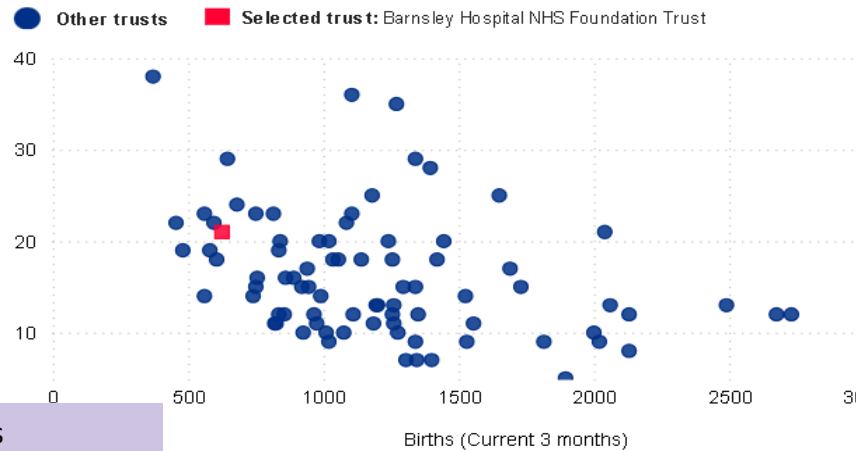
SPC Charts



Best for
Performance



Trust level CQIM values comparison with peers (Rate per 1,000)



The red dot shows the position of BHNFT per 1000 births for Apgar score between 0 and 6 from MSDS in comparison to other Trusts

What is the data telling us?

- The local SPC has minimal data for APGARs but is maintaining the rate. This is also measured by MSDS, see chart below.

What is going well?

- Breast feeding initiation rates and preterm breastmilk continue to increase.
- Thematic review of APGAR scores has resulted in a more in-depth review of CTG management

What do we need to focus on?

- Maintaining the good

Where do we want to be?

- Continue increased breastfeeding initiation rates
- Ensure care is in line with guidance supporting optimum birth APGAR scores

Mandatory training – Aug 25



Best for
Performance

	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Safety	Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
CBU 3 Management Team	100 → 20/20	95 → 19/20	95 ↓ 19/20	100 ↑ 20/20	100 ↑ 20/20	90 → 9/10	90 ↑ 9/10	90 ↑ 18/20	100 → 20/20	50 ↓ 2/4	100 → 5/5	100 ↑ 9/9	100 ↑ 7/7	89 ↑ 8/9	88 ↑ 7/8	94 ↑
Maternity Establishment	95 ↑ 178/187	91 ↓ 171/187	87 → 162/187	99 ↑ 186/187	99 ↑ 186/187	100 → 8/8	95 ↑ 170/179	86 ↓ 160/187	100 → 187/187	33 → 1/3	96 ↑ 169/176	98 ↓ 175/179	100 ↑ 13/13	100 ↑ 8/8	100 ↑ 11/11	95 ↑
Obs & Gyna Medical Services	91 ↓ 32/35	94 ↓ 33/35	91 ↓ 32/35	89 ↑ 31/35	89 ↑ 31/35	100 ↑ 16/16	79 ↓ 15/19	89 ↓ 31/35	97 ↓ 34/35	74 ↓ 14/19	N/A	89 ↓ 17/19	91 ↓ 21/23	92 ↑ 11/12	100 ↑ 4/4	90 ↓
NNU	95 ↑ 41/43	95 ↑ 41/43	86 ↓ 37/43	97 ↑ 42/43	97 ↑ 42/43	100 1/1	88 ↑ 37/42	88 → 38/43	97 → 42/43	N/A	72 ↓ 29/40	95 ↑ 38/40	92 ↑ 24/26	100 → 1/1	100 → 2/2	93% ↑
Paediatric Medical Services	95 ↑ 22/23	95 ↑ 22/23	91 ↑ 21/23	95 ↑ 22/23	95 ↑ 22/23	100 ↑ 7/7	87 ↑ 14/16	86 ↑ 20/23	100 23/23	N/A	N/A	87 14/16	93 ↑ 15/16	100 → 7/7	100 ↑ 1/1	94% ↑

What is the data telling us?

- Overall compliance has been maintained above the Trust target of 90%.
- Most staffing groups have seen an increase in compliance apart from the medical services due to rotation of those staff

What do we need to focus on?

- Ensuring all training subjects achieve and maintain the Trust compliance target of 90%

What is going well?

- Overall compliance for MAST training has been maintained above the Trust target of 90% for the past seven months.

Where do we want to be?

- Compliance to be maintained above the Trust target of 90% across all subjects, this will support staff to provide a safe service.

Mandatory Training



Best for
Performance

Children's level 3 safeguarding training	Percentage Compliance % (n)												
	August 24	September	October	November	December	January 25	February	March	April	May	June	July	August
Maternity establishment	97↑	97↓	93↓	87↓	88↑	89↑	89↑ (153/171)	92 ↑ (153/166)	92 → (160/174)	91 ↓ (157/172)	89 ↓ (150/169)	90 ↑ (153/170)	91 ↑ (153/169)
Neonatal unit	81↑	88↑	88.24→	79↓	84↑	85↑ (34/40)	89 ↑ (36/41)	88↓ (36/40)	90 ↑ (36/40)	89 ↓ (35/39)	87↓ (34/39)	87→ (34/39)	87→ (35/40)
Obstetrics and Gynaecology medical staff	78↑	75↓	67↓	67→	68↑	77↑	79↑ (19/24)	79 → (19/24)	86 ↑ (19/22)	95 ↑ (19/20)	95 → (18/19)	95 → (18/19)	95 → (18/19)
Paediatric medical staff	80↓	73↓	73→	80↑	80→	80→	73↓ (10/16)	63↓ (11/17)	64 ↑ (11/17)	56↓ (9/16)	58↑ (10/17)	64↑ (11/17)	66↑ (10/15)
Adult level 3 safeguarding training	Percentage Compliance % (n)												
	August 24	September	October	November	December	January	February	March	April	May	June	July	August
Maternity establishment	96↑	96↓	92↓	88↓	88↓	89↑	90↑ (152/169)	91 ↑ (150/164)	92 ↑ (158/172)	89↓ (152/170)	88 ↓ (147/167)	90 ↑ (151/168)	90 → (151/167)
Neonatal Unit	94↓	100↑	100→	100→	100→	100→ (17/17)	100→	100 → (16/16)	100 → (15/15)	100→ (16/16)	100→ (16/16)	93↓ (15/16)	93→ (15/16)

What is the data telling us?

- Safeguarding Level 3 compliance for the Maternity Establishment has met the Trust target of 90% for the past two months

What is going well?

- All staff who are non-compliant with Safeguarding Level 3 training have been allocated to attend within the next three months
- Obstetrics and Gynecology Medical staff compliance is now being monitored monthly by the Pathway Facilitator which has improved compliance

What do we need to focus on?

- Ensuring staff are allocated to attend the 'Think Family' training day before expiry of their competency and on commencement at the trust to ensure maintained compliance.

Where do we want to be?

- All compliance to be above the Trust target of 90% across both subjects and for this to be maintained to support staff with the right knowledge to provide a safe service

MIS Training



Staff Group	Neonatal basic life support training - Required standard: 90% attendance in each relevant staff group (n)											
	September 2024	October	November	December	January 2025	February	March	April	May	June	July	August
Neonatal or paediatric consultants & SAS doctors covering neonatal units	45.45	63.63↑	90.90↑	↓45 (5/11)	82↑ (9/11)	91 ↑ (10/11)	75 ↓ 9/12	78↑ 11/14	85↑ 12/14	92↑ 13/14	73↓ 11/15	73→ 11/15
Neonatal junior doctors who attend any births	96.87	100↑	100→	100→	100→	75%↓ (3/4)	75→ 3/4	100→ (25/25)	100→ 25/25	100→ 25/25	100→ 25/25	100→ 25/25
Neonatal nurses (band ≥5 who attend births)	100	100→	100→	↓84% (21/25)	84 (21/25)	86↑ (19/22)	86→ (19/22)	95.4↑ (21/22)	84↓ 21/25	84↓ 21/25	95↑ 21/22	91↓ 20/22
Trainee Advanced Neonatal Nurse Practitioners	100	100→	100→	100→	100%	100(2/2)	100→ (2/2)	50→ (1/2)	50→ (1/2)	50→ (1/2)	50→ (1/2)	100 ↑ (2/2)
MSWS	81.08	100↑	97↓	92.85↓ (26/28)	92.30↓ (24/26)	92.30→ (24/26)	92.30→ (24/26)	100↑ (25/25)	100→ (27/27)	100→ (26/26)	100 → (24/24)	100 → (27/27)
Midwives	84.21	98.55↑	99.29↑	98.56↓ (137/139)	95.77↓ (136/142)	97.18 ↑ (138/142)	99↑ (141/143)	100↑ (144/144)	100→ (143/143)	99 ↓ (139/140)	98 ↓ (139/142)	98 → (137/140)

Staff Group	PROMPT Rolling annual compliance (%)															
	May 24	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 25	Feb 25	March 25	April 25	May 25	June 25	July 25	August 25
Hospital Midwives	98.01↓	98.98 ↑	97.97↓	97.97→	98.98↑	93.20↓	99.05↑	100↑ 103/103	97.22↓ 105/108	100↑	100→ 110/110	100→ 112/112	100→ 110/110	100→ 108/108	99 ↓ 109/110	99 → 108/109
Community Midwives	100→	100→	100→	100→	100→	94.28↓	100↑	100→ 36/36	97.05↓ 33/34	96.96↓ 32/33	97→ 32/33	100 → 32/32	100 → 33/33	100 → 32/32	100 → 32/32	100 → 32/32
Support workers	97.22↓	100 ↑	100→	92.10↓	94.59↑	100↑	96.87↓	93.93↓ 31/33	94.11↑ 32/34	93.93↓ 31/33	94→ 33/35	100 → 33/33	100 → 34/34	100 → 33/33	100 → 33/33	97 ↓ 33/34
Obstetric consultants & SAS doctors	90↓	90 →	88.88↓	88.88 →	100↑	100→	100→	100→ 9/9	100 → 9/9	88.88 ↓ 8/9	100↑ 9/9	100→ 14/14	100→ 13/13	100→ 13/13	100 → 13/13	92↓ 12/13
All other obstetric doctors	82.60↓	82.60→	90.90↑	60.87 ↓	23.80↓	65↑	95.45↑	95.45→ 21/22	100↑ 22/22	79.16↓ 19/24	83↑ 20/24	95↑ 19/20	89↓ 17/19	89→ 16/18	89 → 17/19	62 ↓ 13/21
Obstetric anaesthetic consultants	95.23→	95.23→	95.23 →	85.71↓	95.23↑	95.23→	95.23 →	95.23 → 20/21	90.47↓ 19/21	85.71↓ 18/21	90↑ 19/21	100 ↑ 21/21	96↓ 22/23	96→ 22/23	83 ↓ 19/23	83 → 19/23
All other obstetric anaesthetic doctors	86.36↑	86.36 →	90.90 ↑	56.25↓	72.72↑	86.36↑	95.45↑	95.65↑ 22/23	95.65→ 22/23	66.66↓ 16/24	67→ 16/24	83 ↑ 19/23	94↑ 15/16	84↓ 16/19	84 → 16/19	50 ↓ 10/20

MIS Training



Best for
Performance

Staff Group	Rolling compliance for all Midwives and Doctors who require Face to Face fetal monitoring training												
	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	April 25	May 25	June 25	July 25	Aug 25
Midwives	99.2↓	100↑	100%→	100%→	98.75↓	98.75 →	100↑	99↓ 142/143	100↑ 144/144	100→ 143/143	100→ 140/140	100%→ 141/141	100%→ 141/141
Obstetric consultants & SAS doctors	100→	100→	100%→	100%→	88.8%↓	90.00 →	90 → 9/10	100↑ 9/9	100→ 14/14	100→ 13/13	100→ 13/13	100%→ 13/13	92%↓ 12/13
All other obstetric doctors	100→	100→	91.6%↓	100%↑	100% →	100.00 →	100 →	100 13/13→	100→ 8/8	100→ 9/9	100→ 7/7	100%→ 7/7	100%→ 8/8
Overall percentage	99.4↓	100→	95%↓	100%↑	98%↓	98.00 →	99.43 → 173/174	99→ 164/165	100↑ 166/166	100→ 165/165	100→ 160/160	100%→ 161/161	99%↓ 161/162

What is the data telling us?	What is going well?
- Fetal monitoring training remains above target of above 90% for all staff groups. - Junior paediatric doctors are 100% compliant with NLS training. - Due to the rotation of doctors and new doctors starting at the Trust, compliance has dropped. Extra PROMPT and fetal monitoring sessions are arranged for October 2025.	- Oversight of compliance by the MDT. - Positive staff feedback continues for the training days - MDT PROMPT faculty to support robust training; engaging to all attending - Maintaining 100% compliance for fetal monitoring training for 10 months for all other obstetric doctors
What do we need to focus on?	Where do we want to be?
- Increased teaching in clinical areas to enhance the learning of the fetal monitoring study day. - Paediatric services NLS compliance - Ensure compliance will be achieved in line with the MIS requirements	Ensuring the service maintains a 100% compliance in training so all staff are equipped with the knowledge to provide the best care.

Maternity Incentive Scheme: Year 7



**MATERNITY
INCENTIVE
SCHEME**

	Safety Action 1: National Perinatal Mortality Review On track to achieve, see slides seven to ten.		Safety Action 6: Saving Babies' Lives Care Bundle Version Three The service has presented Q1 data to the LMNS. See slide 31.
	Safety Action 2: Maternity Services Data Set (MSDS) Submission confirmed. Safety Action completed.		Safety Action 7: Listen to women, parents and families and coproduce On target to achieve. Awaiting ICB feedback re escalation of unable to meet MNVP commitments set out in this Safety Action.
	Safety Action 3: Transitional Care (TC) The QI project has been presented at the LMNS meeting in July, The data has been collected and is currently under review. See slide 33.		Safety Action 8: Training On target to achieve see slide 28 and 29.
	Safety Action 4 : Clinical workforce planning to the required standard. On target to achieve. See slides 15-17.		Safety Action 9: Assurance to the Board on maternity and neonatal On target to achieve.
	Safety Action 5: Midwifery workforce planning to the required standard? On target to achieve See slides 15-17		Safety Action 10: MNSI and NHS Resolution's Early Notification(EN) On target to achieve.

Saving Babies Lives v3 Q1



**SAVING BABIES'
LIVES
V3**

Awaiting LMNS review of new SBL V3.2 elements therefore no LMNS validation at the time of writing this paper

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%		0%
Element 2	Fetal growth restriction	Partially implemented	95%		0%
Element 3	Reduced fetal movements	Fully implemented	100%		0%
Element 4	Fetal monitoring in labour	Fully implemented	100%		0%
Element 5	Preterm birth	Partially implemented	96%		0%
Element 6	Diabetes	Partially implemented	67%		0%
All Elements	TOTAL	Partially implemented	94%		0%

What is the data telling us?

- Improvement has been seen in the ongoing audits
- SATOD data for Aug the best seen since data collect began

What do we need to focus on?

- Ensuring ongoing improvement in compliance.
- Early breastmilk for preterm babies
- Recording smoking status at 36 weeks (51%) and Vit D offered at booking (94%)

What is going well?

- No triangulated themes in incidents
- Audits are mainly of all women having care at BHNFT not just spot checks

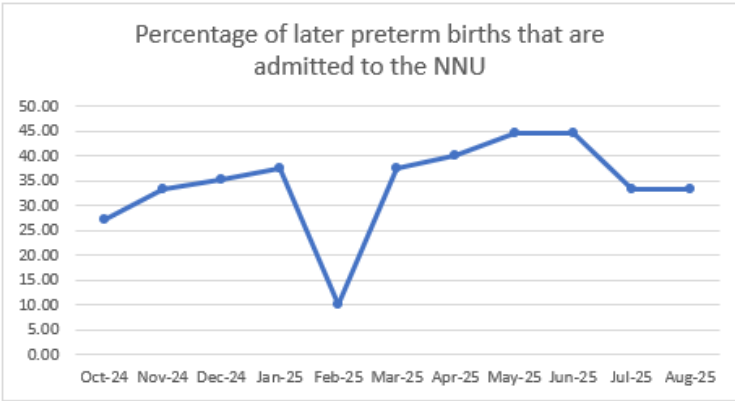
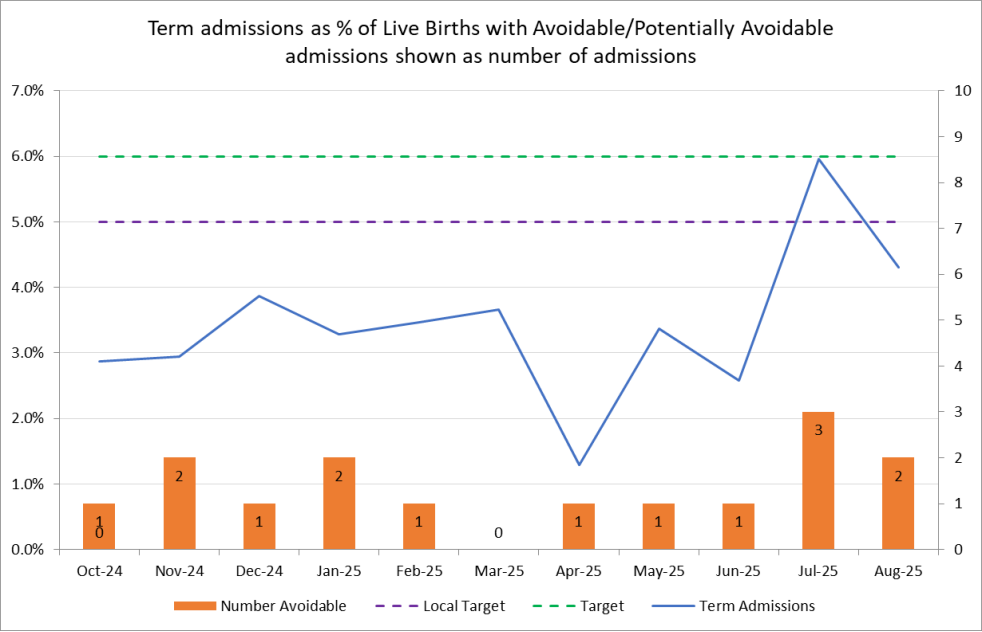
Where do we want to be?

Fully complaint with SBL to reduce the morbidity and mortality and improve patient experience

ATAIN

Review of avoidable admissions from Jan 2024

- Mean time spent on NNU = 43 hours
- No fetal monitoring issues highlighted during the ATAIN review
- Six babies were IOL and four of these require pharmacological methods
- Six babies were in indices of Deprivation (IoD) 1 and 2
- Six babies were White British
- Seven babies were born via cesarean section (six emergency)
- Six were between 38+0 and 39+0 and these were babies born via cesarean section only one baby had steroids
- Three had an APGAR at 5 min <7



Percentage of ATAIN babies from LSCS births

	Emergency LSCS	Elective LSCS
July	10.4%	4.3%
Aug	14.6%	5.4%

In Summary

What is the data telling us?

- There were 3 Avoidable admissions to NNU in July , Duty of Candour has been completed in all 3 cases
- Admissions from LSCS remain a theme for ATAIN admissions
- No theme emerging for date and time of LSCS

What do we need to focus on?

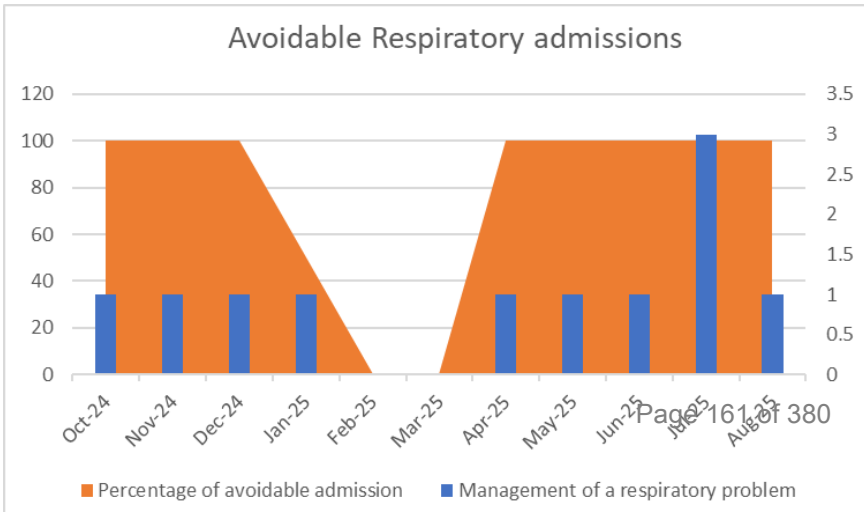
- Explore further emergency LSCS ATAIN admissions
- Ensure correct communication takes place when escalating for emergency help
- Improve the share learning to all clinical staff
- Review of later preterm babies admitted to the NNU for

What is going well?

- MDT review of ATAIN cases
- Proactive thematic reviews to identify and action any themes identified
- Listening to families and staff

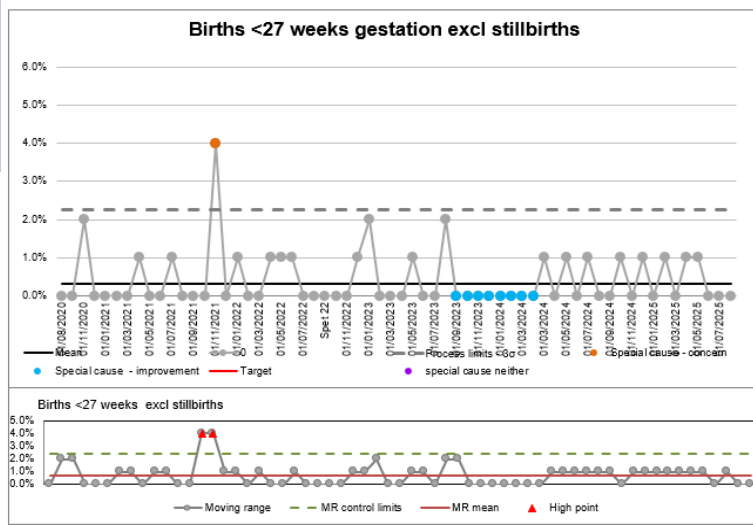
Where do we want to be?

- 100% compliance with MIS SA 3 for 2025
- ATAIN admissions to be below National Target of 6% and local LMNS target of 5%





Babies less than 34 weeks PRETERM



What is the data telling us?

- There has been a drop in the compliance with multiple elements in July.
- During July there were three mothers who birthed. Two sets of twins. All births were via emergency cesarean sections due to fetal complications resulting in difficulty completing the full optimisation.

What is going well?

- Sustained optimisation with admission temperature, and the right place of birth.
- Review of care for each baby did not determine that optimisation could have been achieved due to the clinical need.

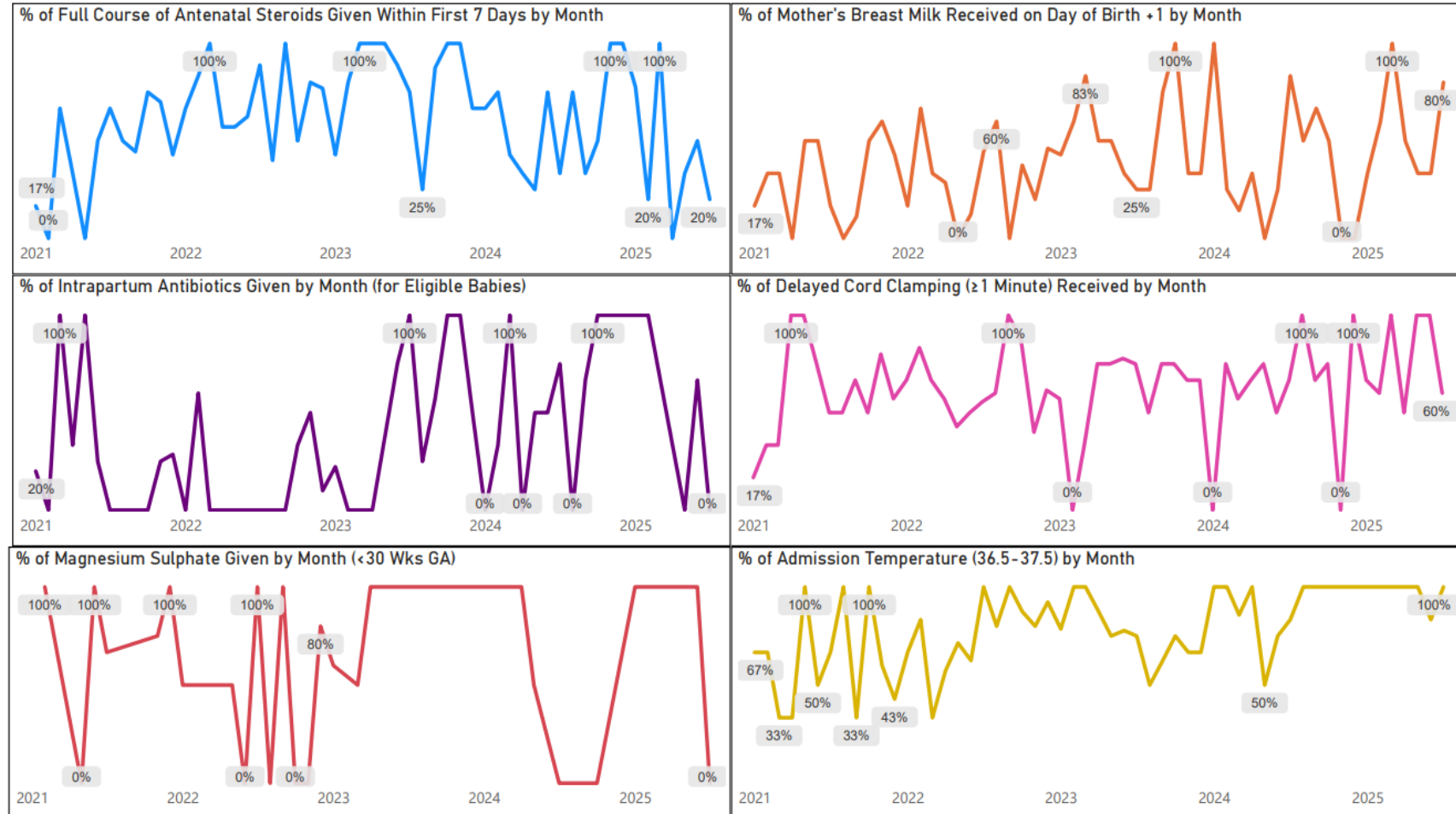
What do we need to focus on?

- Ensure the Lifestart trolley is used for preterm births to support Delayed Cord Clamping (DCC).
- Ensure the Neonatal Operational Delivery (ODN) data is accurate.

Where do we want to be?

- Ensure every preterm baby has the right optimisation appropriate to the clinical picture at the time.

Monthly Performance by Metric





Three-year delivery plan quarterly

Barnsley Hospital NHS Foundation Trust outlier summary: comparison to national result/benchmark					
	Total measures	Negative outliers	Positive outliers		
Total	36	3	4	T1a: Awareness of medical history during antenatal check-ups	41.7%
Listening to and working with women and families with compassion	12	3	2	T1f: King and compassionate treatment during labour and birth	90.9%
Growing, retaining and supporting our workforce	11		2	T1j: Adequacy of time spent discussing physical and mental health at the 6-8 weeks GP check	23.8%
Developing and sustaining a culture of safety, learning and support	10			T1ni: Baby Friendly Accreditation – Maternity	100.0%
Standards and structures that underpin safer, more personalised, and more equitable care.	3			T1nii: Baby Friendly Accreditation – Neonatal	0.0%
				T2hi: Midwife Turnover Rate	6.9%
				T2iii: Obstetric Sickness Rate	0.1%

Theme families 1: Listening and working with families

- Ongoing engagement work with families,
- New reclining chairs in place on the ANPN to support partners staying.

Theme 3: Developing and sustaining a culture of safety, learning and support

- No triangulated themes between incident, complaints and claims.
- A six-month thematic review of complaints and concerns has been undertaken identifying and actioning improving communication with patients.
- The GMC survey is the best in South Yorkshire

Theme 2: Growing, retaining and supporting the workforce

- A further workforce review has enabled further NQM recruitment
- Two specialist midwives are undertaking the RCM leadership course

Theme 4: Standards and structures to underpin safe, more personalised and equitable care

- Internal review of SBL has seen an improvement in compliance.
- The service has been approved for a piolet site for MEWS, via BadgerNet launching Q4.

Patient Survey annual (IQVIA): November 2024	Awareness of medical history	Involved in AN care decisions	Listened to during AN care	Response to concerns during labour	Involved in decision during labour and birth	Kind and compassionate treatment	Adequate information during PN hospital care	Choice	Listened to during PN care
	41.7%	78.5%	79.4%	81.9%	81.4%	90.9%	67.1%	63.7%	68.7%

Action plan

MEOWS is embedded in the Trust outside of Maternity service

Remains on the risk register, repeat audit scheduled for Q4

Escalation

In progress

Completed



5.2. Integrated Performance Report

For Assurance

Presented by Michael Wright



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02/5.2

SUBJECT: INTEGRATED PERFORMANCE REPORT

DATE: 02 October 2025

PURPOSE:		Tick as applicable			Tick as applicable
	For decision/approval	✓		Assurance	✓
	For review	✓		Governance	✓
	For information	✓		Strategy	✓

PREPARED BY: Lisa Fox Deputy Director – Data and Insights

SPONSORED BY: Michael Wright, Managing Director

PRESENTED BY: Michael Wright, Managing Director

STRATEGIC CONTEXT

The monthly Integrated Performance report is aligned to the Trust objectives and informs the Board of Directors on key delivery indicators against local and national standards.

The report is currently being developed to reflect 3 of the 6 'P's' as per the Trust strategic objectives. The report does not currently contain metrics directly related to Place & Planet as these are reported separately, with all objectives reported quarterly via the strategy report. The place dashboard is shared as available.

EXECUTIVE SUMMARY

The main points are covered in the Executive Summary of the core report

Of Note:

- One Page National Oversight Framework (NOF) Summary ([Home - NHS England Data Dashboard](#))
- Updated Page in the Place section with a Deep Dive on ED attendances.

RECOMMENDATIONS

The Board of Directors is asked to receive and review the August 2025 performance report.



Our Integrated Performance Report (IPR) provides a summary of our performance by assessing progress against a series of measures for each strategic theme.

Our strategic planning framework translates our strategy into action. The reports reflects 4 of the 6 'P's' as per the Trust strategic objectives. The report does not currently contain metrics directly related to Planet or Partnership as these are reported separately, with all objectives reported quarterly via the strategy report. *The place dashboard is shared as available.*





IPR Executive Summary

Quality (Patients)

- **VTE and Sepsis** performance are good and continue to achieve the targets.
- The **HSMR** remains within externally set limits and the **SHMI** is rated by NHSD ‘as expected’
- **Falls/ 1000 bed days** remain below target overall. Acorn unit had its lowest ever month.
- **Pressure Ulcers / 1000 bed days** – following significant reductions last year we set an ambitious target for this year which we met during June with our lowest ever number of pressure ulcers and we remained below target for July.
- **Clostridioides Infections** met the in-month trajectory in August but are above the mandated NHSI target year to date.
- Performance against the 40 day **complaint** target has sustained improvements and met the standard for 40 and 60 day response times.
- **Family and Friends** (excl ED) positivity scores decreased very slightly, remaining below target. Extensive work is taking place in response to this. ED figures increased to achieve the target

People

- **Sickness Absence:** The sickness absence rate remains at 5.5% for the second consecutive month, with 3.6% attributed to long-term and 1.9% to short-term sickness absence. The primary reason for absence continues to be mental health-related issues, a trend that is also observed across the region
- **Return to Work:** While there has been steady improvement, the return-to-work rate remains below target.
- **Mandatory Training:** Continues to exceed the target throughout 2025 to date.
- **Appraisals:** Current reported rate of 87.3% exceeds the rate achieved last year of 86.6%. Rate is expected to increase as data input continues.
- **Staff Turnover:** Turnover remains fairly static at around 8%, having decreased from 11% at the start of 2025. This is significantly below the lower target range of 10%.
- **Vacancy Rate:** Vacancy rate is 3.7% which is a decrease of 0.47% compared to last month when it was at 4.17%.
- **Bank and Agency Spend:** Expenditure on bank and agency staff has increased to **£2115k** per month.
- **Consultant Job Planning:** Currently, 89% of clinicians have signed off their job plans.

Performance

- **Urgent & Emergency Care:** Performance against 4 hrs for type 1 was 78.3% against the England performance of 62% . The stretch target is 80%, with daily attention on evening and overnight and particular focus on Paediatric and Low Acuity pathways especially for non-admitted patients.
- **Bed Occupancy** for August 2025 was 92.4%.
- **Referral To Treatment:** 68.8% performance, England performance for the same period. There were 119 patients waiting 52 weeks and 3 patient above 65 weeks. Clinical business units are working to speciality specific recovery to 92%, including speciality specific stretch to >95% in year to achieve a robust RTT delivery.
- **Capped Theatre Utilisation:** 79.3%:
- **Diagnostic** 8.1% patients waiting longer than 6 weeks for a diagnostic test against the recovery target of 5%. and constitutional standard of 1%.
- **Cancer:** The trust has achieved the 28-day faster diagnosis standard @ 83.1% against a target of 80%, the 31-day treatment standard was not achieved @ 88.9% against a target of 96%, Performance against the 62-day treatment standard of 75% was not achieved at 71.9%. Lung, Urology and Colorectal being the largest under achieving tumour site.
- **DNA Rates** for New patients were 6.8% and Follow Ups were @ 5%.

Finance

- **Planned Financial Position:** As at Month 5 the Trust has a consolidated deficit of £64k against a planned deficit of £66k. NHS England (NHSE) adjusted performance after taking into account depreciation in respect of donated assets (£23k) and granted assets (£41k) is breakeven against an adjusted plan of breakeven. However, this is after releasing additional surge funding above the level originally planned.
- **Planned Cash Position:** Cash balances have increased in month by £0.119m and are £9.707m higher than planned, mainly due to capital program slippage and timing of creditor payments.
- **Capital Plan:** Capital expenditure for the year is £3.343m, which is £4.334m below plan. . .

Key Measures

18 Weeks
68.8%

Avg Wait to
First App
18 wks

% of WL
>52wks
0.60%

DM01
8.1%

28 FDS
83.1%

62 Days
71.5%

PIFU
4.1%

Missed Appts
5.5%

A&G
11.6%

Capped
Theatre
79.3%

4hr
78.3%

Day Case Rate
91.3%

Ambulance
handover Avg
16.7 mins

Agency Spend
£2,115k

ED 12 hr
trolley waits
0

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RAG rating aligns
with in month
performance.

A summary of the NHS England National Oversight Framework (NOF) has been included following the most recent national publication. Future reports will incorporate these measures more fully into the overall IPR. The table below will give initial oversight of the performance metrics associated with the NOF while that is in development.

This Trust is placed in **Segment 3** (*below average and/or financial deficit*) with an average score of **2.31**.
The Trust is ranked of **64** out of **134** trusts

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q1 2025/26	69.88	percent	2.75	65 out of 118	71.12	75
Access to services	Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Q1 2025/26	78.99	percent	2.22	39 out of 118	76.88	80
Access to services	Elective care	Difference between planned and actual 18 week performance	Jun-25	-2.68	percentage points	3.57	121 out of 131	0.99	0
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun-25	70.76	percent	1.30	14 out of 131	60.72	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Jun-25	0.48	percent	1.00	15 out of 131	2.40	1
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2025	67.40	percent	3.61	107 out of 123	76.00	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q1 2025/26	2.18	percent	1.34	15 out of 123	8.36	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	2.30	days	3.95	124 out of 126	0.70	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	2.00			
Effectiveness and experience	Patient experience	Summary Hospital Level Mortality Indicator	Apr 24 - Mar 25		score	2.00			
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	2.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-1.03	percent	3.00	56 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.00	percent	1.00	54 out of 134	0.00	
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	1.72	percent	2.87	84 out of 134	2.91	
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.79	out of 10	1.25	12 out of 134	6.42	
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	0.00	count	1.00	1 out of 134	3.00	0
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.39	rate	3.53	106 out of 134	1.22	1
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.40	rate	3.73	119 out of 134	1.16	1
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.12	out of 10	1.52	24 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	5.65	percent	2.85	94 out of 134	5.21	

Best for Patients and the Public

We will provide the best possible care for our patients and service users

- We will treat people with compassion, dignity and respect at all times, make our services as accessible as possible and our communications clear, timely and simple to understand.
- We will listen to our patients and involve them in decisions about their care.
- We will focus on continuous improvement, patient engagement, best evidence and research to improve patient safety, transform services and introduce new ways of working.
- We will invest in research and development and adopt new innovations as soon as practicable and appropriate to do so.
- We will continue to use digital transformation to support new ways of working and will build on solutions that enable our team to work fully electronically and remotely.
- We will develop our estate to provide the best experience for patients and service users.



Executive Lead(s): Simon Enright, Medical Director & Sarah Moppett, Director of Nursing, Midwifery and AHPs

Quality in patient care is one of the Trust's core objectives and is key to all we do. We take great pride in keeping our patients and service users at the heart of everything we deliver. We believe every person that uses our services deserves the highest possible quality of care and should be listened to, involved in their own care, feel able to give feedback and be treated with compassion, dignity and respect at all times

Quality: Matrix

		ASSURANCE			
		Pass 	Hit Or Miss 	Fail 	No Target
VARIATION / PERFORMANCE			Complaints closed within 40 days (simple)		SHMI HSMR
					
		Venous Thromboembolism (VTE) - % of Patients Screened	Falls per 1000 Bed Days (exc Acorn) Harmful Falls per 1000 Bed Days (All Areas) Hospital Acquired Pressure Ulcers per 1000 Bed Days Handwashing Clostridioides difficile infections MRSA Bacteraemia Infections Single Sex Breaches Friends & Family Test (Excl. Emergency Department) - % Positivity Friends & Family Test Emergency Department - % Positivity Falls per 1000 Bed Days (Acorn only) E.coli infections Sepsis – antibiotics given within 1 hour		Patient Safety Incident Investigations Severe Incidents Incidents resulting in Fatal Outcome Complaints
					
					

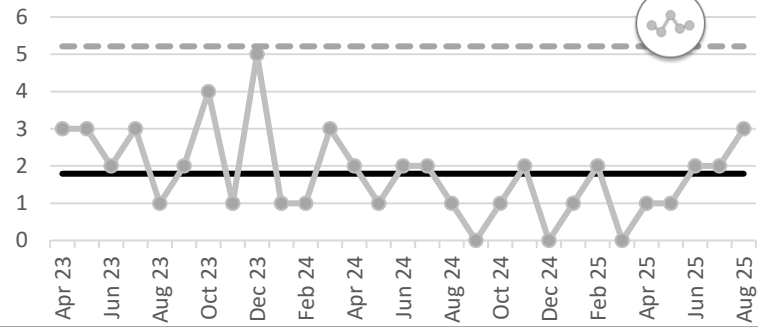


Quality: Summary

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile
Patient Safety Incident Investigations	-	3	Aug 2025		No Target		
Incidents Resulting In Severe Harm	-	2	Aug 2025		No Target		
Incidents Resulting In Fatal Outcome	-	3	Aug 2025		No Target		
Falls Per 1000 Bed Days (exc Acorn)	6.6	6.3	Aug 2025				
Falls Per 1000 Bed Days (Acorn only)	15.1	1.5	Aug 2025				
Harmful Falls per 1000 Bed Days (All Areas)	0	0.2	Aug 2025				
Pressure Ulcers per 1000 per Bed Days	2	1.98	Jun 2025				
Clostridioides difficile infections	4	4	Aug 2025				
MRSA Bacteraemia Infections	0	0	Aug 2025				
E. Coli infections	4	3	Aug 2025				
Single Sex Breaches	0	0	Aug 2025				
Complaints	-	23	Aug 2025		No Target		
Complaints closed within 40 Days (Simple)	90%	96.6%	Aug 2025				
Complaints closed within 60 Days (Complex)	100%	100.0%	Aug 2025		Not SPC	Not SPC	
Friends & Family Test (exc ED) - % Positivity	95%	92.1%	Jul 2025				
Friends & Family Test ED - % Positivity	85%	86.3%	Jul 2025				
Venous Thromboembolism - % Screened	95%	99.2%	Jul 2025				
Sepsis – antibiotics given within 1 hour	90%	93.0%	Jun 2025				
SHMI	-	95.02	Mar 2025		No Target		Page 171 of 380
HSMR	-	71.04	Jun 2025		No Target		

Data, Context and Explanation

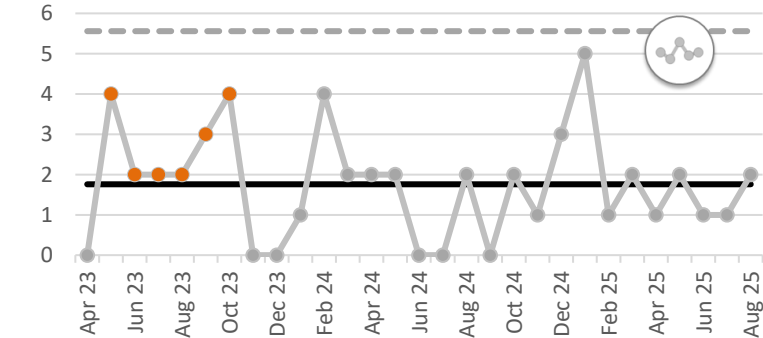
Patient Safety Incident Investigations



Patient Safety Incident Investigation (PSII) consist of an in depth review of a single incident or cluster of incidents to understand what happened and how.

- There were three patient safety incident investigations (PSII) declared in the month
- Lack of clinical assessment of septic patient
 - Discharge process failure for an absconding patient
 - Obstetric incident: baby only

Severe Incidents



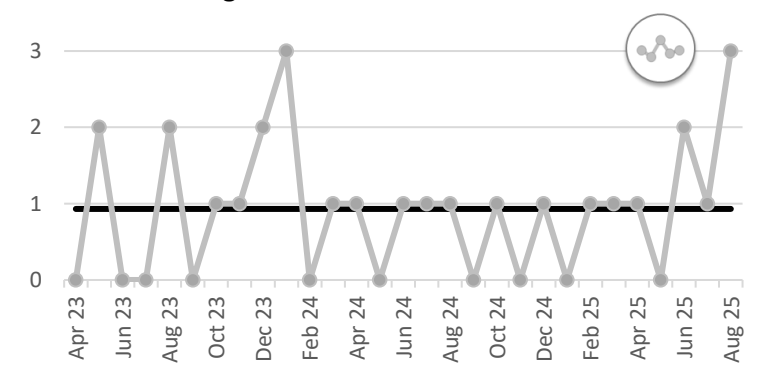
There was one incident resulting in severe physical harm

- An inpatient experienced a delay in treatment in gynaecology. Further information is being obtained and the level of harm remains under review

There was one incident resulting in severe psychological harm

- An obstetric patient experienced a lack of clinical assessment. Further information is being obtained and the level of harm remains under review

Incidents resulting in Fatal Outcome



There were three incidents resulting in a fatal outcome

- An inpatient experienced a cardiac arrest. Further information is being obtained and the level of harm remains under review
- An inpatient experienced a lack of clinical assessment in general surgery. Duty of candour has been confirmed and a PSII declared.
- An inpatient experienced a delay in treatment in general surgery. Further information is being obtained and the level of harm remains under review

Metric	Value	Target	Lead	Reporting Period
Patient Safety Incident Investigations	3	-	Sarah Moppett	Aug 2025
Incidents Resulting in Severe Harm	2	-	Sarah Moppett	Aug 2025
Incidents resulting in Fatal Outcome	3	-	Sarah Moppett	Aug 2025

What Actions Are Planned & By When?

Improvements will be implemented to reduce the risk of the recurrence of future incidents based on the investigation and findings

Staff and CBUs are supported to ensure that appropriate learning from incidents is identified and shared.

Expected Impact?

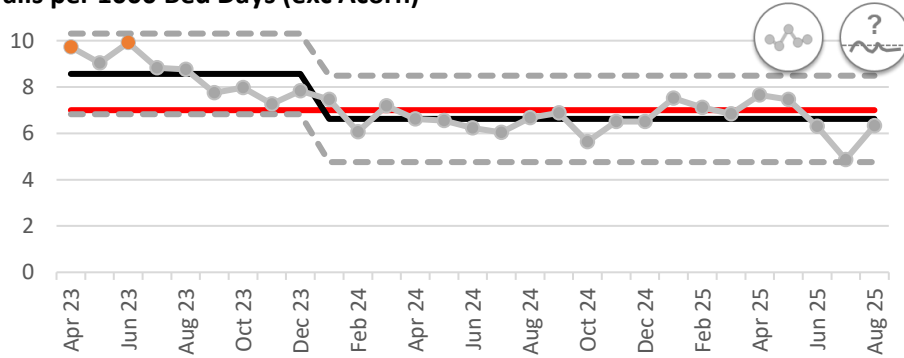
Reduced number of repeat incidents

Challenges/Risks

There are well developed, embedded, effective and sustained processes for the patient safety investigations aligned to the National PSIRF and Trust PSIRF Policy and Plan. The implementation of the process is closely monitored via PSP and PSHG with no known risks or challenges to delivery.

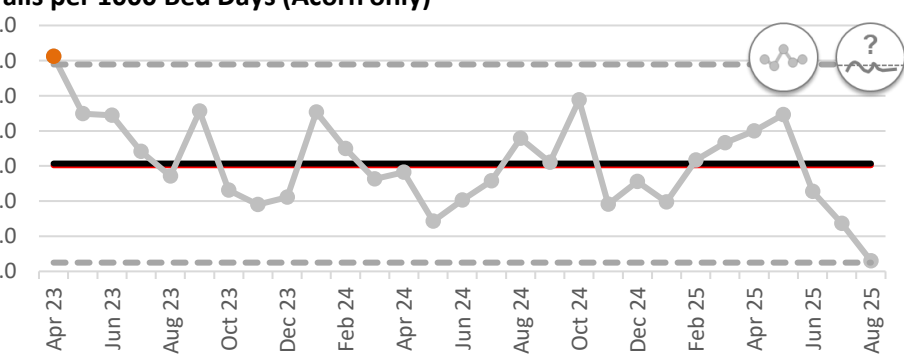
Data, Context and Explanation

Falls per 1000 Bed Days (exc Acorn)



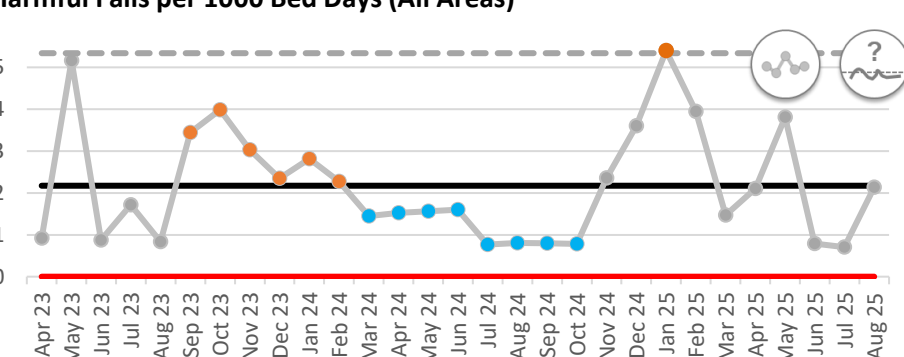
Aug 2025 - Falls rate is 6.3 falls per 1000 bed days, excluding Acorn, falling below the Trust target of 6.6, and remains within normal variation.

Falls per 1000 Bed Days (Acorn only)



Aug 2025 - Falls rate for the Acorn Unit is 1.5 falls per 1000 bed days which is significantly below the target of 15.1.

Harmful Falls per 1000 Bed Days (All Areas)



Aug 2025 - There were 0.2 falls per 1000 bed days with moderate harm or above (with a target of zero).

All harmful falls are subject to an After Action Review for learning and recommendations.
Themes - out of hours and unwitnessed falls..
Learning - Provision of enhanced care. Caution with bedrails and confusion. Completion of L+S BPs. Referrals to therapy.

Metric	Value	Target	Lead	Reporting Period
Falls per 1000 Bed Days (exc Acorn)	6.3	6.6	Sarah Moppett	Aug 2025
Falls per 1000 Bed Days (Acorn only)	1.5	15.1	Sarah Moppett	Aug 2025
Harmful Falls per 1000 Bed Days (All Areas)	0.2	0	Sarah Moppett	Aug 2025

What Actions Are Planned & By When?

QI project - 'de-caff drinks' rolled out trust-wide in May 2025.
Post fall de-brief will be trust wide - by 31/12/2025
Removal of nurse station trial – ongoing (Wards 35 & 36 added to the trial in July) – slow rollout.
Deconditioning workstreams ongoing for 2025/2026.
Multifactorial Falls Risk Assessment to be improved- by 30/09/2025
Falls at night audit ongoing by site matron team to give assurance of nursing locations overnight - Jul 2025– Sep 2025.

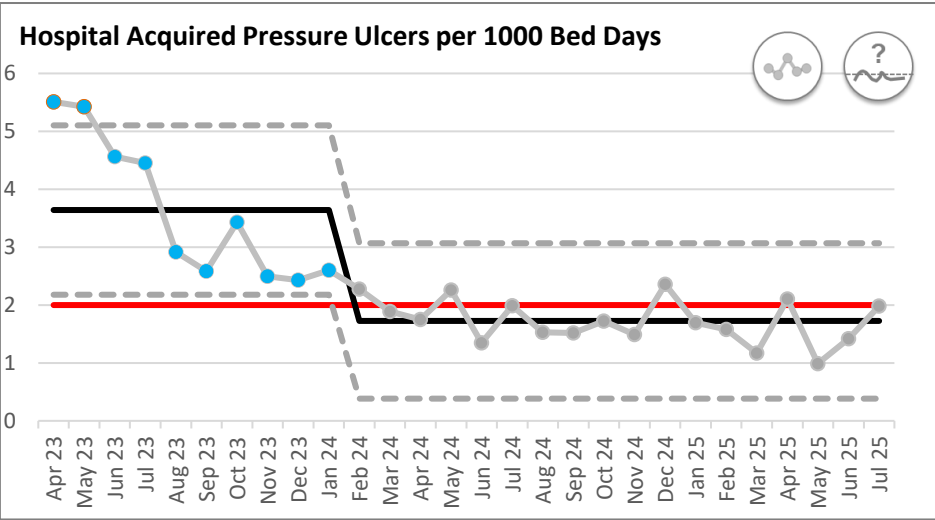
Expected Impact?

De-caff drinks expected to reduce falls by reducing urine urgency and falls overnight.
Post fall de-brief expected to improve safety, encourage MDT learning from falls and prevent repeat fallers.
Removal of the nurse station should improve visibility of both staff and patients, and encourage staff mobility.
Deconditioning workstreams expected to improve patient movement and activity.
Changes to MFRA expected to ensure patients have a comprehensive falls risk assessment.
Night audit expected to highlight any areas of concern linked to falls overnight.

Challenges/Risks

Challenges include adherence to the post fall de-brief from the full MDT team.
Risk of patient satisfaction by switching to decaf drinks, although caffeinated is available on request, respecting patient choice.
Challenge with the availability of IT equipment for the use of computers on wheels.
Risk of an increase in falls due to increasing levels of movement / activity on the ward areas, however we should see a long term positive effect.
Challenges overnight when the site-matron team switch to tele-tracking in September 2025 due to a reduced oversight of the ward areas.

Data, Context and Explanation



The number of hospital acquired pressure ulcers is 1.98 per 1000 bed days which is fractionally below the Trust target of 2.0 per 1000 bed days

Metric	Value	Target	Lead	Reporting Period
Hospital Acquired Pressure Ulcers per 1000 Bed Days	1.98	2.0	Sarah Moppett	Jul 2025

What Actions Are Planned & By When?

- The Tissue Viability Team are working collaboratively with the surrounding Trusts to benchmark and scope services.
- Further Staff to attend the Tissue Viability Study Day – to end of 2025.
- All hospital acquired pressure ulcers are investigated.
- After Actions Reviews formulating specific actions for the ward/area when learning outcomes are identified.
- Working with the digital team to digitalise care plans.

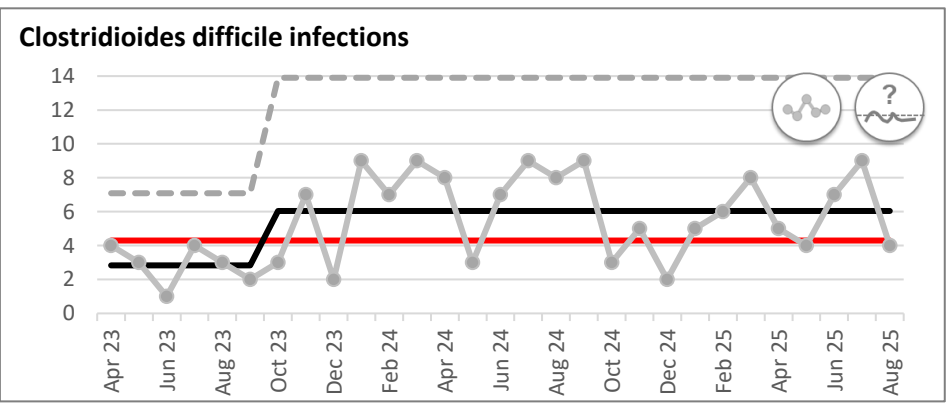
Expected Impact?

- Reduction in hospital acquired pressure ulcers
- Increase in staff knowledge and management of pressure ulcers.
- Positive impact regarding continuous learning from Hospital Acquired Pressure Ulcers through the AAR process.
- Digital care plans and risk assessments can be reviewed and audited in a timely manner.

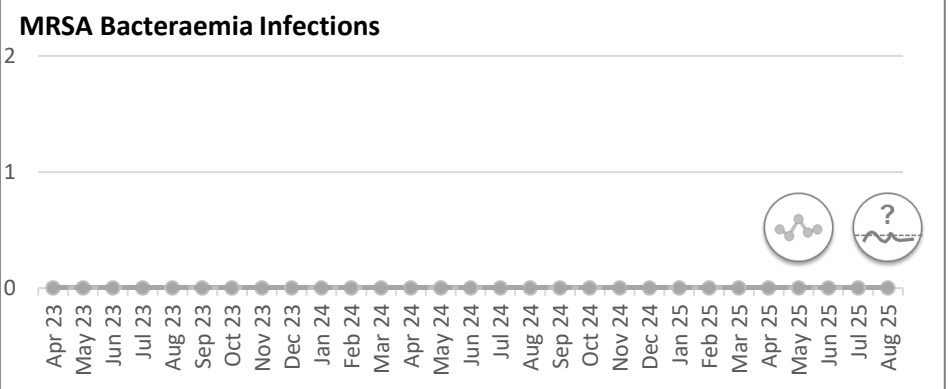
Challenges/Risks

- Patient-Related Factors such as comorbidities and limited mobility.
- Staff being released from the wards to attend training.

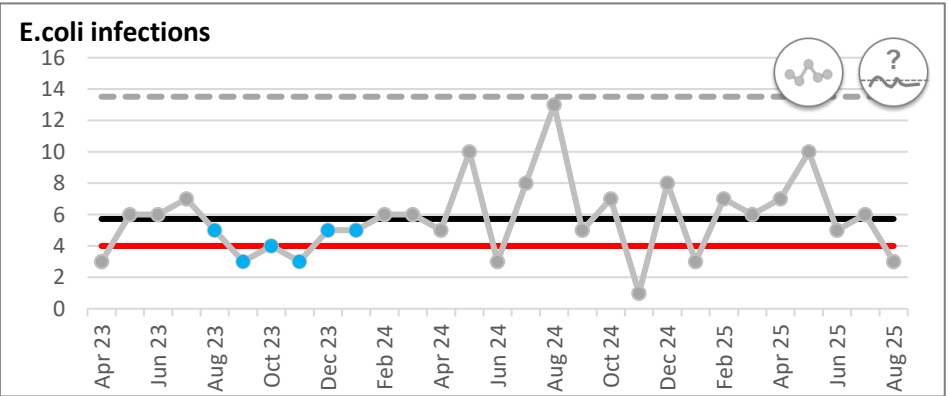
Data, Context and Explanation



In August 4 instances of hospital attributed C.difficile infection were identified across 4 different wards.
This is a decrease of 5 from July.



No MRSA Bacteraemia infections were noted.



3 E. coli infections were recorded.

Metric	Value	Target	Lead	Reporting Period
Clostridioides difficile infections	4	4	Christine Fisher	Aug 2025
MRSA Bacteraemia Infections	0	0	Christine Fisher	Aug 2025
E. coli infections	3	4	Christine Fisher	Aug 2025

What Actions Are Planned & By When?

As agreed by the infection prevention and control group, a different approach to investigating cases would be trialled. After action reviews will be paused and an MDT approach to establish any themes not previously identified would be implemented. Work is currently underway to identify stakeholders and develop a terms of reference for the group. A review of the data in preparation for the MDT meeting is planned for early September.

Ward deep cleaning has been completed on ward 33; in total 3 wards as well as the decant ward have been deep cleaned. Deep cleaning on ward 19 is currently underway. This will complete the planned deep cleaning programme for 2025.

Targeted training on antimicrobial stewardship for nursing staff has commenced.

With regard to E.coli reduction; training has been delivered as part of the nursing Quality Summit with a focus on external urinary catheters as a method of reducing indwelling urinary catheters.

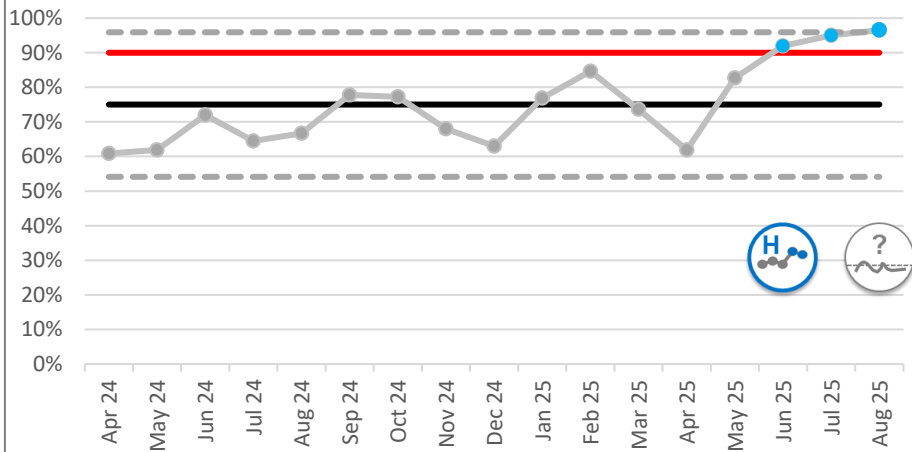
Expected Impact?

Improvements in learning outcomes identified from after action reviews.
Reduction in the numbers of cases of CDI/HCAI

Challenges/Risks

Data, Context and Explanation

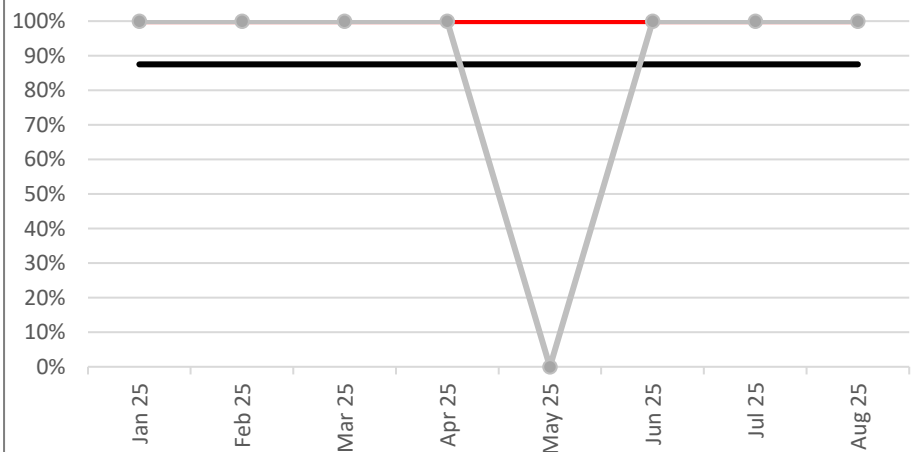
Complaints closed within 40 days (simple)



29 complaints closed in the reporting month with initial timeframe of 40 working days:

- 97% closed in target
- 1 case closed outside of the 40 working day target:
 - 1 due to CBU Meeting Arrangements (CBU 3)
- average of 34 working days across the reporting month.

Complaints closed within 60 days (Complex)



2 complaints closed in the reporting month had an initial timeframe of 60 working days:

- 100% closed in target
- average of 46 working days across the reporting month.

Metric	Value	Target	Lead	Reporting Period
Complaints closed within 40 days (Simple)	96.6%	90%	Sarah Moppett	Aug 2025
Complaints closed within 60 days (Complex)	100.0%	100%	Sarah Moppett	Aug 2025

What Actions Are Planned & By When?

The Associate Director of Quality and Clinical Governance and the Patient Advice and Complaints Manager are:

- New process for formal complaint caseload and overview
 - Weekly CBU formal caseload circulated with CBU triumvirates/quadrumvirate with exception reports to the DoN, M & AHP and MD
 - Weekly email escalation processes to continue support the timely access to information and statements required to respond to formal complaints
 - Weekly meetings with ADoN and Patient Advice and Complaints Manager to address any complex cases and associated issues
 - Continue to engage and work closely with CBU and clinical colleagues to address delays in statement provision
 - All complainants to be kept informed of the progress of their complaint response
- All actions are implemented.

Expected Impact?

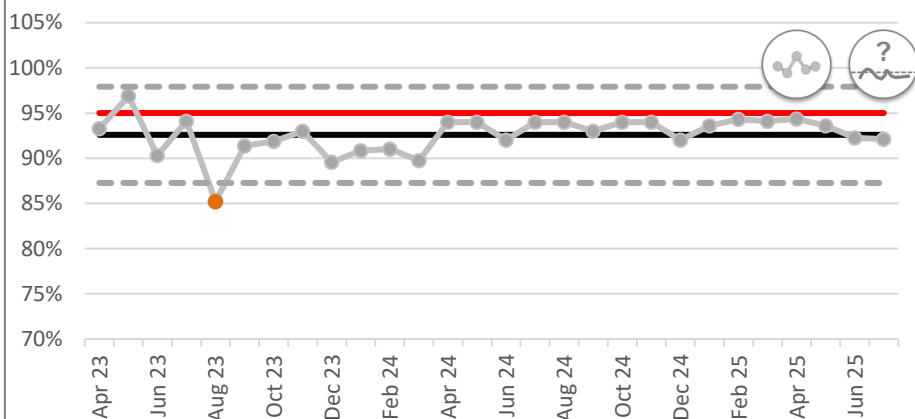
- To proactively identify any cases that are not progressing in line with the allocated KPI
- To identify early action and resolution for any cases not progressing in line with the allocated KPI
- Maintain high quality responses to all formal complaints
- Improve performance against the agreed KPI
- Improve patient and family experience of BHNFT formal complaint response process

Challenges/Risks

- Team resilience (sickness absence and annual leave of IOs)
- Unpredicted caseload of formal complaints
- Unpredicted complexity of formal complaints under investigation
- Operational challenges impacting on provision of information from clinical teams

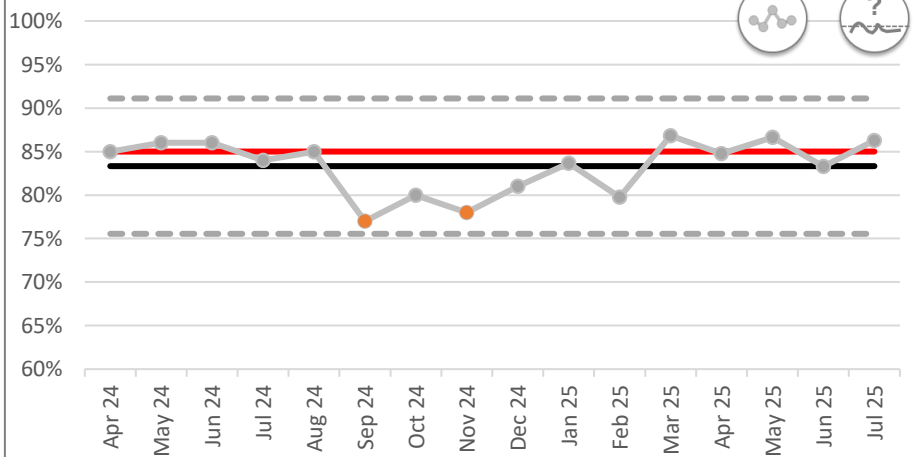
Data, Context and Explanation

Friends & Family Test (Excl. Emergency Department) - % Positivity



Negative feedback across the reporting month has increased ever so slightly again this month, locations remain sporadic and low reporting areas continue to contribute to the overall lower positivity rates this month (July 2025 – 73 comments, previously 70).

Friends & Family Test Emergency Department - % Positivity



The majority of negative feedback from ED relates to waiting times within the department, and this month has seen a decrease in those comments (July 2025 - 55 comments, previously 63). There were some other comments relating to staff attitude and patient care whilst on the unit but these were minimal in comparison to waiting times and the number of ED responses.

Metric	Value	Target	Lead	Reporting Period
Friends & Family Test (Excl. Emergency Department) - % Positivity	92.1%	95%	Gill Feerick	Jul 2025
Friends & Family Test Emergency Department - % Positivity	86.3%	85%	Gill Feerick	Jul 2025

What Actions Are Planned & By When?

- ED waiting times are displayed throughout the department
 - Low reporting areas encompass all three CBUs
- Patient Experience CBU Leads continue to work closely with areas reporting low response rates to improve participation. This includes:
- Meeting with leads to provide oversight and discuss trends.
 - Monitoring and addressing persistently low response rates.
 - Introducing volunteers in some areas to support data collection.
 - Updating devices with a short FFT form link to reduce staff time spent collecting feedback.
 - Collaborating with ward clerks to gather responses.
 - Providing postcard-sized QR codes for patients and displaying posters in main waiting areas.
 - Attending governance meetings to maintain focus on improvement.
- The team are working towards the implementation of strategically placed kiosks throughout the Trust during Q3. This will enable patients, families and carers to provide feedback either before leaving the hospital or when visiting other locations, such as colliers and other key areas. The aim is to make it as easy and accessible as possible for everyone to share their experiences and help drive continuous improvement.

Expected Impact?

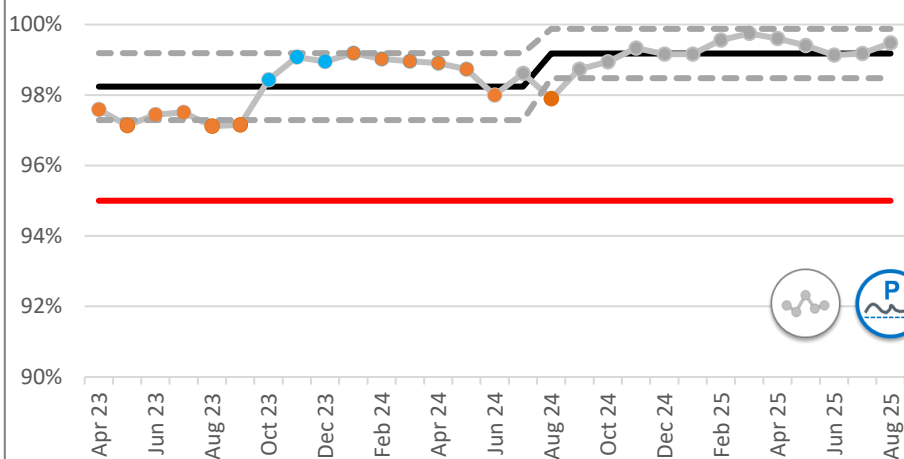
- Increased levels of positive feedback continue to be collected via FFT month on month

Challenges/Risks

- Trust-wide - The challenge is around staff engagement and participation in the collection of FFT.
- ED - A key ongoing challenge is the waiting time for patients. Due to sustained high pressures in the Emergency Department (ED), significant improvements in waiting times are unlikely in the short term.

Data, Context and Explanation

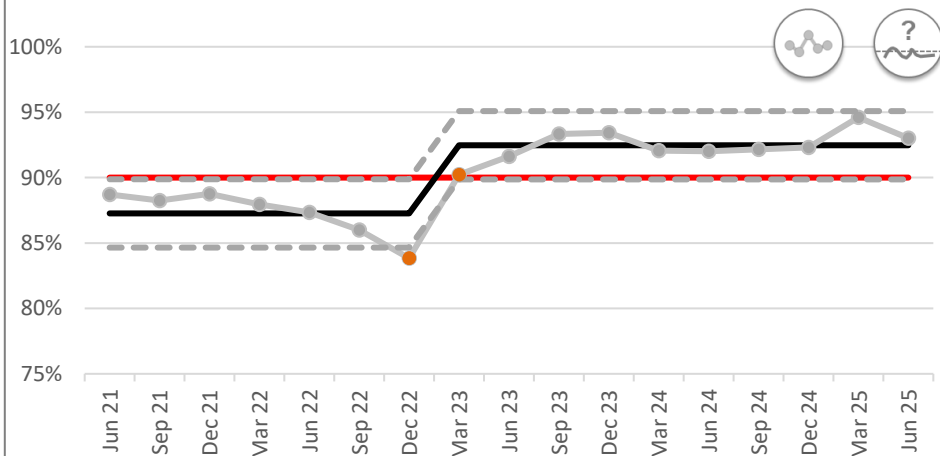
Venous Thromboembolism (VTE) - % of Patients Screened



VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2025/2026.

The target is consistently being achieved.

Sepsis - Antibiotics given within an hour



Sepsis is a National Quality Requirement in the NHS Standard Contract 2025/26

The overall target continues to be achieved.

Metric	Value	Target	Lead	Reporting Period
Venous Thromboembolism (VTE) - % of Patients Screened	99.5%	95%	Simon Enright	Aug 2025
Sepsis-Antibiotics given within an hour	93.0%	90%	Simon Enright	Jun 2025

What Actions Are Planned & By When?

VTE

- Ensuring all data sources are utilised including EPMA - monthly
- Any clinical teams that have not achieved the target or are marginally above the target are informed and support is offered – monthly
- Review and update on the data specification - annual
- If necessary manual validation of data is completed to accurately reflect performance - monthly

SEPSIS:

- Ensuring all data sources are utilised – monthly
- Any areas that have not achieved the target or are marginally above the target are informed and support is offered – monthly
- If necessary manual validation of data is completed to accurately reflect performance - monthly
- Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning - monthly

Expected Impact?

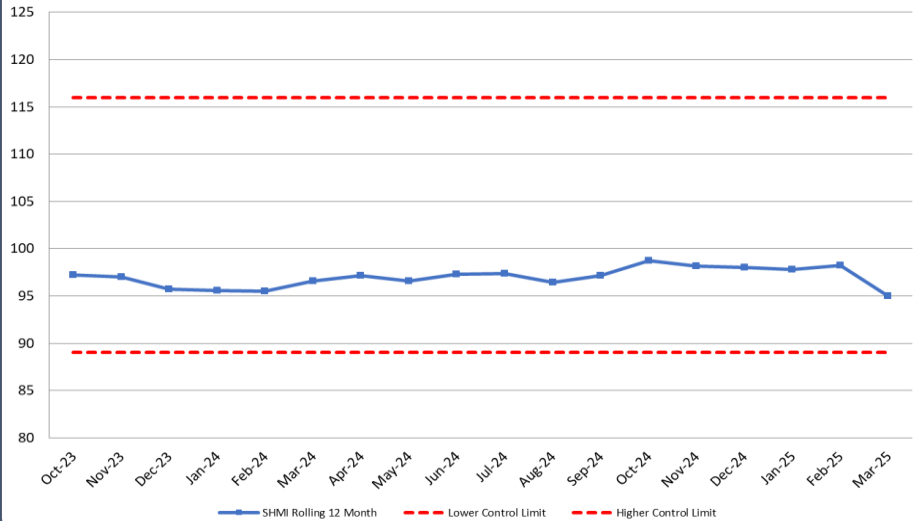
Continued achievement of the targets.

Challenges/Risks

None anticipated.

Data, Context and Explanation

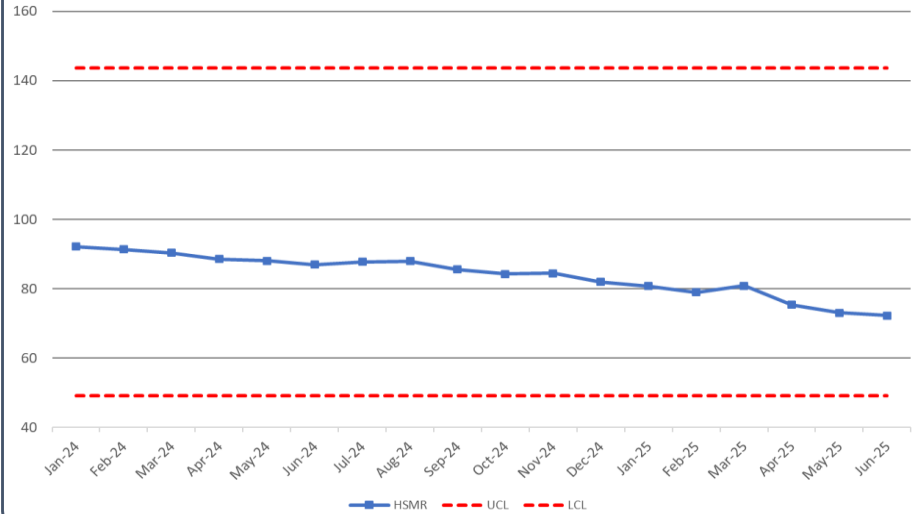
SHMI: Rolling 12 Month



SHMI latest reporting period:

Mar 2025 **95.02**

CHKS Rolling 12 Month HSMR



HSMR Rolling 12 Month:

Jun 2025 **71.04**

Metric	Value	Target	Lead	Reporting Period
SHMI	95.02	-	Simon Enright	Mar 2025
HSMR	71.04	-	Simon Enright	Jun 2025

What Actions Are Planned & By When?

Maintain current actions through the variance group and mortality overview group. This includes data quality checks, coding checks and Learning from Deaths.

These are monthly actions which are completed by the end of each calendar month

Expected Impact?

Maintenance of the HSMR within externally set limits, and SHMI with the 'as expected' category

Challenges/Risks

The SDEC element of the Emergency Care Data Set (ECDS) Version 4 has yet to be implemented at BHNFT. Based on estimated volumes of activity data that could be moved from admitted care to ECDS could result in a decrease of 2.5 points to the HSMR and an increase of 2.6 points to the SHMI (source CHKs July 2025) due to the decreased denominator in the expected death rate calculations. As the SHMI has a lag of six months this will not be apparent until six months after the SDEC element has been implemented. There is no confirmed date for implementation.

Data, Context and Explanation

Charts Under Development

Registered staff CHPPD in Aug 2025 was 4.78 against a plan of 5.04 (94.8%).

Charts Under Development

Non-Registered staff CHPPD in Aug 2025 was 3.59 against a plan of 4.01 (89.5%)

Metric	Value	Target	Lead	Reporting Period
Registered Staff Planned v Actual CHPPD hours	94.8%	-	Sarah Moppett	Aug 2025
Non-Registered Staff Planned v Actual CHPPD hours	89.5%	-	Sarah Moppett	Aug 2025

What Actions Are Planned & By When?

- Continued use of NHSP to fill outstanding shifts, monitored by Lead Nurses & Matrons.
- Golden Key facility in place for critical shift cover.
- Dynamic staffing risk assessments undertaken via daily staffing huddles within each CBU with oversight by the ADoN.
- Nursing Establishment review complete for Summer 2025 and recommendations approved by the Executive Team
- Recruitment of newly graduating nurses & midwives complete and beginning to join the organisation.

Expected Impact?

- Improvement seen in day shift fill rates for registered staff – 9 areas below 90% in August compared to 14 areas in July
- New graduates commencing in post across autumn months

Challenges/Risks

- All areas had staff unavailability for both registered and non-registered above establishment headroom
- Continued high levels of sickness and maternity leave

Best for People

We will make our Trust the best place to work by:

- Ensuring a caring, supportive, fair and equitable culture for all.
- Creating an organisational climate that supports Equality, Diversity and Inclusion.
- Ensuring we recruit and retain staff to achieve future workforce sustainability and to ensure our organisation is correctly resourced.
- Supporting our staff's health and wellbeing.
- Trusting our staff to care for our patients to a high standard.
- Supporting our staff to continuously improve their own work and the work of others.



Our people, the NHS staff working in our organisation, are our most important asset and we are committed to delivering the intentions set out in the NHS People Plan. The NHS has experienced the biggest challenge seen in our lifetime with the Covid-19 pandemic. We will support our people in their recovery with health and wellbeing support and, as we recover and build back better, we will develop them and our teams and provide a motivational environment in which to work, with a positive organisational culture.

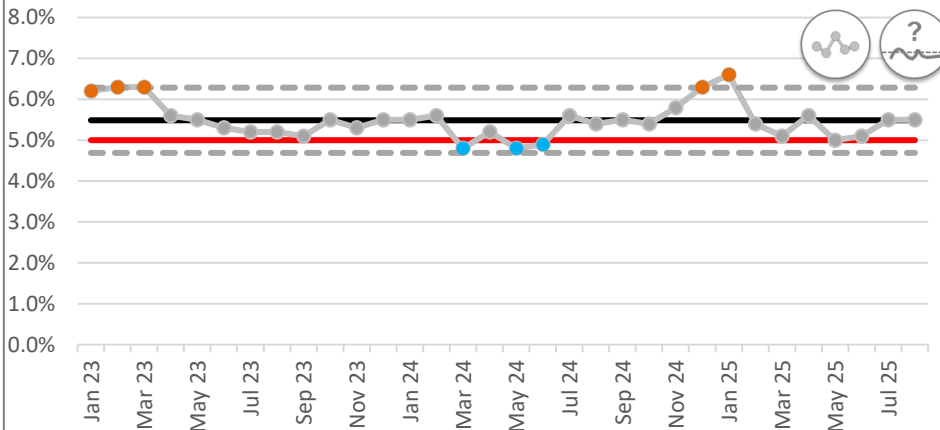
People and Culture: Matrix

		ASSURANCE			
		Pass 	Hit Or Miss 	Fail 	No Target
VARIATION / PERFORMANCE			Mandatory Training	Return to Work Consultant Job Planning - Doctor Sign off	Staff Turnover - Rolling 12 months
					
			Sickness Absence Appraisals		Vacancy Rate - Per month Bank/Agency Spend £k Consultant Job Planning - Final Sign off Consultant Job Planning - Aligned to Payroll
					
					

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile
Sickness Absence	5%	5.5%	Aug 2025	✗			
Return to Work	70%	66.1%	Jun 2025	✗			
Mandatory Training	90%	93.0%	Aug 2025	▲			
Appraisals	90%	87.3%	Aug 2025	✗			
Staff Turnover	10-12%	7.6%	Aug 2025	✗	-		
Vacancy Rate	-	3.7%	Aug 2025	-	-		
Bank/Agency Spend £k	-	£2,115k	Aug 2025	-	-		
Consultant Job Planning - Doctor Sign off	95%	89.0%	Aug 2025	✗	Not SPC	Not SPC	
Consultant Job Planning - Final Sign off	-	70.0%	Aug 2025	-	Not SPC	Not SPC	
Consultant Job Planning - Aligned to Payroll	-	68.0%	Aug 2025	-	Not SPC	Not SPC	Page 183 of 380

Data, Context and Explanation

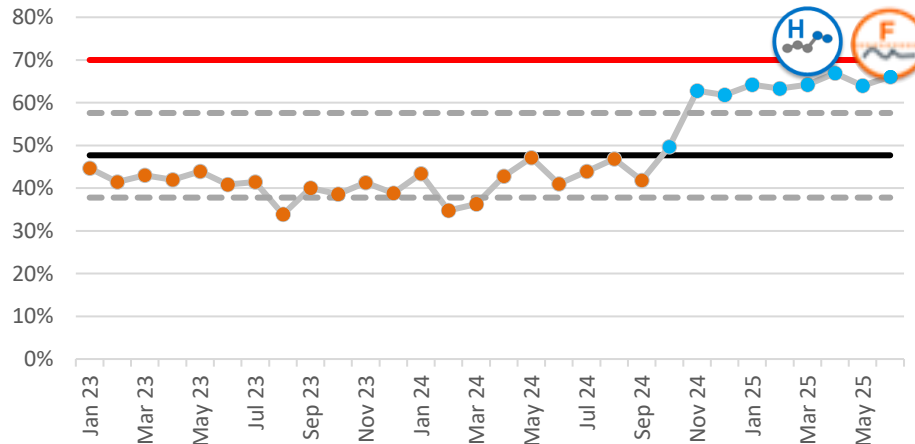
Sickness Absence



5.5% is the Trust sickness absence rate in month, of which 3.6% is long term and 1.9% is short term sickness absence.

The main reason for absence continues to be mental health related and this is reflected across the region.

Return to Work



Metric	Value	Target	Lead	Reporting Period
Sickness Absence	5.5%	5.0%	Steven Ned	Aug 2025
Return to Work Interviews	66.1%	70%	Steven Ned	Jun 2025

What Actions Are Planned & By When?

FlourishDX psychosocial risk assessment pilot areas action plans agreed. Health and wellbeing Strategy, easy read version and publicity poster approved and currently preparing to launch these. 6-monthly re-analysis of CBU high cost sickness areas for focus completed and update provided at Sept Improvement Programme Board. Supporting attendance task and finish group ToR to be approved at Sept People & Engagement Group. New procedure to tighten up medic's sickness reporting, recording and management co-created with ADO's in September and is currently being finalised for circulation. 2025 staff flu vaccination plan agreed and communications campaign has commenced. Augmented exec-led organisational plan to be developed to support operational Winter Plan. Joint Senior Leaders meeting in Sept to share learning and insights to address high priority challenges, including sickness, attendance and wellbeing. Following successful award of NHS Charities Together bid for MSK workforce wellbeing fund, steps will be taken to enhance Occ Health Team's musculoskeletal (MSK) specialist resource and service.
By October 2025

Expected Impact?

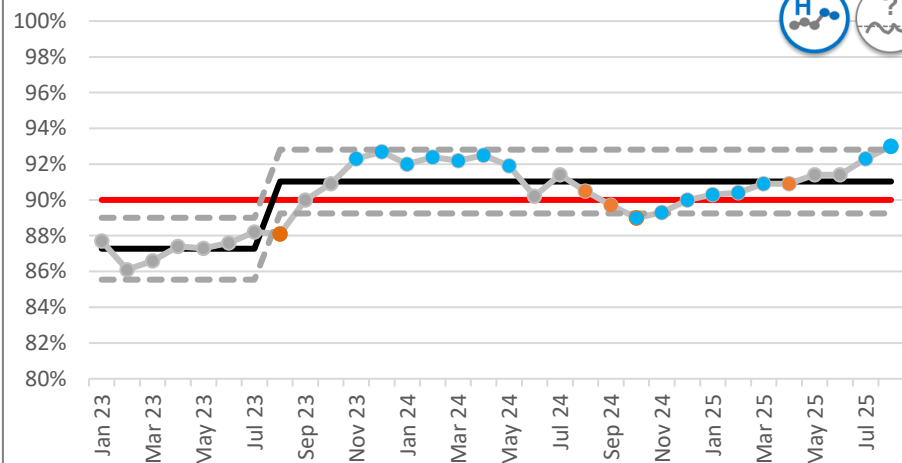
Increased awareness and application of sickness absence prevention, risk assessment, promotion and targeted support offer to enable colleagues to attend and stay well at work.

Challenges/Risks

- Long term sickness will increase without continued focus.
- Attention also needs to shift to short term sickness.
- HR and line manager capacity to give dedicated focus to sickness absence management at pace

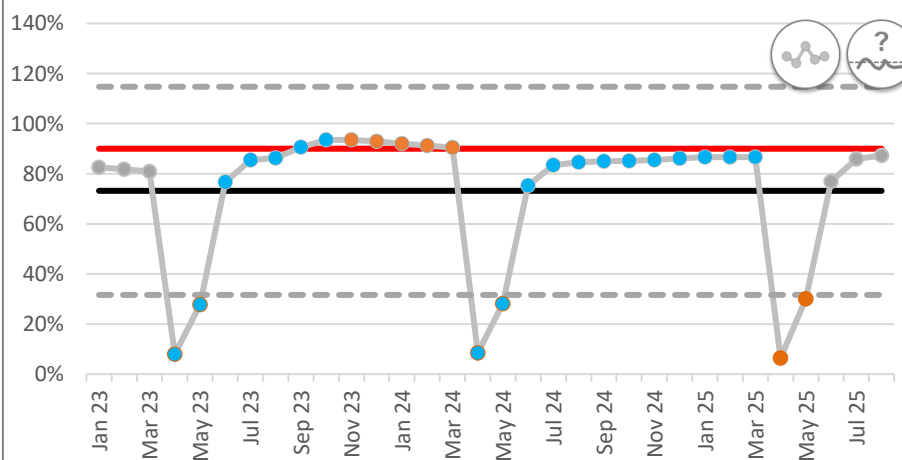
Data, Context and Explanation

Mandatory Training



Mandatory training has increased slightly to 93% and continues to exceed target throughout 2025 to date.

Appraisals



Current Appraisals reported rate of 87.3% exceeds the rate achieved last year of 86.6%. Rate is expected to increase as data input continues.

Metric	Value	Target	Lead	Reporting Period
Mandatory Training	93.0%	90%	Steven Ned	Aug 2025
Appraisals	87.3%	90%	Steven Ned	Aug 2025

What Actions Are Planned & By When?

- Deployment of training admin RPA products, involving automating class registration, annual class scheduling, outstanding training monthly reminders and bulk enrolments. Progress update of the review of relevance, role requirement accuracy and active monitoring of all section 2 essential training subjects at the Mandatory Learning Oversight Group meeting. Weekly appraisals and training compliance monitoring reports continue.
- By when? October 2025

Expected Impact?

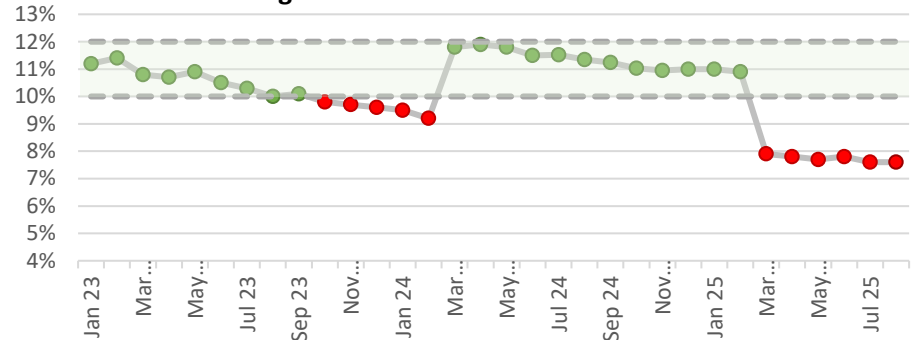
- Improved data quality and accuracy on ESR.
- Reduction in admin time for trainers, learners and admin team.
- Real-time training registration process and updating of learner records.
- Better learning experience for staff.
- Clearer real-time picture and potential increase in training compliance.
- Colleagues' quality appraisals experience.

Challenges/Risks

- Maintaining target.
- ESR data entry lag for timely recording and reporting of appraisal compliance.

Data, Context and Explanation

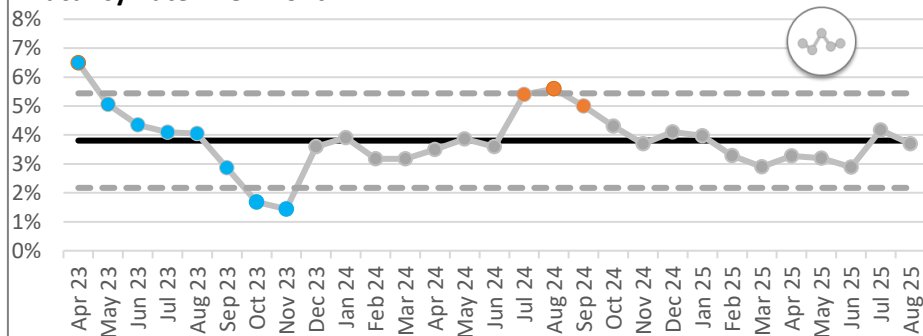
Staff Turnover - Rolling 12 months



Turnover remains fairly static at around 8%, having dropped from 11% at the start of 2025.

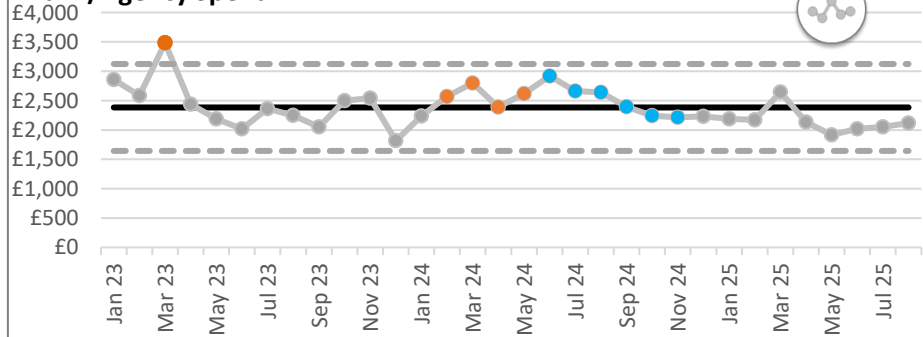
Vacancy rate is 3.17% which is a decrease of 0.47% compared to last month when it was at 4.17%.

Vacancy Rate - Per month



In the last 12 months there has been a 30% reduction in weekly medical agency spend due to substantiating a number of roles, particularly at Resident Grade in CBU1. Nursing and Midwifery Bi annual establishment reviews with any recommendations presented to the Executive team for agreement of investment, resulting in investment over the past 2 years which has reduced agency spend. E roster check and confirm sessions scheduled for all CBUs and corporate services have brought more scrutiny to rota production, approval and improved KPIs.

Bank/Agency Spend £k



Metric	Value	Target	Lead	Reporting Period
Staff Turnover – Rolling 12 months	7.6%	10-12%	Steven Ned	Aug 2025
Vacancy Rate – per month	3.7%	-	Steven Ned	Aug 2025
Bank Agency Spend £k	£2,115k	-	Steven Ned	Aug 2025

What Actions Are Planned & By When?

- Completion of testing and deployment of the recruitment vacancy to advert RPA App and dashboard.
- Completion of Time to Hire dashboard to be presented at PEG.
- Work is ongoing to provide better management information on medical bank and extra-contractual spend.
- The PMO have begun the first phase of rolling out the LMS electronic booking system initially to Consultants.
- Continued monthly reporting of nursing, midwifery, AHPs, pharmacy and medical agency and bank spend to the executive team highlighting any areas to address for further reductions to be made.

By October 2025

Expected Impact?

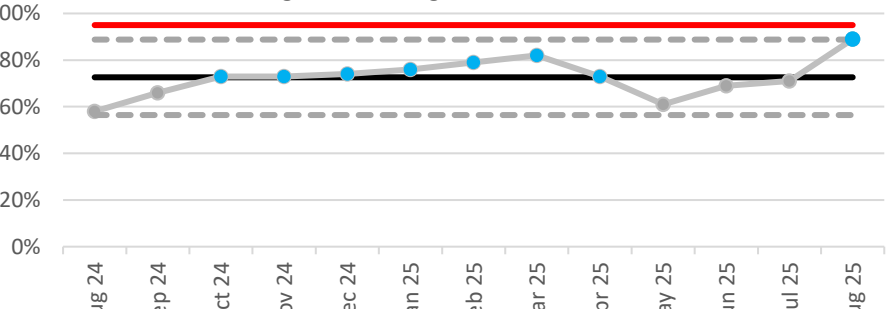
- Higher quality, efficient recruitment process requiring less manual intervention, leading to improved Time to Hire.
- Better understanding of bank and extra-contractual spend to inform spend reduction strategies.

Challenges/Risks

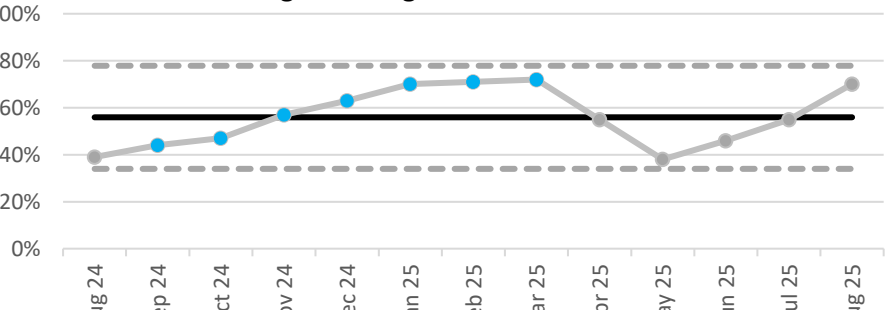
- Low staff turnover in current climate.
- Operational pressures and service disruptions including potential for further industrial action may put at risk controls to reduce bank and agency spend

Data, Context and Explanation

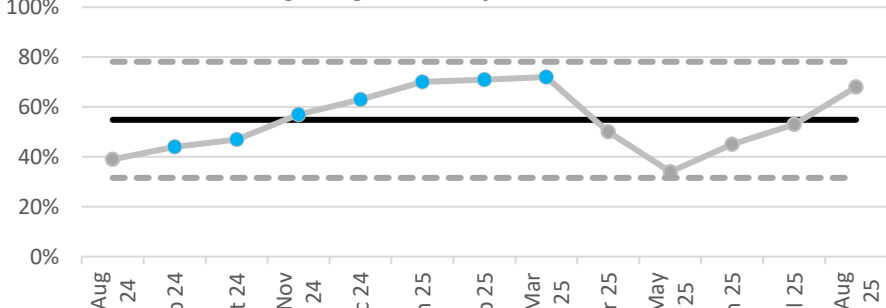
Consultant Job Planning - Doctor Sign off



Consultant Job Planning - Final Sign off



Consultant Job Planning - Aligned to Payroll



What the chart tells us

89% describes the Trust level performance and shows the number of Consultants who have signed off their job plan in the last 12 months.

Performance at CBU level is as follows:

CBU1 = 89%

CBU2 = 88%

CBU3 = 89%

Corporate = 100%

Final Sign off = 70%

Aligned to payroll = 68%

Metric	Value	Target	Lead	Reporting Period
Consultant Job Planning - Doctor Sign off	89.0%	95%	Simon Enright Lorraine Burnett	Aug 2025
Consultant Job Planning - Final Sign off	70.0%	-	Simon Enright Lorraine Burnett	Aug 2025
Consultant Job Planning - Aligned to Payroll	68.0%	-	Simon Enright Lorraine Burnett	Aug 2025

What Actions Are Planned & By When?

We have developed an action plan to improve performance and quality, based on a 360 assurance audit. We continue working through actions set out by the audit.

Expected Impact?

There has been an 18% improvement month on month in clinician sign off. Final sign off has increased by 15%. We remain below the 95% NHSe target, but are on trajectory to achieve before the end of March 2026.

Challenges/Risks

Best for Performance

We will meet our performance target and continuously strive to deliver sustainable services:

- We will deliver our Covid-19 recovery plan.
- We will meet our locally agreed performance targets.
- We will work with individual specialties to deliver the best performance, developing each service using best practice examples.
- We will focus on maximising our productivity and increasing the financial sustainability of our services to meet demand.
- We will closely monitor the performance of new models of care.
- We will use effective planning, operational and administrative processes that enable patients to easily access services and deliver the best performance.
- We will deliver our financial plan and eradicate our financial deficit.



Executive Lead: Lorraine Burnett, Chief Operating Officer

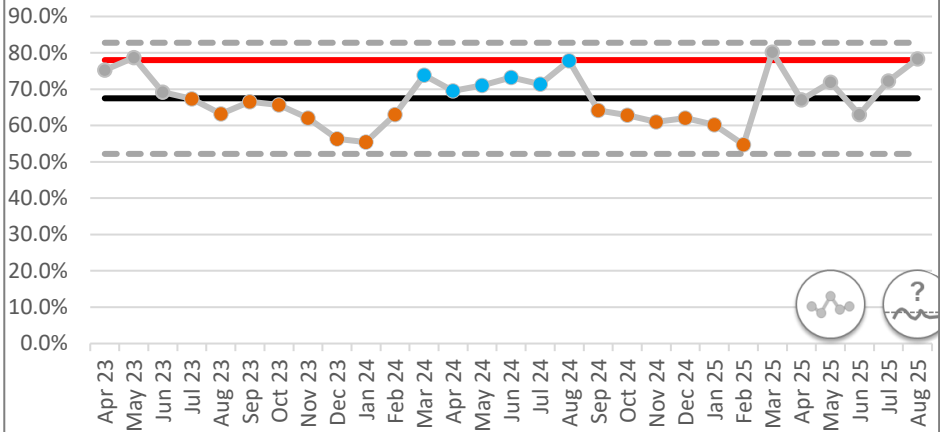
We are committed to meeting our performance targets and will continuously strive to deliver sustainable services. We will do this through a renewed and constant focus on productivity and efficiency so that our organisation provides value for money and has the required resources, equipment and infrastructure to support the highest standard of quality care for our patients.

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Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile
% Patients waiting <=4 Hours in Emergency Department	78%	78.3%	Aug 2025				
Total Number of Ambulance Handovers	-	1992	Aug 2025	-	-		
% Ambulance Handovers less than 15 mins	95%	58.5%	Aug 2025				
% Ambulance Handovers 15 - 45 mins	-	37.7%	Aug 2025	-	-		
% Ambulance Handovers over 45 Mins	0%	2.5%	Aug 2025				
No Ambulance Handover Time recorded	-	1.3%	Aug 2025	-	-		
RTT Incomplete Performance	80%	68.8%	Jul 2025				
RTT Total	21000	25973	Jul 2025				
RTT 52 Weeks Breaches	0	166	Jul 2025				
DM01 % Diagnostic patients waiting more than 6 Weeks	5%	8.1%	Aug 2025				
DNA Rates – All Appointments	5.9%	5.5%	Aug 2025				
DNA Rates– New Appointments	5.9%	6.8%	Aug 2025				
DNA Rates – Follow Up Appointments	5.9%	5.0%	Aug 2025				
28 Day - Faster Diagnosis Standard	80%	83.1%	Jul 2025				
31 Day - Treatment Standard	96%	88.9%	Jul 2025				
62 Day - Treatment Standard	75%	71.5%	Jul 2025				
Average LOS Elective - Spell	3.5	2.5	Aug 2025				
Average LOS Non-Elective - Spell	3.5	3.5	Aug 2025				
General and Acute Bed Occupancy	94%	92.4%	Aug 2025				
Capped Theatre Utilisation %	85%	79.3%	Jul 2025				
% Cancelled Operations	0.9%	1.9%	Aug 2025				

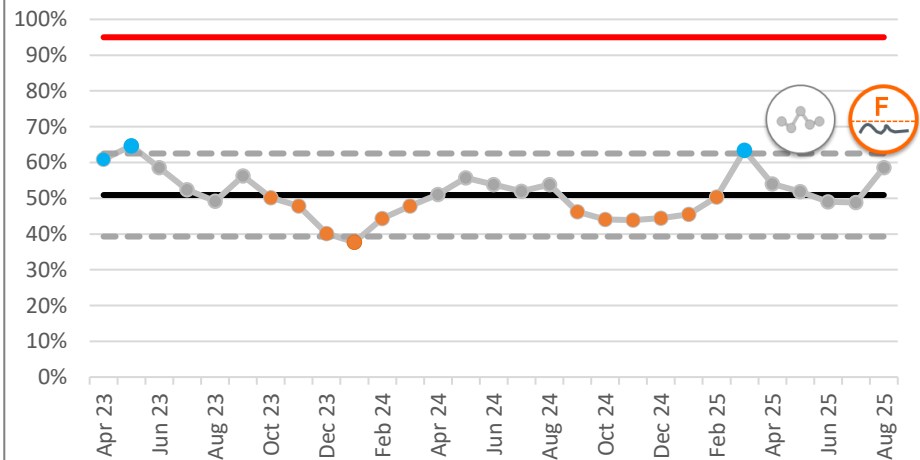
Data, Context and Explanation

% Patients waiting <=4 Hours in Emergency Department



4 hour performance is at 78.3% against an England performance of 62.0%.

% Ambulance Handovers Less than 15 mins



58.5% of ambulance handovers took less than 15 mins.

Metric	Value	Target	Lead	Reporting Period
% Patients waiting <=4 Hours in Emergency Department	78.3%	78%	Lorraine Burnett	Aug 2025
% Ambulance Handovers < 15 mins	58.5%	95%	Lorraine Burnett	Aug 2025

What Actions Are Planned & By When?

- Continued daily oversight via bed meetings and morning escalation calls.
- Service Manager presence in ED to support clinical teams and unblock challenges.
- Ongoing focus on independent ED streams – LAM, GP and Paediatrics – with resource allocation, recognising medical recruitment delays.
- Recruitment to outstanding roles from the ED Medical Staffing business case
- Ongoing demand management work with internal and external partners (e.g. treat and discharge, cardiology virtual ward).
- Implementation of Tele-tracking in September 2025 to deliver significant flow/bed benefits.
- Persistent scrutiny of performance with visible leadership presence in ED.
- Commence AMU/Medical SDEC review process – explore opportunities to increase throughput.
- Continue to progress the excellent work across medical wards re. Golden patients.
- A planned and focused piece of work re. evening/overnight breaches within the ED.
- Tele-tracking rollout: September 2025.

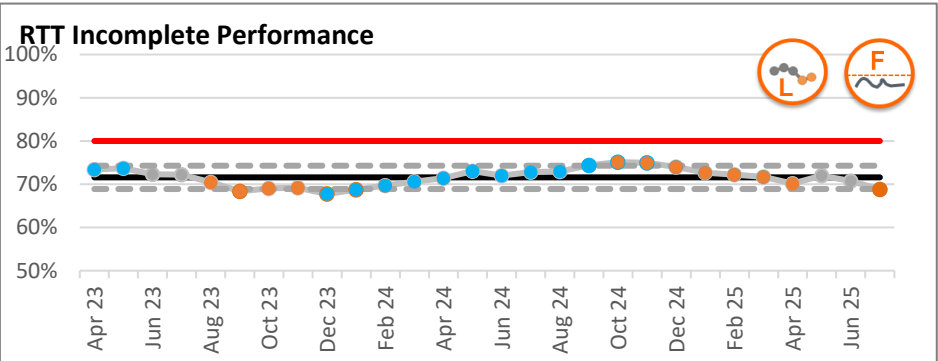
Expected Impact?

- Improved 4-hour performance, particularly in Paediatrics.
- Reduced length of stay and improved SDEC throughput.
- Reduced cubicle blocking in ED, supporting timelier ambulance handovers.

Challenges/Risks

- Delays in recruitment to remaining ED roles.
- Rising GP referrals to ED.
- Attendances consistently above plan (April–July).
- Nurse staffing consultation – may exacerbate pressures.
- Infection control cleans reducing bed availability.
- Mental health attendances and admissions, impacting CDU and ED flow.

Data, Context and Explanation



RTT 68.8% performance

England performance same period 60.4%

There were 166 patients waiting 52 weeks of which two patients were above 65 weeks.

Clinical Business Units are working to speciality specific recovery to achieve a Trust wide 80% achievement at year end in line with operational planning expectations.

SPEC DH DESC REFERRAL	RTT %	< 18	18-26	27-51	52-64	65-77	Total
AUDIOLOGY	89.82%	150	17				167
BREAST SURGERY	99.53%	210	1				211
CARDIOLOGY	70.59%	953	289	108			1350
CLINICAL HAEMATOLOGY	58.55%	356	151	101			608
COLORECTAL SURGERY	90.32%	401	29	14			444
DERMATOLOGY	59.44%	1310	406	488			2204
DIABETIC MEDICINE	100.00%	29					29
DIRECT ACCESS GASTROENTEROLOGY	100.00%	1					1
ENDOCRINOLOGY	81.61%	324	50	23			397
ENDOSCOPY	100.00%	17					17
ENT	77.98%	1813	457	54	1		2325
GASTROENTEROLOGY	76.88%	1054	179	138			1371
GENERAL MEDICINE	85.71%	12	1	1			14
GENERAL SURGERY	66.35%	773	175	212	5		1165
GERIATRIC MEDICINE	94.63%	194	10	1			205
GYNAECOLOGY	58.22%	1789	558	712	13	1	3073
HEPATOLOGY	78.50%	241	50	16			307
MAXILLO-FACIAL SURGERY	57.63%	812	256	329	12		1409
OPHTHALMOLOGY	86.39%	2189	263	82			2534
ORAL SURGERY	25.37%	85	105	122	23		335
ORTHODONTICS	78.49%	73	19	1			93
PAEDIATRIC CARDIOLOGY	83.33%	20	3	1			24
PAEDIATRIC DERMATOLOGY	98.44%	126	2				128
PAEDIATRIC EAR NOSE AND THROAT	77.56%	401	93	22	1		517
PAEDIATRIC EPILEPSY	100.00%	3					3
PAEDIATRIC OPTHALMOLOGY	84.98%	249	31	12	1		293
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	84.87%	101	9	8	1		119
PAEDIATRICS	87.45%	655	88	6			749
RESPIRATORY MEDICINE (THORACIC MEDICINE)	89.45%	492	48	10			550
RHEUMATOLOGY	93.67%	444	29	1			474
STROKE MEDICINE	100.00%	4					4
TRAUMA & ORTHOPAEDICS	51.00%	1659	592	932	69	1	3253
UROLOGY	57.97%	916	280	354	30		1580

Metric	Value	Target	Lead	Reporting Period
RTT Incomplete Performance	68.8%	80%	Louise Deakin	Jul 2025
RTT Total Waiting List Size	25973	21000	Louise Deakin	Jul 2025
RTT 52 Week Breaches	166	0	Louise Deakin	Jul 2025

What Actions Are Planned & By When?

- Gastroenterology:** Recovery plan in place; on track to return to constitutional standard by February 2026.
- Endocrine:** Pathway changes underway to complete diagnostics pre-1st OP appointment, reducing follow-ups. Supported by new admin/validation team implementing partial booking to cut DNAs. Additional sessions being planned to address longest follow-up waits.
- Respiratory:** Fortnightly recovery meetings reinstated. Validation underway for >18-week patients. Service impacted by long-term consultant sickness – locum support approved to protect planned activity.
- Clinical Haematology:** Locum consultant support approved to focus on RTT recovery. Supports partnership with TRFT. Specialty Doctor interviews scheduled 21st August 2025 were successful – two candidates offer roles.
- Cardiology:** Recovery trajectory aiming for 92% by December 2025. Additional locum capacity being sought and is pivotal to that timescale. New Specialty Doctor commenced in August delivering an extra 2.5 clinics per week. Reviewing test bundles to reduce follow-ups.
- Dermatology:** insourcing capacity is being sought to support long wait patients requiring treatment – whilst this will not recover the RTT position to 92%, it is anticipated to have a material impact on the waiting list (approx 175 patients).
- Oral Surgery:** insource capacity is being sought to support long wait patients requiring treatment
- Trauma & Orthopaedics:** New Lower Limb Arthroplasty Consultant commenced in post 4th August, increase in elective and outpatient capacity

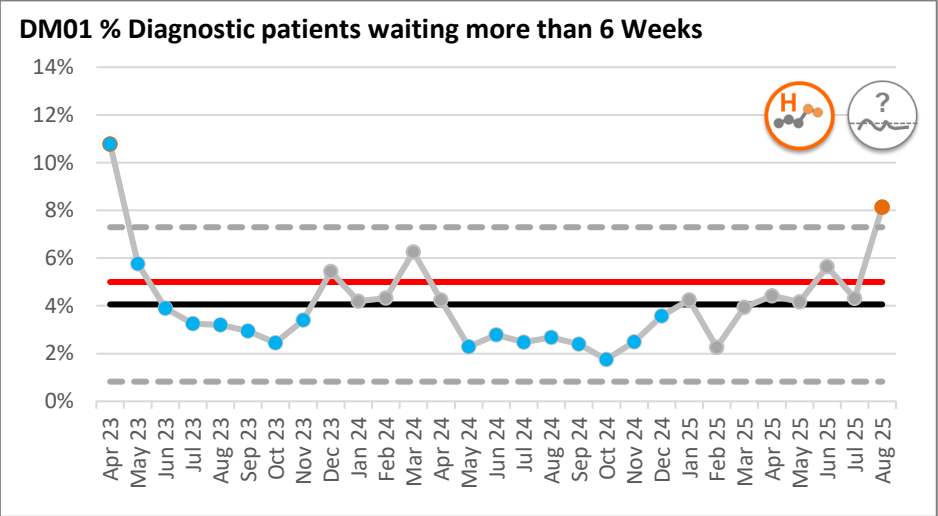
Expected Impact?

- Reduction in patient waiting list.
- Deliver against monthly activity plan.

Challenges/Risks

- Increase in 2 week wait/urgent referrals that displace routine activity.
- Risk of Industrial Action.
- Gaps in workforce due to sickness or vacancy.

Data, Context and Explanation



Cancer and Urgent referrals continue to be prioritised. Pressured specialities working to recover diagnostic position with additional sessions.

The main areas for the deteriorating position are Echocardiology, Endoscopy and Audiology. Sickness and vacancies in addition to annual leave in August have significantly impacted on capacity.

Patients waiting for Diagnostic	Total	>6 wks	%
Magnetic Resonance Imaging	393	0	0.0%
Computed Tomography	170	0	0.0%
Non-Obstetric Ultrasound	1818	17	0.9%
DEXA Scan	148	0	0.0%
Audiology – Audiology Assessments	243	84	34.6%
Cardiology – Echocardiography	477	121	25.4%
Urodynamics – Pressures & Flows	5	4	80.0%
Colonoscopy	287	30	10.5%
Flexi Sigmoidoscopy	51	5	9.8%
Cystoscopy	92	26	28.3%
Gastroscopy	297	37	12.5%
TOTAL	3981	324	8.1%

Metric	Value	Target	Lead	Reporting Period
DM01 % Diagnostic patients waiting more than 6 Weeks	8.1%	5%	Lorraine Burnett	Aug 2025

What Actions Are Planned & By When?

- ECHO:** Physiologist staffing challenges has impacted capacity within the service (national pressure). Recruitment of band 7 roles has been unsuccessful – focus will be to recruit band 5 appreciate roles to train – longer term solution. In the interim additional sessions from existing staff is being provided as well as exploring insourcing options to help clear the backlog – recover of the position is not expected until December 2025.
- Endoscopy:** The service has experienced some staffing challenges and sickness which has impacted the delivery of the service. The service will continue to provide additional capacity to reduce the wait times – current waits are up to 8 weeks.

Expected Impact?

Interim plans are expected to recover current performance while more longer term plans are worked up and put in place.

Challenges/Risks

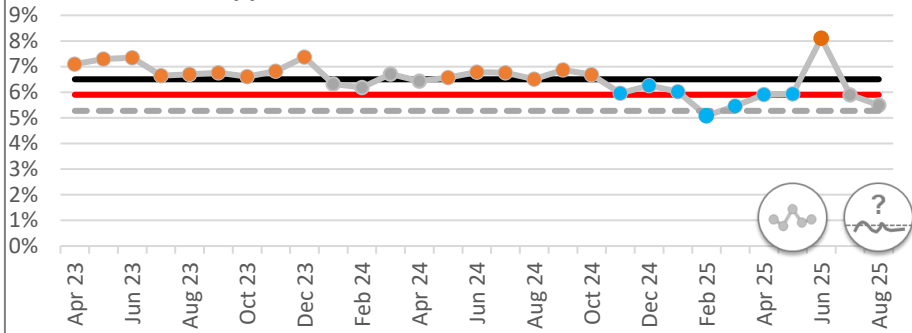
New soundproof booth and additional staffing resource required for Audiology.

Challenges in relation to Urology support from Mid Yorkshire impacting Cystoscopy performance.

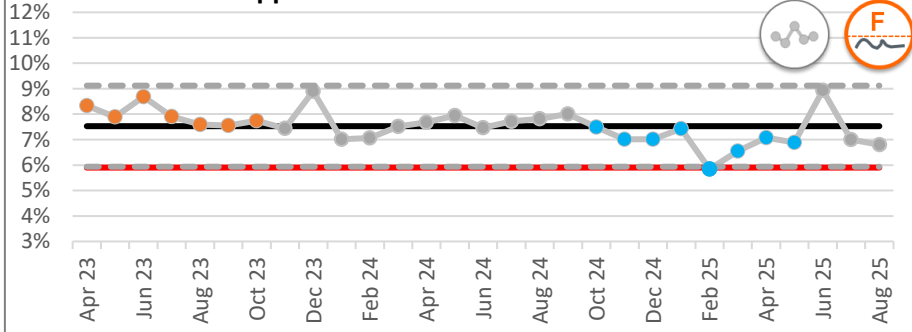
Staff have declined additional WLI clinics. Challenges with staffing resource

Data, Context and Explanation

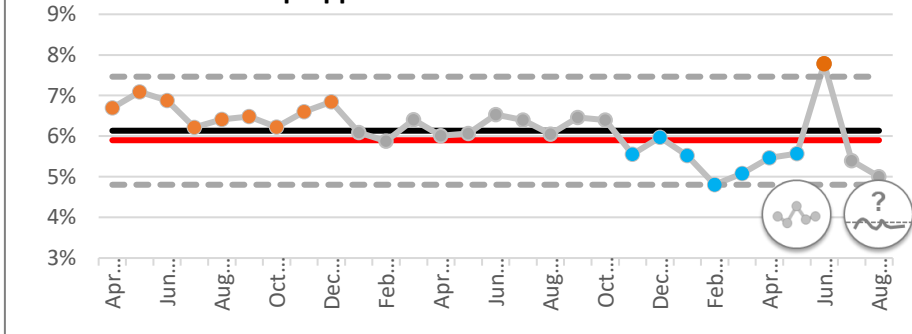
DNA Rates - All Appointments



DNA Rates - New Appointments



DNA Rates - Follow Up Appointments



DNA rates show a pattern of improvement, with a reduction in the average over the last seven months.

Missed appointments contribute to longer waiting times, inefficient use of clinical resources, and delays in care.

DNAs are often linked to health inequalities, such as socioeconomic barriers, language issues, or lack of transport.

DNA Rates for New patients currently stand at 6.8% down from 7% last month, however still above expected rates.

DNA Rates for Follow Up patients currently stand at 5.0% and within expected rates.

Metric	Value	Target	Lead	Reporting Period
DNA Rates – All Appointments	5.5%	5.9%	Shaun Garside	Aug 2025
DNA Rates – New Appointments	6.8%	5.9%	Shaun Garside	Aug 2025
DNA Rates – Follow Up Appointments	5.0%	5.9%	Shaun Garside	Aug 2025

What Actions Are Planned & By When?

- Text validation and two way texting to enable patients to change appointments.
- Regular reviews of Patient Tracking List (PTL) by all specialities
- Increase uptake of PIFU.

Expected Impact?

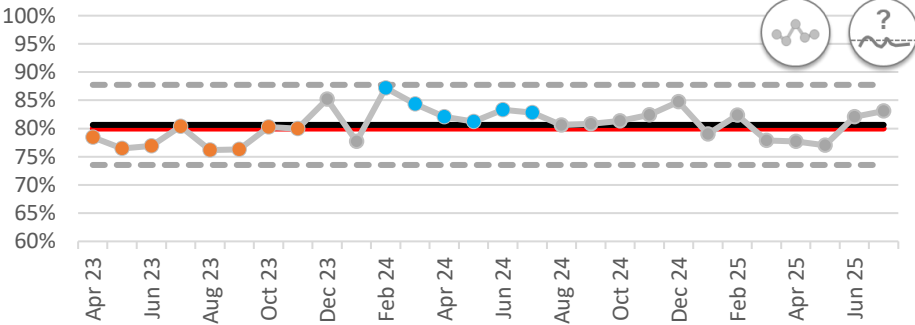
- Reduce in DNA's for 1st appointment.
- Improved clinic utilisation.
- Improved productivity metrics.
- Deliver activity levels as per plan.

Challenges/Risks

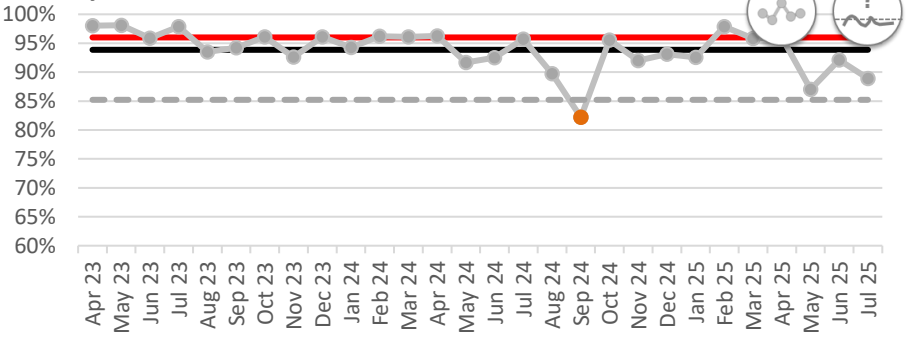
- Increased demand.
- Patient utilisation levels of digital solutions.
- No uptake for PIFU.

Data, Context and Explanation

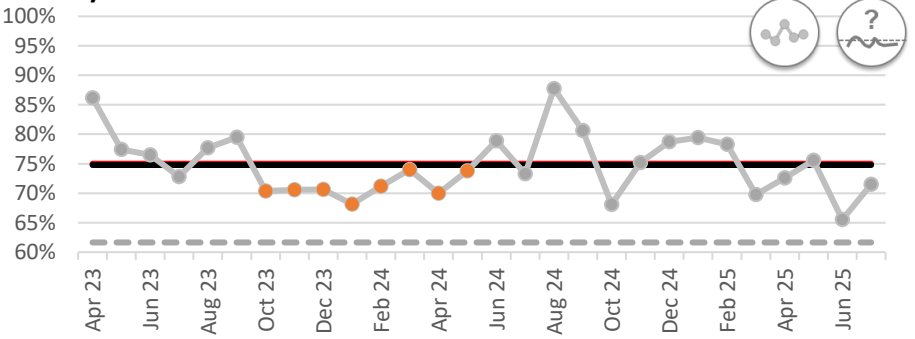
28 Day - Faster Diagnosis Standard



31 Day - Treatment Standard



62 Day - Treatment Standard



The 28-day Faster Diagnosis Standard (FDS) is for 80% of patients to receive a diagnosis or have cancer ruled out within 28 days of referral. The FDS applies to anyone with a suspected cancer, including those who have been previously treated.

The 31-day standard for cancer treatment aims to ensure that all cancer patients start treatment within 31 days of a decision to treat, with a target of 96%. The standard has not achieved the required standard for the last 3 months challenges at STH for Oncology and Surgical Treatment with local challenges with Urology and Colorectal capacity.

The 62-day referral to treatment standard for cancer patients is 75% by March 2026. This means that 75% of patients who have an urgent suspected cancer referral should start treatment within 62 days.

62 Day Standard continuing to perform well against peers. Ongoing oversight of specific specialities, specifically colorectal, urology, Gynae, lung.

Metric	Value	Target	Lead	Reporting Period
28 Day - Faster Diagnosis Standard	83.1%	80%	Lorraine Burnett	Jul 2025
31 Day - Treatment Standard	88.9%	96%	Lorraine Burnett	Jul 2025
62 Day - Treatment Standard	71.5%	75%	Lorraine Burnett	Jul 2025

What Actions Are Planned & By When?

- Escalation of patients @ 50 days without a plan
- Detailed and regular review of all long waiters and agree actions and support to resolve/address.
- Room being made safe for X-Ray to enable Urology patients to have Transurethral Laser Ablation (TULA)
- Additional Theatre sessions for Urology being explored

Expected Impact?

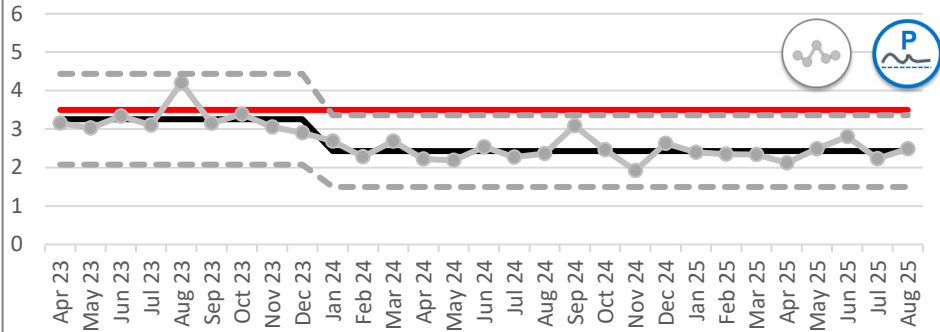
- Reduction in long waiters and sustainable delivery of 62 Day Standard.
- Reduced wait for diagnostic tests for Urology
- Reduced need for theatre

Challenges/Risks

- Workforce constraints.
- Capacity challenges in Urology.
- Training requirement for TULA
- Increase in Cancer referrals

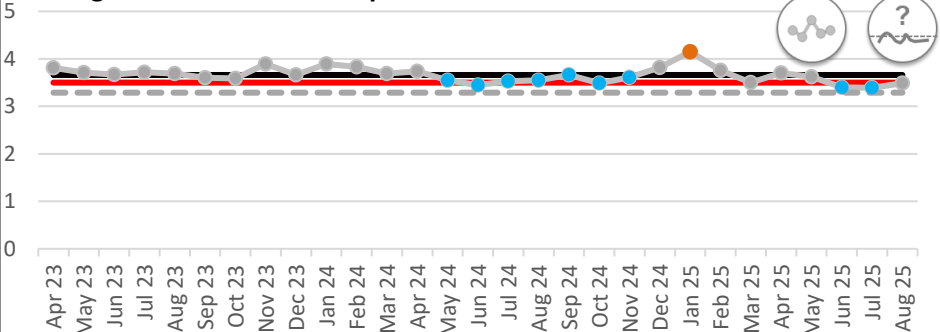
Data, Context and Explanation

Average LOS Elective - Spell



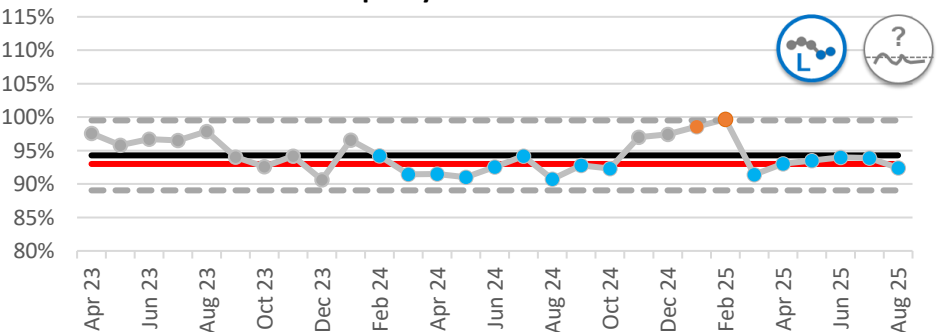
Consistent Elective LoS for the past 18 months, below the target of 3.5 days.

Average LOS Non-Elective - Spell



The trusts non elective hovers around the target, and has reduced to meet the target in August.

General and Acute Bed Occupancy



Bed occupancy, while still challenging has reduced back inline with previous levels following a busy winter period

Metric	Value	Target	Lead	Reporting Period
Average LOS Elective - Spell	2.5	3.5	Lorraine Burnett	Aug 2025
Average LOS Non-Elective - Spell	3.5	3.5	Lorraine Burnett	Aug 2025
General and Acute Bed Occupancy	92.4%	93%	Lorraine Burnett	Aug 2025

What Actions Are Planned & By When?

Implementation of TeleTracking patient flow solution by 30th September 2025.

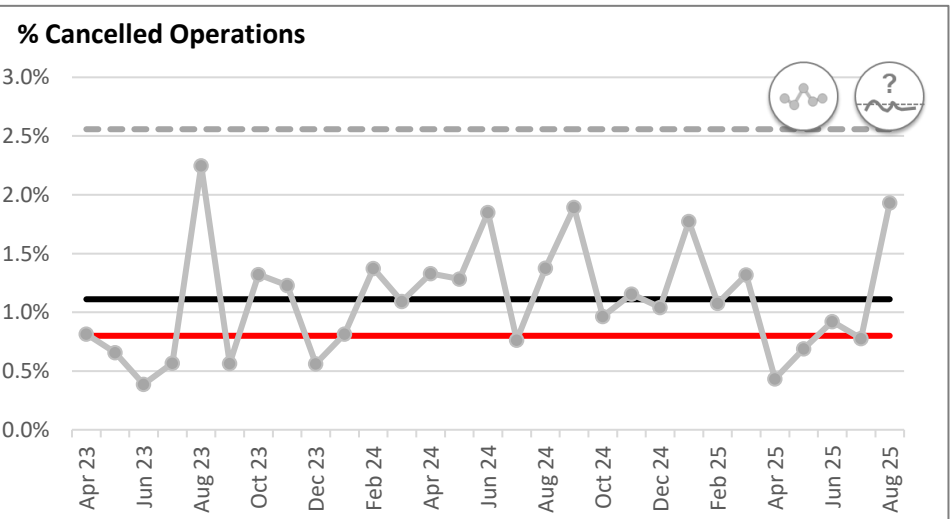
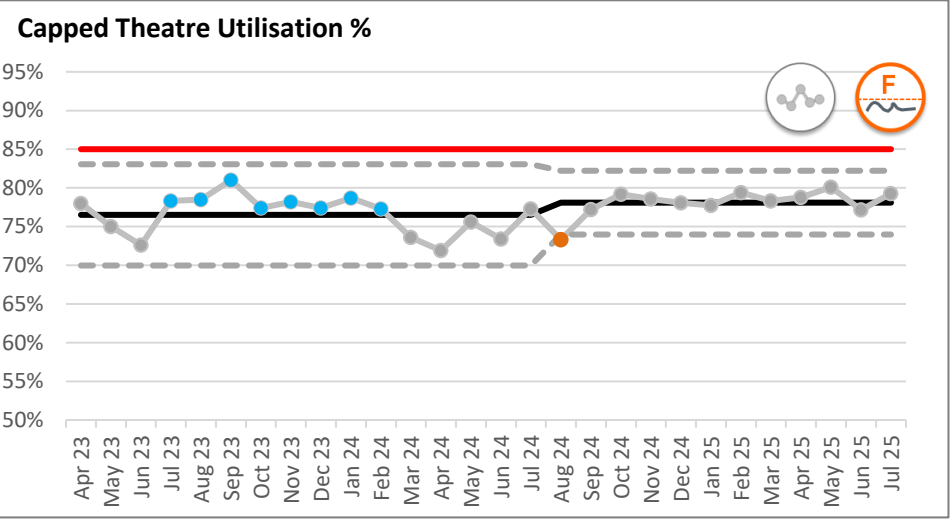
Expected Impact?

Improved processes for flow.
Reduction in time from discharge to next patient in bed.

Challenges/Risks

Tele tracking Project completion.
Staff engagement.
Non elective demand for beds.

Data, Context and Explanation



Focus remains on capped theatre utilisation and improvements in year have stayed consistent. Over 60% of specialities consistently benchmark well against model hospital peers and are consistently achieving >80%. Two specialities remain a challenge bringing the overall capped utilisation down (Ophthalmology/OMFS).

Metric	Value	Target	Lead	Reporting Period
Capped Theatre Utilisation %	79.3%	85%	Lorraine Burnett	Jul 2025
% Cancelled Operations	1.9%	0.8%	Lorraine Burnett	Aug 2025

What Actions Are Planned & By When?

Late start monitoring and escalating any areas of concern for appropriate management. Crib call sheet to contact patients three-day prior to op date to ensure patient intend to arrive and are fit and well to proceed which has demonstrated evidence of minimised cancellations. This commenced in 2024/2025 and is a continual process, improvement in escalation to Clinical Leads and Clinical Director is now the focus. Focussed work in Ophthalmology includes job plan alignment and arrival times and has seen a 20% increase (further work to be done). Productivity discussions are taking place in OMFS as work is ongoing to improve clinical engagement and leadership. Appointment of Oral Surgery Consultants, one commenced, the second requiring confirmation start date. M&M approach to on the day cancellations by specialities. Backfilling cancelled operations where possible. Staffing establishment review underway to align staffing requirements to demand needs. Paper for theatre 9 staffing in development. Review potential options for Anaesthetist recruitment to include exploration of overseas recruitment.

Expected Impact?

Better alignment between job plans to theatre start times will demonstrate improvement. Currently the theatre start time isn't accounting for the pre-operative review and slit lamp assessment where cases per list have increased, therefore productivity gains already made but not reflective in capped data. Improved utilisation and increased cases per list in OMFS/Oral. Minimising reductions will ultimately improve capped utilisation and increase patient experience. [LF edited] Expect to see improved performance as a result of actions. Oral Surgery Consultant appointments expected in post Sep 2025.

Challenges/Risks

Clinical buy-in and engagement, staffing resource as often on the day cancellations occur as a result of theatre and/or anaesthetic staffing absence. Patients able to disclose and understand what it means to be fit and well during the cribs sheet call (narrative in script changed), patient adherence to pre-op instructions, staffing resource and sickness. Ability to recruit to Anaesthetic gaps

Executive Lead: Chris Thickett, Chief Finance Officer

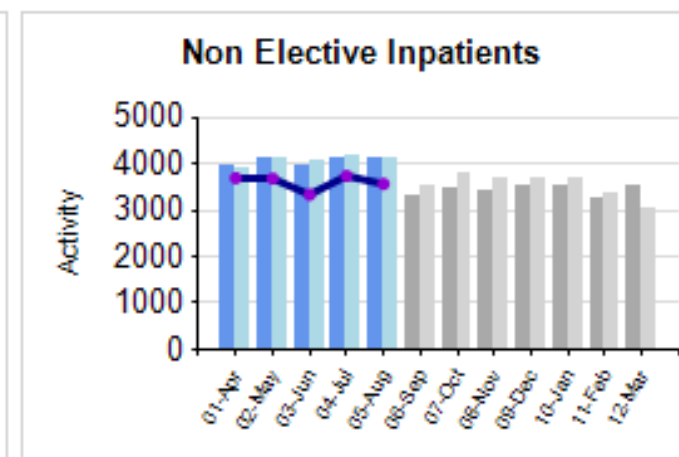
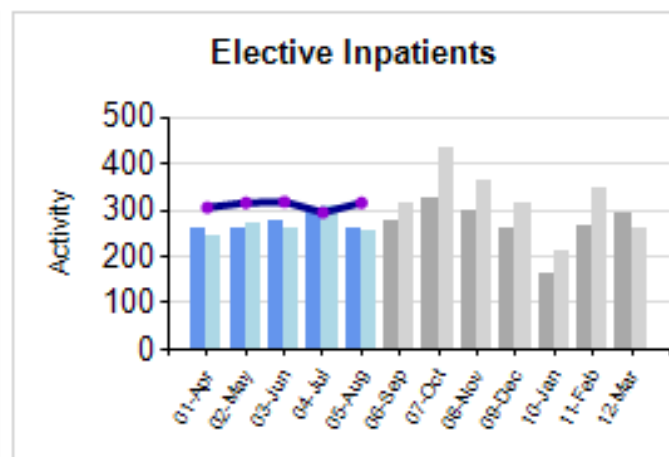
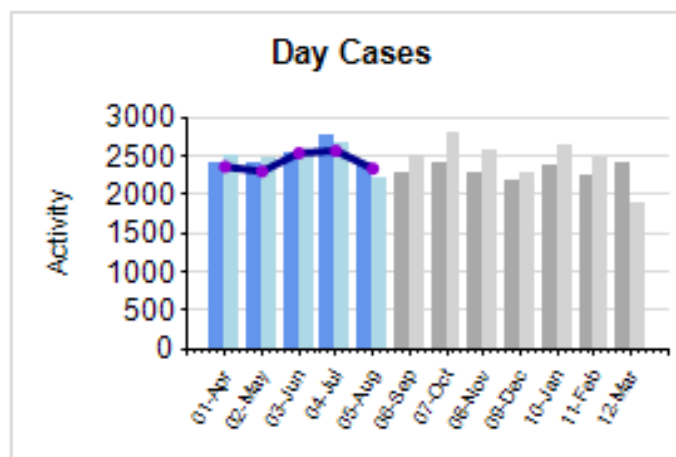
August 25 Summary

RAG Rating Summary Performance:

Finance	Planned Financial Position	As at Month 5 the Trust has a consolidated deficit of £64k against a planned deficit of £66k. NHS England (NHSE) adjusted performance after taking into account depreciation in respect of donated assets (£23k) and granted assets (£41k) is breakeven against an adjusted plan of breakeven. However, this is after releasing additional surge funding above the level originally planned.
	Planned Cash Position	Cash balances have increased in month by £0.119m and are £9.707m higher than planned, mainly due to capital program slippage and timing of creditor payments.
	Capital Plan	Capital expenditure for the year is £3.343m, which is £4.334m below plan.

2025/26 Year to Date Activity

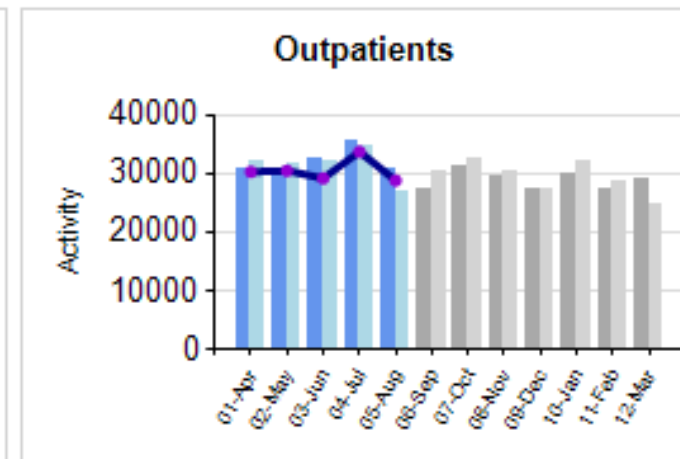
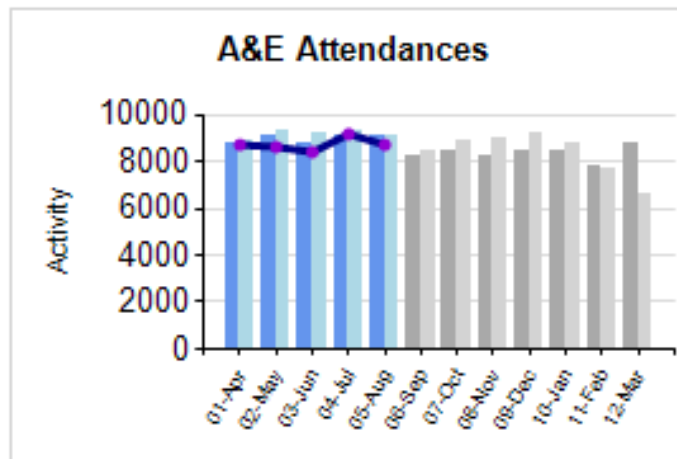
	19/20 Actuals	2025/26 Plan	2025/26 Actuals	Variance	%
Elective Daycases	12,114	12,511	12,337	(174)	-1%
Elective Inpatients	1,551	1,361	1,334	(27)	-2%
Elective Total	13,665	13,871	13,671	(200)	-1%
Non Elective	18,019	20,201	20,335	134	1%
Non Elective Total	18,019	20,201	20,335	134	1%



2025/26 Year to Date Activity

	19/20 Actuals	2025/26 Plan	2025/26 Actuals	Variance	%
A&E Att.	43,661	44,796	45,994	1,198	3%
A&E Total	43,661	44,796	45,994	1,198	3%

Outpatients	152,422	160,608	157,226	(3,382)	-2%
Outpatients Total	152,422	160,608	157,226	(3,382)	-2%



Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Commentary
ACTIVITY LEVELS (PROVISIONAL)									
Elective inpatients	262	256	(6)	-2.29%	1,361	1,334	(27)	-1.98%	The key points derived from this table are as follows: - As at Month 5 the Trust has a consolidated deficit of £64k against a planned deficit of £66k. NHS England (NHSE) adjusted performance after taking into account depreciation in respect of donated assets (£23k) and granted assets (£41k) is breakeven against an adjusted plan of breakeven. However, this is after releasing additional surge funding above the level originally planned. - In-month activity is 13.57% less than last month and 8.32% below plan for the month with non-elective inpatients and A&E favourable to plan. The acuity of patients presenting at ED and requiring admission continues to be high.
Day Cases	2,417	2,225	(192)	-7.94%	12,511	12,337	(174)	-1.39%	
Non-elective inpatients	4,095	4,112	17	0.42%	20,211	20,350	139	0.69%	
Outpatients New	6,522	5,498	(1,024)	-15.70%	33,915	31,781	(2,134)	-6.29%	
Outpatients Follow Up	16,832	15,203	(1,629)	-9.68%	87,529	87,282	(247)	-0.28%	
Outpatients Procedure	5,342	4,801	(541)	-10.13%	27,763	29,571	1,808	6.51%	
A&E	9,076	9,152	76	0.84%	44,796	45,994	1,198	2.67%	
Other (excludes direct access tests)	11,654	10,280	(1,374)	-11.79%	58,574	55,310	(3,264)	-5.57%	
Total activity	56,201	51,527	(4,674)	-8.32%	286,660	283,959	(2,701)	-0.94%	
INCOME									
	£'000	£'000	£'000		£'000	£'000	£'000		- Total income is £0.719m favourable to plan mainly due to overperformances on NHS clinical activity income, additional surge income recognised in the position. - Pay costs are £1.655m adverse to plan mainly due to a combination of pay efficiencies and a very challenged operational site including ED, which has seen additional costs incurred as a consequence of having winter capacity open earlier in the year and additional resources deployed in ED; and higher than expected sickness levels. - Non-pay costs are £0.778m favourable to plan mainly due to underspends linked to lower than planned activity levels and reduced outsourcing costs. - The forecast year-end NHSE adjusted financial position is break-even in-line with plan.
Elective inpatients	1,058	983	(75)	-7.09%	5,354	5,279	(75)	-1.40%	
Day Cases	2,252	1,834	(418)	-18.56%	11,340	10,426	(914)	-8.06%	
Outpatients	3,903	3,624	(279)	-7.15%	19,600	19,725	125	0.64%	
Non-elective inpatients	12,108	11,909	(199)	-1.64%	58,176	57,639	(537)	-0.92%	
A&E	2,164	2,199	35	1.62%	10,409	10,739	330	3.17%	
Other Clinical	6,602	6,331	(271)	-4.10%	31,985	34,390	2,405	7.52%	
Other	2,224	2,033	(191)	-8.59%	11,114	10,499	(615)	-5.53%	
Total income	30,311	28,913	(1,398)	-4.61%	147,978	148,697	719	0.49%	
OPERATING COSTS									
	£'000	£'000	£'000		£'000	£'000	£'000		
Pay	(22,114)	(21,030)	1,084	4.90%	(107,352)	(109,007)	(1,655)	-1.54%	
Drugs	(1,710)	(1,725)	(15)	-0.88%	(8,528)	(8,457)	71	0.83%	
Non-Pay	(5,616)	(5,350)	266	4.74%	(27,975)	(27,197)	778	2.78%	
Total Costs	(29,440)	(28,105)	1,335	4.53%	(143,855)	(144,661)	(806)	-0.56%	
EBITDA									
	871	808	(63)	-7.23%	4,123	4,036	(87)	-2.11%	
Depreciation	(741)	(673)	68	9.18%	(3,461)	(3,359)	102	2.95%	
Non Operating Items	(144)	(148)	(4)	-2.78%	(728)	(741)	(13)	-1.83%	
Surplus / (Deficit)	(14)	(13)	(1)	7.14%	(66)	(64)	2	2.54%	
NHSE adjusted financial performance									
	0	0	0		0	(0)	(0)		

Performance - Financial Overview

	Month	Month			Plan	Actual			
	Plan	Actual	Variance	Variance %	YTD	YTD	Variance	Variance %	Commentary
Capital Programme	£'000	£'000	£'000		£'000	£'000	£'000		
Capital Spend - internally funded	(1,405)	(1,539)	(134)	-9.54%	(6,360)	(3,339)	3,021	47.50%	The internally funded underspend is mainly on estates schemes. However, the slippage is expected to be recovered before year-end.
Capital Spend - externally funded	(632)	(5)	627	99.21%	(1,279)	(5)	1,274	99.61%	
Statement of Financial Position (SOFP)									
Inventory					1,852	1,962	110	5.94%	- Receivables are below plan due to collection of outstanding debts and a reduction in debtor accruals. - Payables are above plan due to timing of trade creditors payments and capital accruals. - Other Net Liabilities are below plan due to lower than expected income being treated as deferred income.
					12,507	10,887	(1,620)	-12.95%	
Receivables									
Payables (includes accruals)					(39,476)	(46,668)	(7,192)	-18.22%	
Other Net Liabilities					(3,840)	(2,941)	899	23.41%	
Cash & Loan Funding					£'000	£'000	£'000		
Cash					12,696	22,403	9,707	76.46%	Cash balances have increased in month by £0.119m and are £9.707m higher than planned, mainly due to capital program slippage and timing of creditor payments.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)					£'000	£'000	£'000		
Income					800	818	17	2.17%	YTD EPP savings lower than planned due to delays in developing the activity plans. The run rate for EPP savings is expected to increase over the coming months.
Pay					3,125	1,811	(1,314)	-42.06%	
Non-Pay					1,535	948	(587)	-38.23%	
Total EPP					5,460	3,576	(1,884)	-34.50%	
KPIs									
EBITDA %	2.87%	2.79%	-0.08%	2.75%	2.79%	2.71%	-0.07%	-2.58%	The BPPC requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Performance has deteriorated slightly from last month on value and volume; both remain below the 95% target.
Surplus / (Deficit) %	-0.05%	-0.04%	0.00%	2.65%	-0.04%	-0.04%	0.00%	3.01%	
Better Payment Practice Code (BPPC)									
Number of invoices paid within target					95.0%	94.3%	-0.67%	-0.71%	
Value of invoices paid within target					95.0%	91.7%	-3.32%	-3.50%	

Best for Place

We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health:

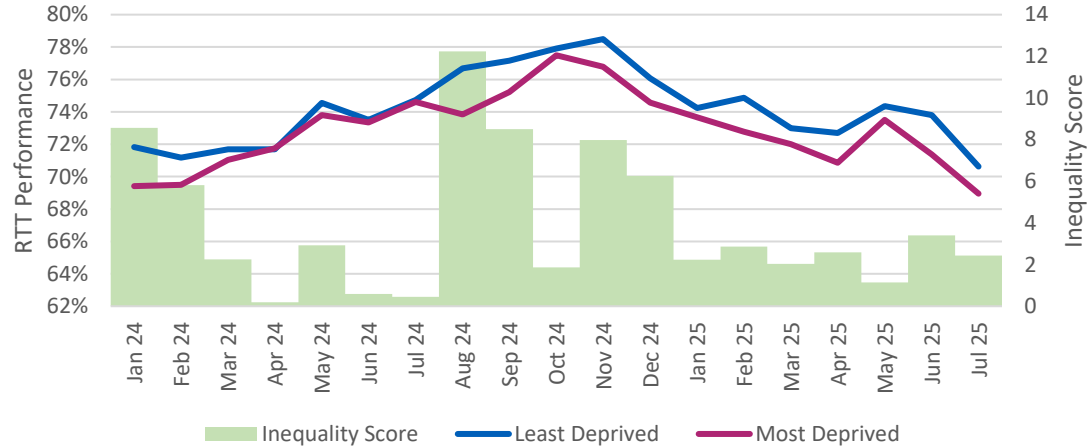
- We will continue to play a key role in the delivery of Barnsley Place priorities including emergency and planned care.
- We will act as an Anchor Institution to increase local employment and spend, reduce environmental impact and work as part of place to reduce health inequalities and improve population health.
- We will work with our partners in Barnsley to deliver the vision set out in the Barnsley 2030 plan to make Barnsley the home and place of possibilities.

As an organisation we believe that we can have major influence and impact at a local Place level in Barnsley. We intend to focus our efforts at Place to improve patient services, support a reduction in health inequalities and improve population health through building on existing relationships with our partner organisations in Barnsley health and social care and the third sector.



Explanation: The lines in the graphs tell us the performance of our most (IMD 1) and least deprived (IMD 7-10) across three indicators to highlight the inequalities which exist for our patients. The inequality score allows us to compare the relative difference between the two cohorts. We also look at statistical process controls to monitor the performance of these cohorts.

RTT Performance



	Latest Date	Value	Var.	LPL	Mean	UPL
Most Deprived	Jul-25	69%		69%	72%	76%
Least Deprived	Jul-25	71%		71%	74%	77%

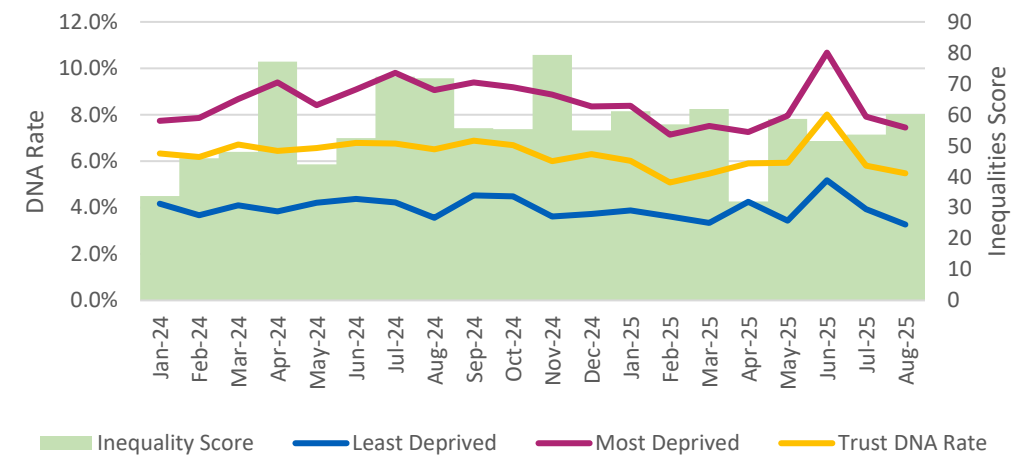
Summary

Those in the most deprived decile have a lower performance against the RTT incomplete standard – meaning they're waiting longer.
The performance of those in our least deprived cohort has triggered an alert, as the fall is outside the expected values.

Actions

- The WHaLES fair waiting initiative is to be expanded from the current pilot to a full trial of all CBU2 surgical waiting lists at the beginning of October.
- We would like to explore ways to integrate health inequalities risk into clinical triage and decision in key services, including emergency care and maternity. Improving data quality and collection is a key instrument in enabling this. We are engaging with the clinical systems to look at alerts, in addition to the patient safety team in how we collect this.

DNA Rates



	Latest Date	Value	Var.	LPL	Mean	UPL
Most Deprived	Aug-25	7.4%		6.8%	8.7%	10.6%
Least Deprived	Aug-25	3.3%		2.8%	4.2%	5.5%

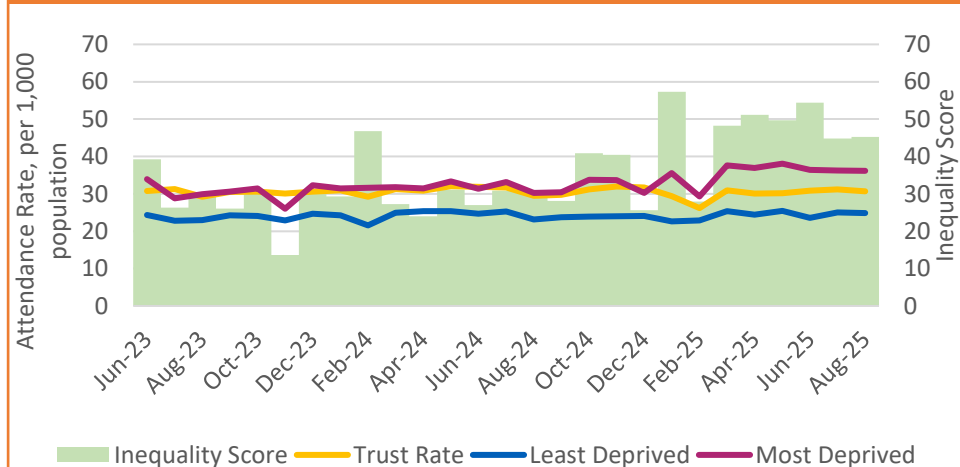
Summary

The most deprived patients are statistically significantly more likely to DNA their appointments, which means the difference is not just due to natural variation.

Actions

- We are working with the outpatients department to highlight how data regarding health inequalities can help services utilise their capacity and improve patient pathways.
- We are looking at the Health on High Street initiative and working on establishing a routine monitoring of the transition of Dermatology and Ophthalmology and Dermatology to their new town centre location.

ED Attendances – Barnsley Residents only



	Latest Date	Value	Var.	LPL	Mean	UPL
Most Deprived	Aug-25	36.1	↗	26.5	32.7	38.8
Least Deprived	Aug-25	24.8	↔	21.3	24.1	26.9

Summary

The attendance rate per 1,000 population has remained at a stable level overall.

Our most deprived patients are more likely to attend our Emergency Department even when adjusting for the population size. This has led to a trigger alerting us to a upward trend for these patients.

Actions

- We are assisting the Barnsley Office of Data Analytics (BODA) in pulling together the South Yorkshire Data Lake to improve analytical potential.
- We are overseeing work under the partnership to increase capacity to support high intensity users of emergency services in their communities.

Deep Dive into Most Deprived ED Attendances – August Data

Outlines

8,859 attendances to ED in August.
1,997 were from the most deprived areas.

- 1,713 patients (189 with 2 visits, 38 with 3+ visits)
- 27.8% were aged 60 and over, and 87.5% were White British.
 - 9.6% of attendances were streamed to Type 5
 - 8.6% were referred from 111, and 8.6% were referred by a GP.
 - 2.6% (53) of attendances were from non Barnsley residents.
 - 266 attendances recorded No abnormality recorded or patient walked out as the diagnosis. The other most frequently ascribed diagnoses were:
 - Sprain of ankle (disorder)
 - Lower respiratory tract infection (disorder)
 - Costal chondritis (disorder)
 - Sprain of knee (disorder)
 - Migraine (disorder)
 - Upper respiratory infection (disorder)
 - Lower urinary tract infectious disease (disorder)

Attendance Source



24.3% attended via an emergency ambulance.

Triage



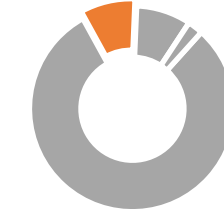
9.6% were categorised as a type 5 attendance.

Number of Visits



12% had more than one visit in the month

Referral



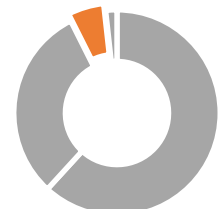
8.6% were referred from 111.

Comorbidities

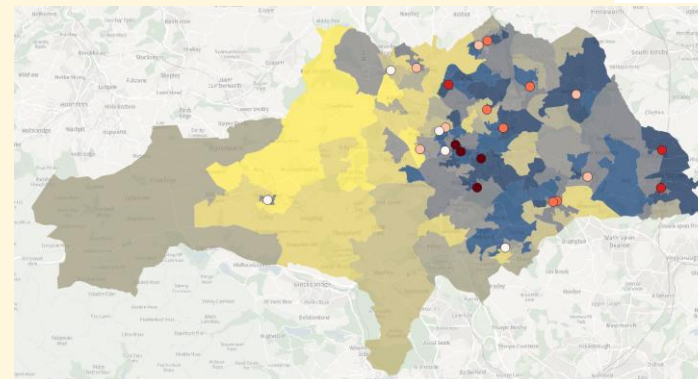


18.2% had 4 or more comorbidities

Outcome



5.7% left before treatment completed.



This map shows the most deprived areas of Barnsley in dark blue with our most affluent areas in yellow. This has been overlaid with the ED attendance rate by registered GP practice.

Darker red indicates a higher rate of ED attendances.

590 were from 5 GP practices

- BHF Lundwood Surgery
- Ashville Medical Centre PMS Practice
- The Kakoty Practice
- Burleigh Medical Centre
- The Dove Valley PMS Practice

How to read the icons in this report:

Have we achieved in month?

Are we consistently passing (P)/failing (F) or is it hit and miss?

Are we significantly **improving**/**deteriorating** or is there no significant change?

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile
DM01 % Diagnostic patients waiting more than 6 Weeks	5%	5.6%	Jun 2025	✗	?		
DNA Rates – All Appointments	5.9%	8.5%	Jun 2025	✗	?		
28 Day - Faster Diagnosis Standard	80%	77.1%	May 2025	✗	?		
31 Day - Treatment Standard	96%	87.9%	May 2025	✗	?		
62 Day - Treatment Standard	75%	75.4%	May 2025	▲	?		

How do we compare?

First bar – poorest performing quartile,

Last Bar – highest performing quartile

This month's performance

Month data relates to

APPENDIX : Statistical Process Control (SPC)

SPC is an analytical technique that plots data over time to help us understand variation and, in doing so, guide us to take the most appropriate action.

The main aim of SPC charts is to understand what is different and what is normal in order to determine where work needs to be concentrated to make a change.

An SPC chart plots **data over time** and allows us to detect if:

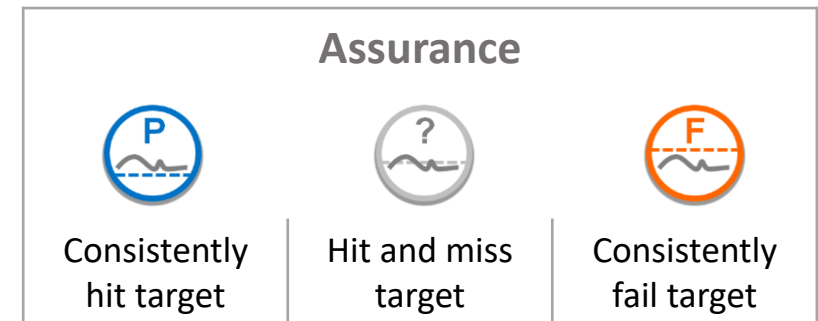
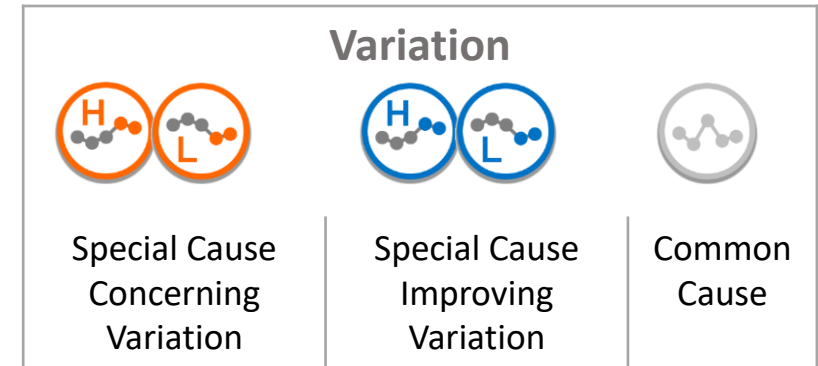
- The variation is **routine, expected and stable** within a range – we call this **common cause** variation, or
- The variation is **irregular, unexpected or unstable** – we call this **special cause** variation and it indicates an irregularity or that something significant has changed in the process.

Each chart shows a **PERFORMANCE** (Variation) icon to identify either common cause or special cause variation.

If special cause variation is detected the icon can also indicate if it is improving **blue** or deteriorating **orange**.

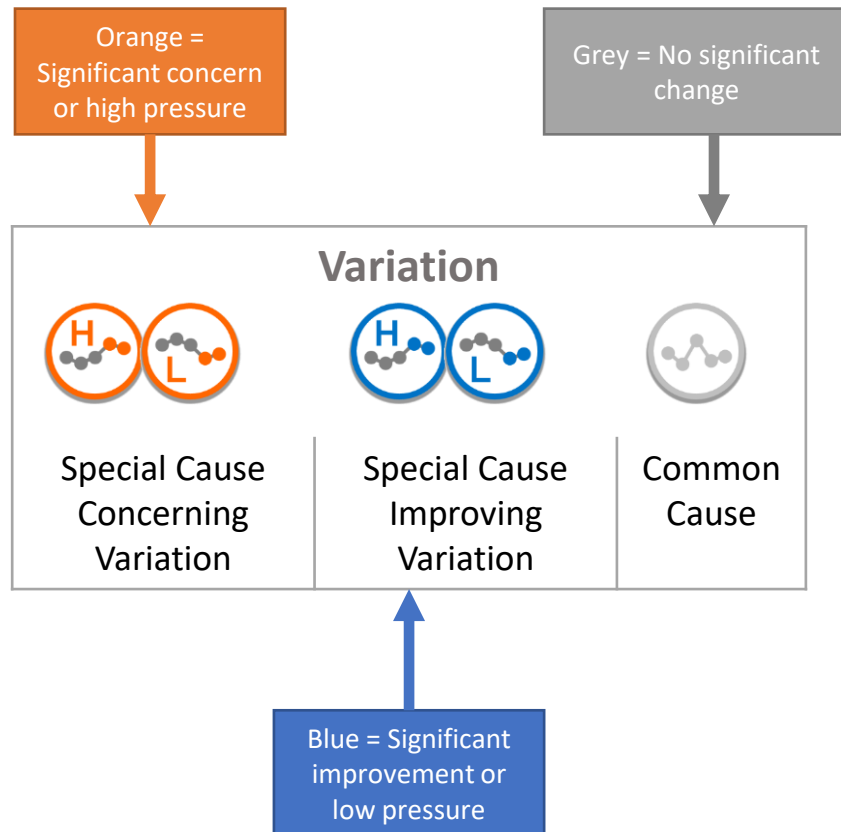
Where we have set a target, the chart also provides an **ASSURANCE** icon indicating:

- If we have consistently met that target – **blue**
- If we hit and miss randomly over time – **grey**
- If we consistently fail the target - **orange**



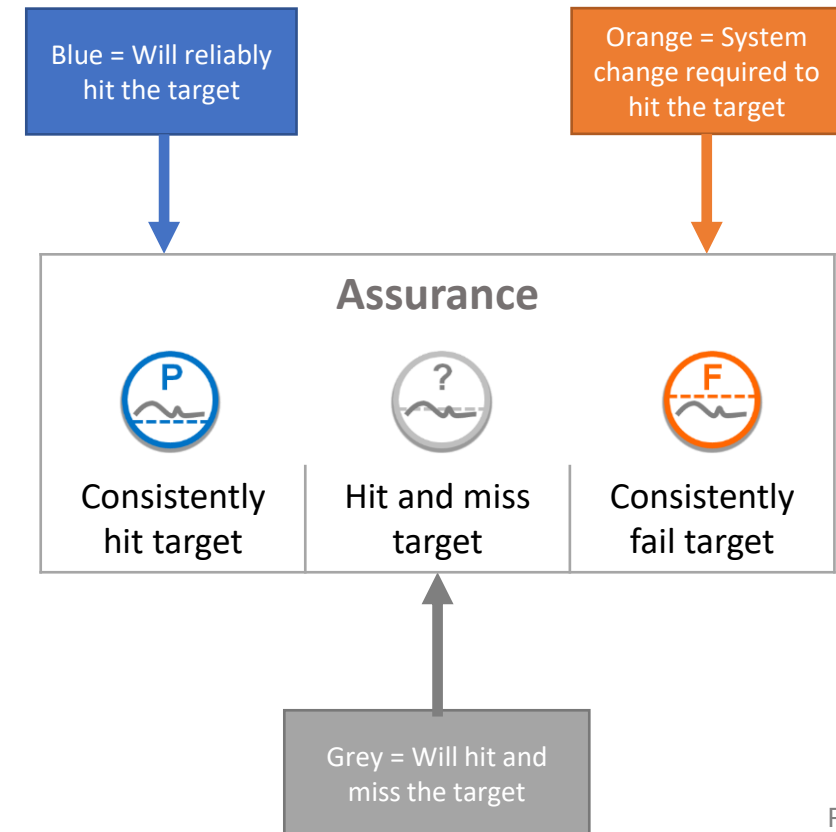
Performance

Are we heading in the right direction?



Assurance

Can we reliably hit the target?



	PASS 	HIT OR MISS 	FAIL 
	<u>VERY GOOD : CELEBRATE AND LEARN</u> - This metric is improving. - Your aim is high numbers, and you have some. - You are consistently achieving the target because the current range of performance is above the target.	<u>GOOD : CELEBRATE AND UNDERSTAND</u> - This metric is improving. - Your aim is high numbers, and you have some. - Your target lies within the process limits so we know that the target may or may not be achieved.	<u>CONCERNING : CELEBRATE BUT TAKE ACTION</u> - This metric is improving. - Your aim is high numbers, and you have some. - HOWEVER, your target lies above the current process limits so we know that the target will not be achieved without change.
	- This metric is improving. - Your aim is low numbers, and you have some. - You are consistently achieving the target because the current range of performance is below the target.	- This metric is improving. - Your aim is low numbers, and you have some. - Your target lies within the process limits so we know that the target may or may not be achieved.	- This metric is improving. - Your aim is low numbers, and you have some. - HOWEVER, your target lies below the current process limits so we know that the target will not be achieved without change.
	<u>GOOD : CELEBRATE AND UNDERSTAND</u> - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - HOWEVER, you are consistently achieving the target because the current range of performance exceeds the target.	<u>STATIC : INVESTIGATE AND UNDERSTAND</u> - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - Your target lies within the process limits so we know that the target may or may not be achieved.	<u>CONCERNING : INVESTIGATE AND TAKE ACTION</u> - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - HOWEVER, your target lies outside the current process limits and the target will not be achieved without change.
	<u>CONCERNING : INVESTIGATE AND UNDERSTAND</u> - This metric is deteriorating. - Your aim is low numbers, and you have some high numbers. - HOWEVER, you are consistently achieving the target because the current range of performance is below the target.	<u>CONCERNING : INVESTIGATE AND TAKE ACTION</u> - This metric is deteriorating. - Your aim is low numbers, and you have some high numbers. - Your target lies within the process limits so we know that the target may or may not be missed.	<u>VERY CONCERNING : INVESTIGATE AND TAKE ACTION</u> - This metric is deteriorating. - Your aim is low numbers, and you have some high numbers. - Your target lies below the current process limits so we know that the target will not be achieved without change.
	- This metric is deteriorating. - Your aim is high numbers, and you have some low numbers. - HOWEVER, you are consistently achieving the target because the current range of performance is above the target.	- This metric is deteriorating. - Your aim is high numbers, and you have some low numbers. - Your target lies within the process limits so we know that the target may or may not be missed.	- This metric is deteriorating. - Your aim is high numbers, and you have some low numbers. - Your target lies above the current process limits so we know that the target will not be achieved without change.

APPENDIX : SPC Summary Icons Key

	Icon	Technical Description	What does this mean?	What should we do?
Assurance Icons		The process will consistently HIT AND MISS the target as the target lies between process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within these limits then we know that the target will not be consistently achieved.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
		This process is not capable and will consistently FAIL to meet the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of these limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target.
		This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of these limits in the right direction then you know that the target can be consistently achieved.	Celebrate the achievement. Understand whether this is by design and consider if the target is still appropriate.
	Icon	Technical Description	What does this mean?	What should we do?
Variation Icons		Common cause variation, NO SIGNIFICANT CHANGE.	The system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable . If the process limits are far apart you may want to change something to reduce the variation in performance.
		Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	Something is going on! Your aim is to have LOW numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	Investigate to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
		Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	Something is going on! Your aim is to have HIGH numbers but you have some low numbers – something one-off, or a continued trend or shift of low numbers.	Investigate to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
		Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	Something good is happening! Your aim is to have HIGH numbers and you have some, either something one-off, or a continued trend or shift of high numbers.	Find out what is going on. Celebrate the improvement and share learning with other areas.
		Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	Something good is happening! Your aim is to have LOW numbers and you have some, either something one-off, or a continued trend or shift of low numbers.	Find out what is going on. Celebrate the improvement and share learning with other areas.

5.3. Annual Trust Self-Assessment for Education and Training: To follow after ET

For Discussion/Approval
Presented by Simon Enright

5.4. Annual Report of Workforce, Race and Equality Standard: Pauline Garnett in attendance

For Assurance/Approval

Presented by Steve Ned



REPORT TO THE BOARD OF DIRECTORS		REF:	BoD: 25/10/02/5.4	
SUBJECT:	WRES ANNUAL REPORT AND ACTION PLAN 2025			
DATE:	2 October 2025			
PURPOSE:		<i>Tick as applicable</i>		<i>Tick as applicable</i>
	<i>For decision/approval</i>	✓	<i>Assurance</i>	✓
	<i>For review</i>		<i>Governance</i>	✓
	<i>For information</i>	✓	<i>Strategy</i>	
PREPARED BY:	Pauline Garnett, Head of Equality, Diversity & Inclusion, Leeann Newsome, Inclusion & Wellbeing Admin Support Officer Roya Pourali, Equality, Diversity & Inclusion Lead			
SPONSORED BY:	Steven Ned, Director of People			
PRESENTED BY:	Steven Ned, Director of People			
STRATEGIC CONTEXT				
This report supports the strategic aims of the National People Plan and the Trust Strategic objectives and goals (2022-2027). Best for People We will make our Trust the best place to work by: - Ensuring a caring, supportive, fair and equitable culture for all - Creating an organisational climate that supports Equality, Diversity and Inclusion				
EXECUTIVE SUMMARY				
This report presents the findings of the 2024/25 WRES data and outline strategic actions to address identified disparities. Key Highlights: Indicator 1: Workforce representation: Overall BME workforce representation has increased from 13.7% to 15.2%, largely driven by international nurse recruitment. - Bands 2–4 and Band 6 has showed a positive movement, with Band 6 rising from 31 to 42 BME staff, supported by initiatives such as Stay and Thrive, Nursing Career Clinics, and Reciprocal Mentoring. - Medical and Dental trainee grades saw a significant increase in BME representation from 82 to 131. Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff: Access to non-mandatory training and CPD improved slightly, with a relative likelihood ratio of 0.99, indicating BME staff are marginally more likely than White staff to access development opportunities. Remain unchanged:				

Indicator 1: Workforce Representation - Consultant Representation: The number of BME consultants remains unchanged at **95**.

Indicator 3: Formal Capability - The number of BME staff entering formal disciplinary proceedings remains low and unchanged, with only **one** case reported.

Persistent Challenges:

- **Indicator 1: Workforce Representation** - Senior leadership representation remains limited, with **no** BME staff at Bands 8d and 9, and only **one** in Band 8c.
- **Indicator 2: Relative likelihood of White candidates being appointed from shortlisting compared to BME candidates** - Recruitment equity remains a concern, with a corrected likelihood ratio of **4.36** indicating White candidates are significantly more likely to be appointed from shortlisting.
- **Indicator 5: BME staff experiencing harassment, bullying, or abuse from patients, relatives, or the public** - Harassment from patients/public rose from **24.1% to 29.2%** for BME staff, while declining slightly for White staff.
- **Indicator 6: Harassment, bullying, or abuse from other staff**: Staff experience disparities have widened, with increased reports of harassment, bullying / abuse and discrimination among BME staff. An increase from **25.6% to 31.8%**
- **Indicator 7: BME staff believing the Trust provides equal opportunities for career progression** - Career progression perceptions declined among BME staff from **58% to 56.3%**, with a disparity gap of 12.49 percentage points compared to White staff.
- **Indicator 8: Discrimination from manager/team/ leader/colleagues** – Increased reports from **17.5% to 20.9%**. Decline for White staff from **5.2% to 4.3%**

Key Priorities:

Anti-Racist Framework

- Launch and embed the Anti-Racist Framework and achieve Bronze Accreditation by Spring 2026.
- Co-produce Anti-Racist commitment statement
- Create an anonymous reporting platform for racism concerns.
- Strengthen allyship campaigns and inclusive leadership behaviours.
- Facilitate listening and focus groups
- Adopt a Zero tolerance approach to Racism

Inclusive Recruitment

- Enhance inclusive recruitment practices through a dedicated Task and Finish Group and collaborate with the ICB Nurse inclusion progression work

The 2024/25 WRES findings highlight encouraging progress in workforce representation and access to development opportunities for BME staff, particularly within nursing and medical trainee grades. However, persistent disparities in senior leadership representation, career progression perceptions, and recruitment equity are pressing concerns. The rise in reported experiences of harassment and discrimination reflects both a challenge and an opportunity, showing increased confidence in reporting, but also the need for important sustained cultural change.

The strategic priorities outlined in this report, including the launch of the Anti-Racist Framework, strengthened inclusive recruitment, and listening mechanisms demonstrate the Trust's commitment to creating a fair, safe, and empowering environment for BME colleagues. These actions will

support the delivery of the Trust's strategic objectives and ensure that equity is embedded across all levels of the organisation

RECOMMENDATION(S)

The Board of Directors is requested to acknowledge the contents of this report for ratification, ahead of its submission to the NHSE Mandated Standards team. Upon approval, the report will be published on the Trust's website by 31 October 2025.



WORKFORCE RACE EQUALITY STANDARD



WRES Annual Report and Action Plan 2025

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Background

The Workforce Race Equality Standard (WRES) was introduced in April 2015 to ensure that NHS employees from Black and Minority Ethnic (BME) backgrounds have equitable access to career opportunities and experience fair treatment in the workplace. WRES is embedded within the contractual requirements of the NHS Standard Contract and the NHS Planning Guidance.

The Care Quality Commission (CQC) incorporates WRES into its inspection of the ‘well-led’ domain. The inspection framework has evolved to place greater emphasis on organisational progress in tackling workforce race inequality through robust implementation of WRES and broader promotion of diversity and inclusion.

The term Black and Minority Ethnic (BME) continues to be used by the WRES Team, consistent with its usage since the standard’s inception. Race terminology remains under review nationally, and further guidance is being awaited on any recommended changes.

WRES is not solely a compliance exercise, it is a strategic challenge that requires NHS organisations to move beyond regulatory behaviour and demonstrate authentic cultural transformation. Board-level leadership and commitment are essential to driving this change and embedding inclusive practices across all levels of the organisation.

As part of its statutory obligations, the Trust must:

- Submit annual data against the nine WRES workforce metrics
- Identify and implement actions to address any disparities
- Publish action plans that are ratified by the Trust Board

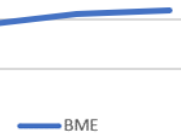
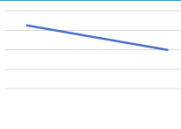
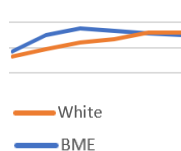
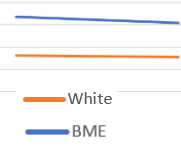
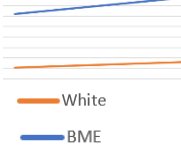
NHS England requires that all WRES action plans be approved by the Trust Board and published by 31 October 2025. A national WRES report will be published by NHS England, providing comparative benchmarking across Trusts and regions.

The WRES is directly aligned with the Equality Act 2010, specifically the protected characteristic of race. This report supports the Public Sector Equality Duty (PSED), particularly its first aim is preventing discrimination as well as its proactive duties to advance equality of opportunity and foster good relations.

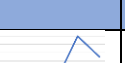
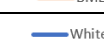
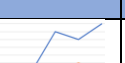
In 2024, the national WRES team provided each Trust with a comprehensive summary of their performance across the nine metrics. This enabled organisations to identify areas of strengths, challenges, share best practice, and collaborate on improvement strategies. For Barnsley Hospital NHS Foundation Trust, the metric on likelihood of appointment from shortlisting was previously identified as an area of best practice. However, it was later identified internally and highlighted to the national mandated standards team, that the data submitted contained inaccuracies due to an oversight during the submission process. This issue could not be rectified as it related to last year’s data, it has been acknowledged by the national standards team, and future reporting will include appropriate caveats to ensure the corrected context is clearly reflected.

WRES Metrics Overview – 2024/25

WRES METRICS 2024/2025 - Overview	
Workforce indicators	
For each of these four workforce indicators, <u>compare the data for White and BME staff</u>	
1. Workforce Representation – Overall BME Staff from 13.7%  to 15.2%	Trend

2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	4.36  Previous year (1:00) – inaccuracy later identified internally due to data submission oversight	
3. Relative likelihood of BME staff entering formal disciplinary processes compared to white staff	0.59 (1 case) BME staff entered formal disciplinary Previous year was 0.38 (1 case) for BME staff compared to 9 cases for white staff Previous year was 16	
4. Relative likelihood of White staff accessing non-mandatory training/CPD compared to BME staff	0.99  - Slight Improvement from the previous year 1.00 showing equity in accessing non-mandatory training/ CPD	
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff		
5. Percentage of staff experiencing bullying, harassment & abuse from patients/relatives/public in last 12 months	BME 29.2%  (negative increase) previous year 24% White 23.3% previous year 24.2%	
6. Percentage of staff experiencing bullying, harassment & abuse from staff in last 12 months	BME 31.8%  (negative increase) previous year 25.8% White 15.6% previous year 17.3%	
7. Percentage believing the Trust provides equal opportunities for career progression and promotion	BME 56.3%  (negative declined) previous year 58% White 68% previous year 70%	
8. In the last 12 months personally experiencing discrimination from manager/team leader/other colleagues	BME 20.9%  (negative increase) previous year 17.5% White 4.3% previous year 5.2%	
Board representation on the board minus BME representation in the workforce		
9. Board Representation - Percentage difference between Board membership and overall workforce	Percentage of overall Board members including non-voting members: 17.65% Percentage of Voting BME Board members: 7.14% Percentage of Executive BME Board members: 7.14%	previous year +4.2% previous year -1.2% previous year -1.2%

Change in the number of BME people in our organisation between 2020 and 2025

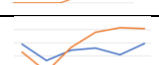
Agenda for change	2020			2021			2022			2023			2024			2025			Trend		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown			
Under band 1	25	1	0	16	1	0	14	1	0	12	2	0	13	1	2	16	2	2			
band 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	0		
band 2	661	13	1	702	13	1	685	17	2	742	21	21	751	46	17	678	↑	67	13		
band 3	512	10	4	529	10	14	563	20	17	835	30	7	862	36	8	820	↑	46	13		
band 4	210	3	1	224	3	2	228	5	3	239	4	3	248	6	1	242	↑	7	2		
Cluster 1 total	1408	27	6	1471	27	17	1490	43	22	1828	57	31	1872	89	28	1756	↑	122	30		
band 5	661	62	8	675	56	10	636	107	41	581	186	58	600	235	49	557	↓	207	91		
band 6	538	24	4	576	25	3	577	19	5	619	31	4	635	38	7	590	↑	42	8		
band 7	309	11	5	315	13	3	330	19	7	341	19	6	325	20	4	314		20	2		
Cluster 2 total	1508	97	17	1566	94	16	1543	145	53	1540	236	68	1560	293	60	1461	↓	269	101		
band 8a	100	7	0	101	7	0	93	5	0	102	6	0	134	7	0	131	↑	8	1		
band 8b	23	2	0	27	3	0	25	2	0	32	2	0	32	4	0	31		3	0		
Cluster 3 total	123	9	0	128	10	0	118	7	0	116	8	0	166	11	0	162		11	1		
band 8c	1	0	0	1	0	0	6	0	0	5	2	0	7	1	2	8		1	0		
band 8d	0	0	0	0	0	0	1	0	0	12	0	0	7	0	0	13	→	0	0		
band 9	1	0	0	1	0	0	1	0	0	5	0	0	3	0	0	1	→	0	0		
Cluster 4 total	2	0	0	2	0	0	8	0	0	22	2	0	33	1	2	22		1	0		

This table illustrates BME staff representation across Agenda for Change pay bands within the Trust, aligned with the clusters identified in the Workforce Race Equality Standard (WRES): A Model Employer framework.

Key Findings

- **Bands 2 to 4: Consistent Growth** - BME representation has steadily increased across Bands 2 to 4. Band 2 rose from **46 to 67**, Band 3 from **36 to 46**, and Band 4 from **4 to 6**. This reflects successful recruitment initiatives and improved access to employment opportunities for BME staff
- **Band 5: Slight Decline** - Although Band 5 remains the largest concentration of BME staff, numbers decreased from **235 to 207**.
- **Band 6: Positive Movement** - An increase from **31 to 42** BME staff in Band 6 suggests encouraging career progression, particularly among internationally recruited colleagues.
- **Band 7: Representation Unchanged** - BME representation at Band 7 has remained unchanged over the past 12 months
- **Band 8a: Modest Progress** - The increase from **7 to 8** BME staff in Band 8a, is small but indicates incremental progress in diversifying mid-level leadership roles. White staff at Band 8a declined slightly from **134 to 131** over the same period.
- **Bands 8b - 8c: Limited advancement** - Band 8b saw a decline in BME staff from **4 to 3**, while Band 8c remained static. White staff at Band 8b decreased slightly from **32 to 31**, and increased from **7 to 8** at Band 8c. These trends highlight a barrier to progression beyond Band 6 for BME staff.
- **Bands 8d – 9 Persistent Leadership Gap**: There continues to be **no BME representation** at Bands 8d and 9. In contrast, White staff increased from **7 to 13** at Band 8d and Band 9 saw a decrease from **3 to 1**. This shows a significant and ongoing gap in senior leadership diversity.

The data highlights a clear trend: Bands 2-4 shows consistent improvements, this diminishes progressively at higher pay bands. Comparative analysis indicates that White staff continue to dominate senior roles, whereas BME staff remain underrepresented, particularly at Bands 8d and 9. This trend reflects broader challenges around equity of opportunity and career progression within the Trust.

Medical and Dental	2020			2021			2022			2023			2024			2025			Trend	
	White	BME	Unknown	White	BME	White	BME	Unknown	White	BME	White	BME	Unknown	White	BME	Unknown	White	BME		
Medical & Dental Consultants	90	79	0	95	84	90	79	0	95	84	90	79	0	90	95	1	96	→ 95		
Medical & Dental Non- consultants career grade	50	88	2	27	61	50	88	2	27	61	50	88	1	25	50	0	12	↓ 37		
Medical & Dental trainee grades	33	16	4	49	53	33	16	4	49	53	33	16	0	59	82	0	57	↑ 131		

Change in the Numbers of BME people in the Trust between 2020 and March 2025

BME representation within Medical & Dental roles remains notably higher compared to Agenda for Change pay bands, with the exception of Band 5 clinical staff.

Medical & Dental Consultants

- **BME staff:** No change, remaining at **95** between 2024 and 2025.
- **White staff:** Slight increase from **95 to 96** over the same period.
- **Non-Consultant Career Grades**
- **BME staff:** Declined significantly from **61 to 37**.
- **White staff:** Also decreased, from **27 to 12**.

Despite the decline, BME colleagues continue to represent a higher proportion than White colleagues in this category.

Trainee Grades

- **BME staff:** Significant increase from **82 to 131** in 2025.
- **White staff:** Improved from **49 to 57**

WRES Metrics

Metric one is split into Clinical and Non- Clinical, the table below shows the breakdown of staff in the clinical and non-clinical groups for period 1 April 2024 to 31 March 2025. Percentages are based on the numbers of staff in that group and show the percentage of White and BME in each Band.

2024	Non-Clinical				Clinical			
Grade	White		BME		White		BME	
Band 2	471	95.9%	13	2.6%	278	86.6%	33	10.28%
Band 3	280	95.9%	9	3.1%	582	94.79%	27	4.40%
Band 4	143	97.9%	3	2.1%	105	96.33%	3	2.75%
Band 5	69	97.2%	2	2.8%	531	65.31%	233	28.66%
Band 6	67	94.4%	4	5.6%	568	93.27%	34	5.58%
Band 7	40	88.9%	3	6.7%	285	93.75%	17	5.59%
Band 8a	38	95.0%	2	5.0%	96	95.05%	5	4.95%
Band 8b	11	84.6%	2	15.4%	21	91.30%	2	8.70%
Band 8c	5	71.4%	0	0.0%	2	66.67%	1	33.33%
Band 8d	7	100.0%	0	0.0%	6	100.0%	0	0.0%
Band 9	1	100.0%	0	0.0%	0	0.0%	0	0.0%

2025	Non-Clinical				Clinical			
Grade	White		BME		White		BME	
Band 2	430	95.6%	19	4.2%	248	80.52%	48	15.58%
Band 3	265	94.3%	12	4.3%	555	92.81%	34	5.69%
Band 4	127	96.9%	3	2.3%	115	95.83%	4	3.33%
Band 5	67	95.7%	1	1.4%	490	62.42%	206	26.24%
Band 6	73	92.4%	5	6.3%	517	92.16%	37	6.60%
Band 7	43	93.5%	3	6.5%	271	93.45%	17	5.86%
Band 8a	31	93.9%	2	6.1%	100	93.46%	6	5.61%
Band 8b	11	84.6%	2	15.4%	20	95.24%	1	4.76%
Band 8c	5	100.0%	0	0.0%	3	75.00%	1	25.00%
Band 8d	7	100.0%	0	0.0%	6	100.00%	0	0.00%
Band 9	0	0.0%	0	0.0%	1	100.00%	0	0.00%

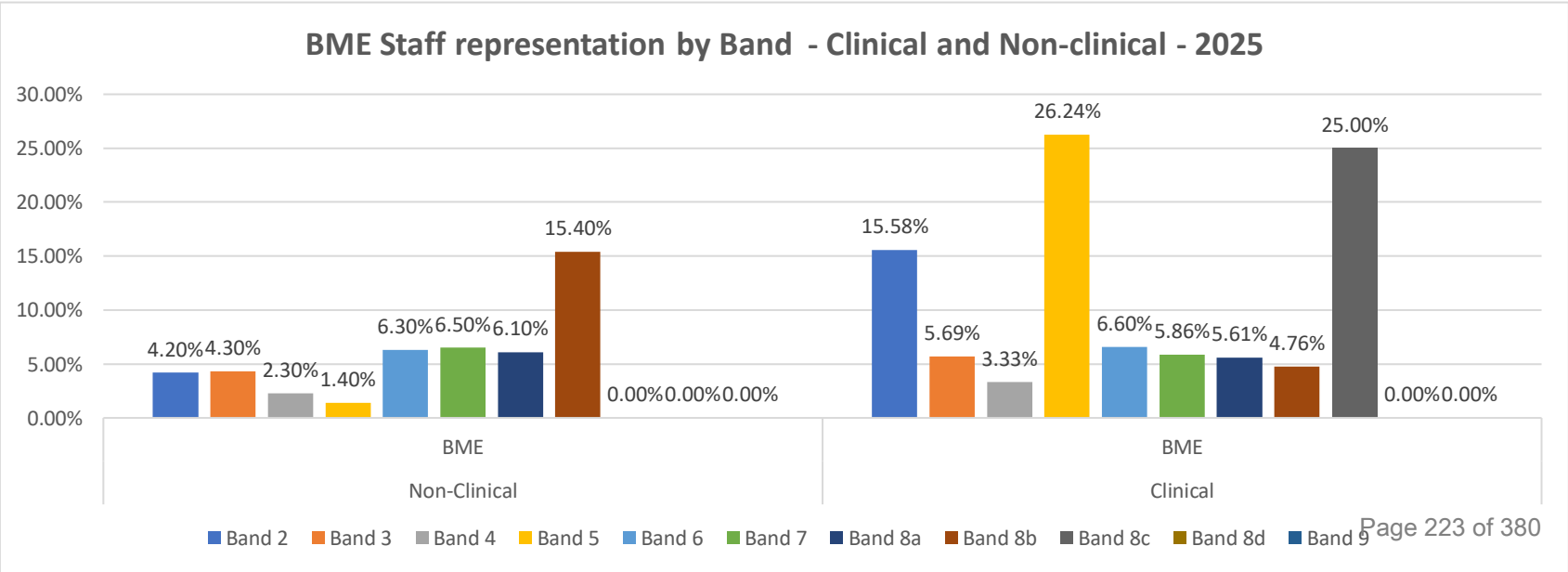
Key Insights:

Band 2 (Clinical): Shows BME representation of **15.58%**, significantly higher than the **4.2%** seen in Band 2 (Non-Clinical),

Band 5 (Clinical): demonstrates the highest BME representation at **26.24%**, highlighting diversity at this level.

Band 8b (Non-Clinical): reflects **15.4%** BME representation, making it a positive exception among senior non-clinical grades

Band 8c and above (Non-Clinical): Shows **no** BME representation and one at Band 8c.

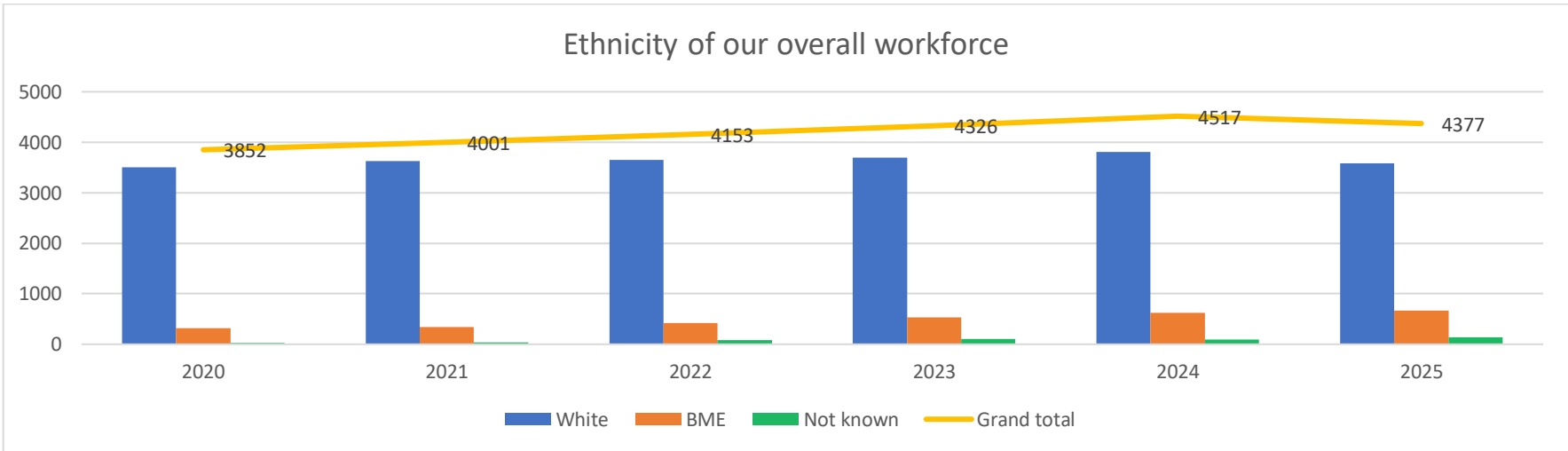


Metric 1 - Percentage of AfC staff by pay bands compared with the percentage in the overall workforce

	2020	2021	2022	2023	2024	2025
White	90.9%	90.6%	88.0%	85.3%	84.2%	81.7%
BME	8.4%	8.4%	10.1%	12.4%	13.7%	↑15.2%
Not known	0.8%	1.0%	1.9%	2.3%	2.0%	↑3.04%

Ethnicity of our overall workforce

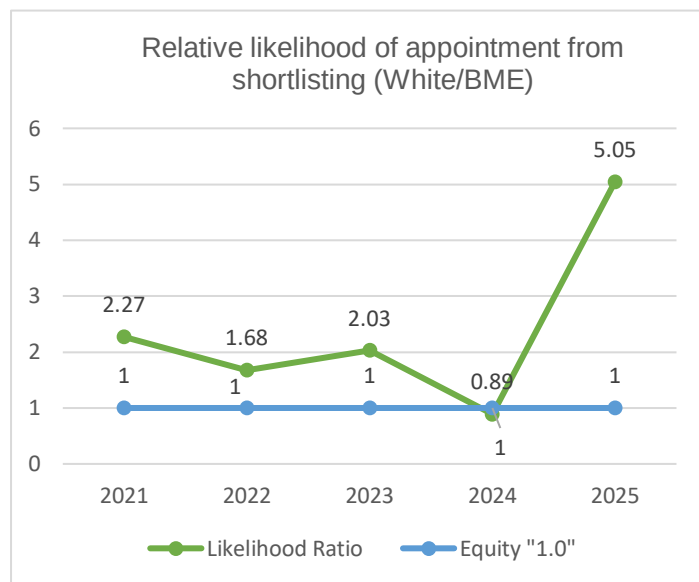
	2020	2021	2022	2023	2024	2025
White	3501	3623	3656	3691	3805	3578
BME	322	337	420	536	621	↑666
Not known	29	41	77	99	91	↑133
Grand total	3852	4001	4153	4326	4517	4377



The percentage of the workforce identified as Black or Minority Ethnic has continued to rise reflecting a positive upward trend from **13.7%** (621) in 2024 to **15.2%** (666 in 2025, an increase of **1.5%**, this is largely due to the international nurses recruitment.

There continues to be a level of non-disclosure in the workforce ethnicity data, now representing **3.04% (133)** of the overall workforce, an increase from **2.0% (91 staff)** the previous year. The majority of ‘these not known’ entries are attributed to our International Nurses who were recruited via NHS Professionals rather than through Barnsley’s NHS Jobs platform. As a result, their equality data was not captured during the recruitment process. Normally, when candidates apply through NHS Jobs, equality monitoring information is recorded as part of the application.

Metric 2 - Recruitment



National Data



2. Note on data accuracy - *Figure submitted national prior to internal data collection

The relative likelihood of white candidates being appointed from shortlisting compared to BME candidates was initially submitted as **5.05*** for the 2025 reporting period. The figure was flagged as unusually high, prompting an internal review. The review identified that data from **the newly qualified nurse cohorts had been omitted**, resulting in a recalculated figure of **4.36**, still significantly above previous years. However, NHS England Mandated Standards Team confirmed that **no amendments could be made** to the national submission due to the stage of the reporting cycle. As a result, the original figure will be reflected in the national report.

In line with guidance from the Mandated Standards Team, this report includes a caveat to ensure board-level discussions reflect both the limitations of the submitted dataset and the revised local figure of **4.36** and **acknowledge the discrepancy** to support informed decision-making and maintain transparency.

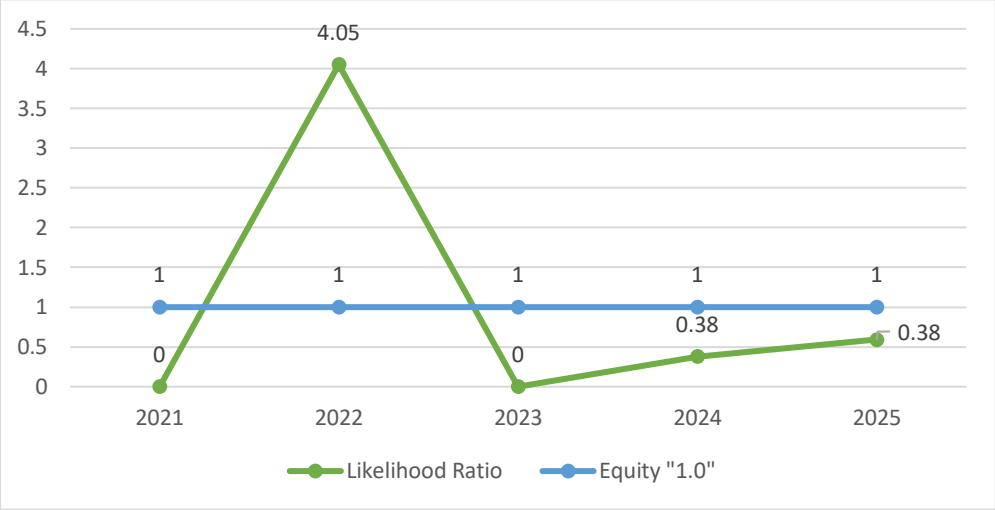
It is important to note that the **previous reporting year's figure of 1.0** has since been identified internally as inaccurate and reported to the national team. This was due to **a different staff member overseeing the data collection process at that time**, which led to inconsistencies methodology.

The unusually high figure of **4.36** will be addressed as an action for the Recruitment & Selection Task and Finish Group (TFG) which will explore root causes and identify future actions to improve equity in recruitment outcomes

Interventions taken:

- **Proud to manage and the former Passport to management training** – programme incorporated unconscious bias and inclusive recruitment inclusive recruitment
- **Career Support:** Nursing career clinics provided international recruited nurses with tailored career conversations in a supportive environment
- **PNAs/PMAs** have been trained to have facilitated career conversations, and signposted professional development opportunities to support staff retention
- **The Proud to Care Culture Diversity Subgroup:** has supported initiatives such as the anti-racist framework, allyship campaigns, and inclusive career progression. It continues to provide a platform for staff voice and co-production of EDI priorities
- **Inclusive Recruitment:** The Inclusive Recruitment Task & Finish Group is undertaking a full overhaul of recruitment practices covering all stages from advertising and shortlisting to selection and onboarding to improve fairness, consistency and candidate experience
- **Inclusive Nurse Progression:** A regional project led by the ICB engaged over 20 nurses across SY to identify barriers to progression. Recommendations include improving interview feedback, coaching on application forms, and increasing access to development opportunities. These are being piloted and aligned with recruitment reform efforts. Further work is underway to support implementation

Metric 3 – Formal Capability

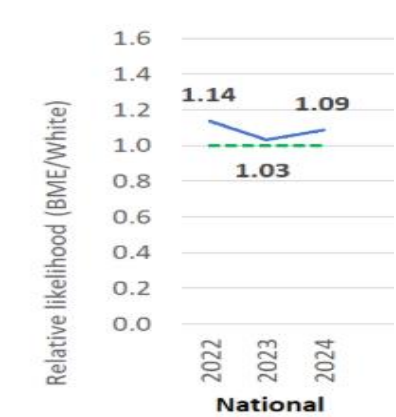


3. In the past 12 months, **1** BME staff entered formal disciplinary proceedings compared to 16 cases for White staff. Relative likelihood of BME staff entering formal disciplinary processes increased from **0.38** to **0.59**, a change of **+0.21**. It is important to note the number of BME disciplinary cases remained the same: **1** case in both years. White staff cases increased from **9** to **16**, a rise of **7** cases. This increase among white staff is the main driver of the change in relative likelihood suggesting that disciplinary processes are not disproportionately targeting BME staff. The shift in relative likelihood reflects of changes in white staff disciplinary rates rather than an increase in BME cases

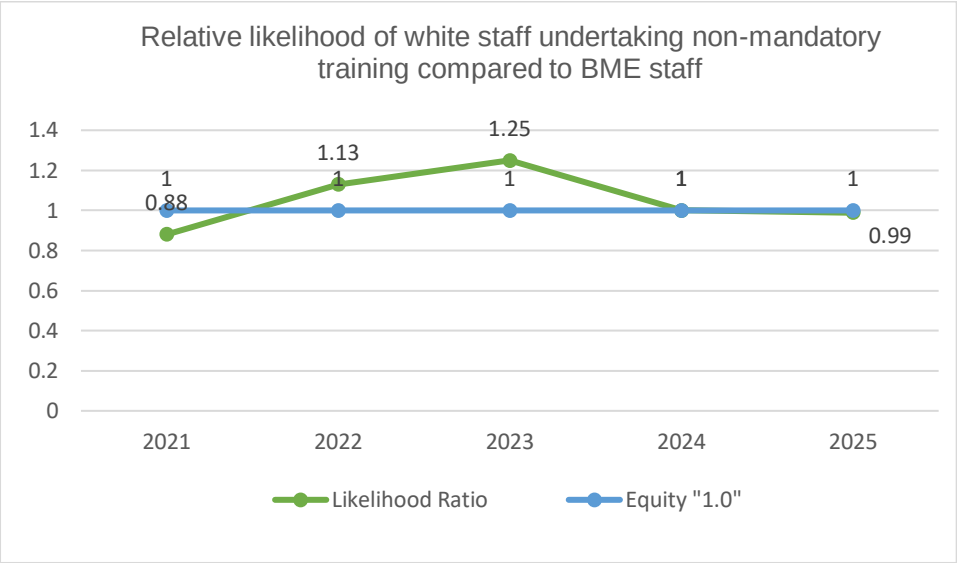
Interventions taken:

- **Ongoing monitoring:** Continued tracking of disciplinary data by ethnicity to ensure equitable treatment across all staff groups
- **Case outcomes by ethnicity:** Regular analysis of disciplinary outcomes to identify any emerging patterns or disparities and targeted action.
- **Just and learning culture:** Promotion of early resolution, reflection and restorative approaches to support continuous improvement
- **Training:** Delivery of training through the Proud to Manage programme, equipping managers with the skills to handle performance, grievance and disciplinaries fairly and consistently
- **Mediation Support:** Mediation is available for staff to provide informal resolution and preventing the escalation of workplace matters.

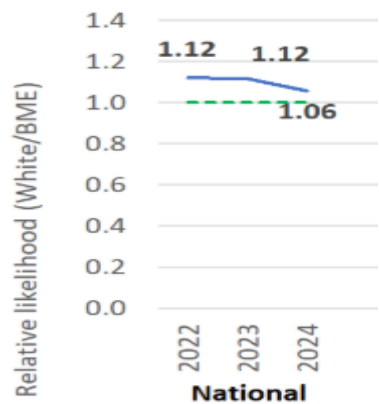
National Data



Metric 4 – Non-mandatory training / CPD



National Data

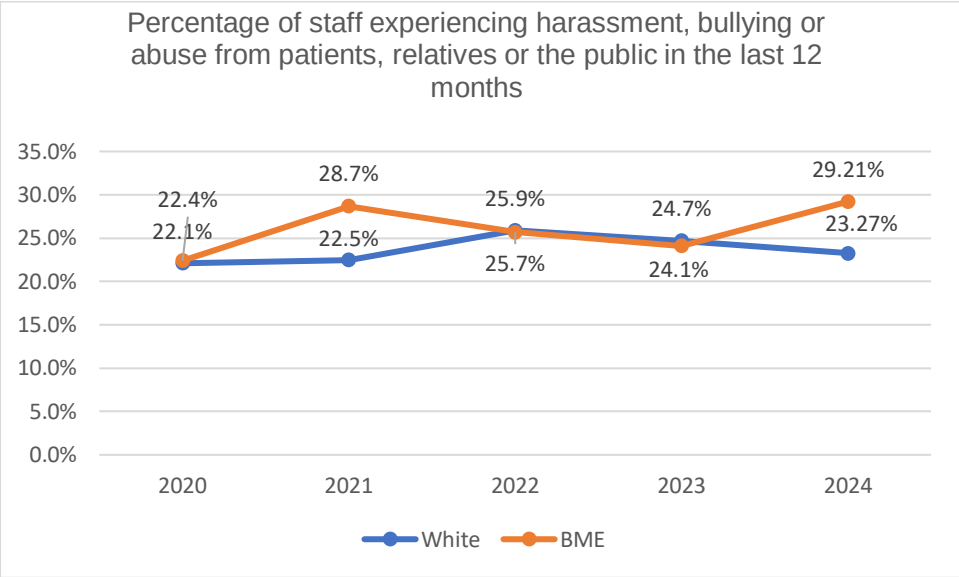


4. The relative likelihood of BME staff accessing non-mandatory training is **0.99**, showing a slight improvement from the previous year's figure of **1.00**. A figure of **1.00** indicates equal access between White and BME staff, this year's figure suggests that BME staff are now accessing training at a marginally higher rate than White staff. However, the difference is minimal and reflects a small shift towards greater access and continued progress toward equitable access.

Interventions taken:

- **Reciprocal Mentoring Programme:** Six BME aspiring leaders participated in the programme, reporting increased confidence, greater career clarity, and in some cases, progression into new roles.
- **Targeted Training Promotion:** Development opportunities have been actively circulated to staff network members to improve visibility and uptake.
- **Nursing Career Clinics:** Guidance and support for nurses mainly accessed by international nurses, helping to navigate career pathways and access development.
- **Manager Development:** Inclusive leadership and development are embedded in Proud to Manage and the former Passport to Management programme to ensure equitable access and support

Metric 5 – Harassment, Bullying / Abuse from patients / relatives / public (Obtained from NHS Staff Survey)

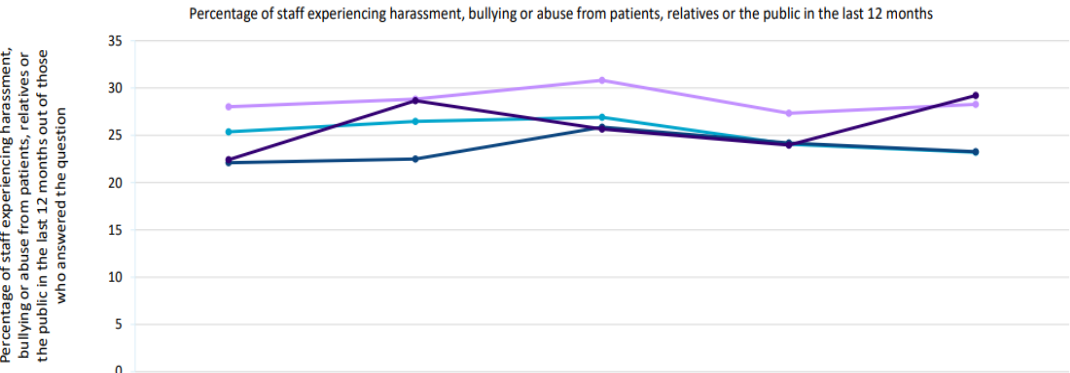


5. BME staff reported experiencing bullying, harassment, or abuse from patients, relatives, or the public has increased from **24.1% to 29.2%**. In contrast, reports from White staff showed a slight decline from **24.7% to 23.3%**.

This represents a **5.1 percentage point** increase for BME staff and a **1.4 percentage point** decrease for White staff. The gap between the two groups has widened. This growing disparity highlights the need for continued and targeted intervention to address the experiences of BME staff and ensure a positive inclusive culture.

Interventions taken and planned:

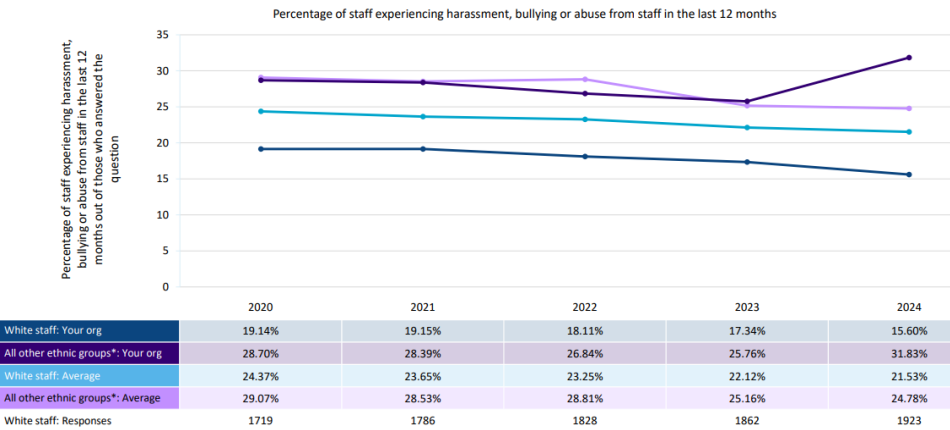
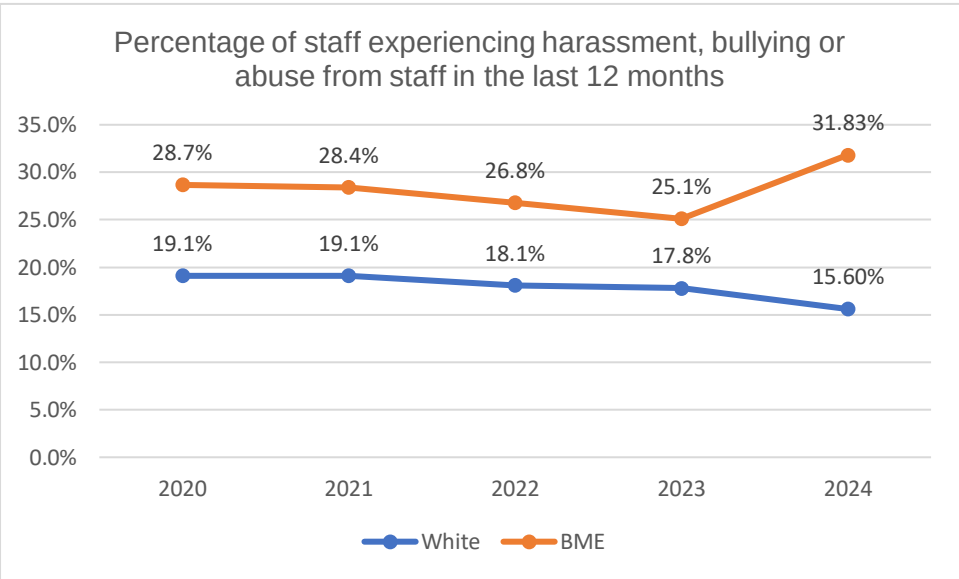
- **Staff Network Engagement:** The BME Staff Network actively encouraged incident reporting and conducted a survey during Black History Month to capture lived experiences of racism and discrimination.
- **Hate Incident Response:** The Hate Incident Coordinator delivered training, provided guidance on reporting, and promoted access to support resources.
- **No place for hate campaign** – is being refreshed and new posters being displayed across the Trust
- **Courageous Conversations Training:** Ongoing training available to all staff to build confidence in addressing inappropriate behaviour and fostering inclusive dialogue.
- **Manager Development:** The refreshed Proud to Manage training which replaced the former Passport to Management programme continues to equip managers with the skills to respond appropriately to concerns and promote a just and inclusive workplace culture
- **Violence and Aggression Management Group:** Monitoring of incidence to the group to identify themes, trends and hotspot areas for targeted interventions including preventative strategies



	2020	2021	2022	2023	2024
White staff: Your org	22.10%	22.49%	25.87%	24.19%	23.27%
All other ethnic groups*: Your org	22.41%	28.66%	25.65%	23.97%	29.21%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	1715	1805	1848	1874	1942
All other ethnic groups*: Responses	116	157	191	246	291

Metric 6 - Harassment, Bullying/ Abuse from staff

(Obtained from NHS Staff Survey)

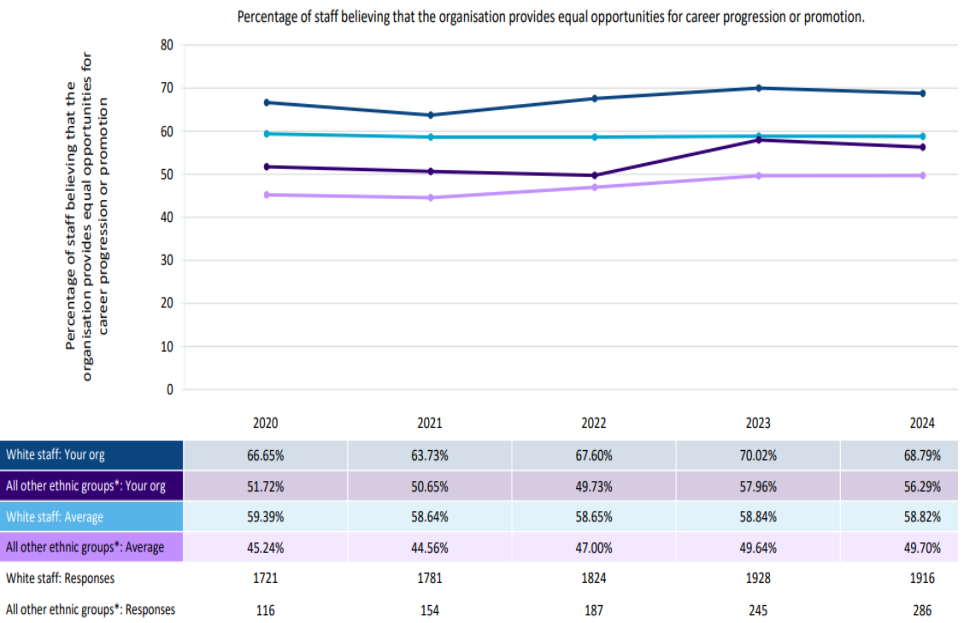
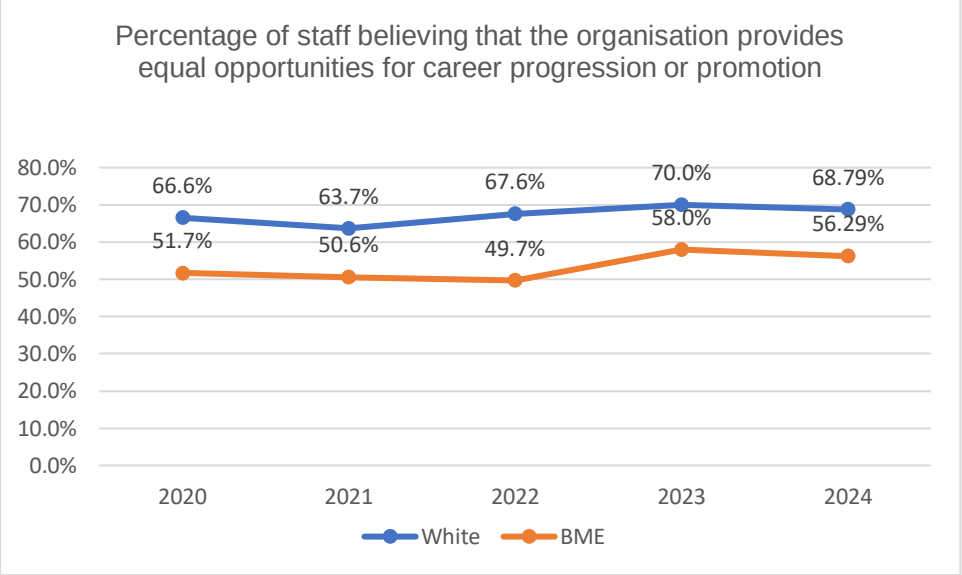


6. The dataset for BME staff, has shown a notable rise and widening gap in negative experiences from **25.1%** to **31.8%**. Reports from White staff have decreased from **17.8%** to **15.6%**. This reflects a **6.7 percentage point** increase for BME staff and a **2.2 percentage point** decrease for White staff highlighting a widening gap in experience between the two groups. The rise in BME staff reporting may indicate staff feeling more empowered to report their experiences, driven by ongoing inclusion efforts and awareness campaigns. However, the persistently higher rates of negative experiences among BME staff reinforces the importance of embedding anti-racism into practice. There is still work to be undertaken as BME staff consistently report worse experiences compared to White colleagues.

Interventions taken and planned:

- **Staff Network Support:** The staff Network provides a safe space for staff to share concerns and access peer support. The Executive Sponsor plays a key role in promoting inclusivity, attending meetings, offering guidance to ensure that issues are heard and addressed.
- **Chaplaincy & Drop-In Sessions:** Emotional and spiritual support are available to all staff.
- **Freedom to Speak Up:** Regular engagement with staff networks to raise awareness of confidential reporting and support options.
- **Counselling & EAP Access:** Staff Counsellor and Vivup Employee Assistance Programme available for wellbeing support.
- **Mediation Services:** Offered to provide informal resolution constructively.
- **Hate Incident Coordinator:** Delivered training to raise awareness and build confidence in reporting incidents. The existing Hate Crime training is available on the hub and will be promoted to ensure accessibility via the hub
- **Courageous Conversations Training:** Ongoing training is delivered to support staff and assist with respectful dialogue and address difficult topics.
- **Anti-Racist Framework:** A range of targeted actions is planned to embed anti-racism into organisational culture and practice.
- **Proud to Care Cultural Leadership Group:** Contributes to shaping interventions that address race equality, inclusion and staff experience
- **Cultural Insights group:** Established to triangulate data across multiple sources to inform cultural development and inclusive practice
- **Cultural resources e.g. Kerala Cultural Guide:** Newly developed guide to enhance cultural awareness among staff, reduce unconscious bias and support respectful interactions. Ramadan Guide is also available
- **Thrive Together Conference:** Provided a platform for staff to engage, share lived experiences and access development opportunities.

Metric 7 – Career Progression (Obtained from NHS Staff Survey)

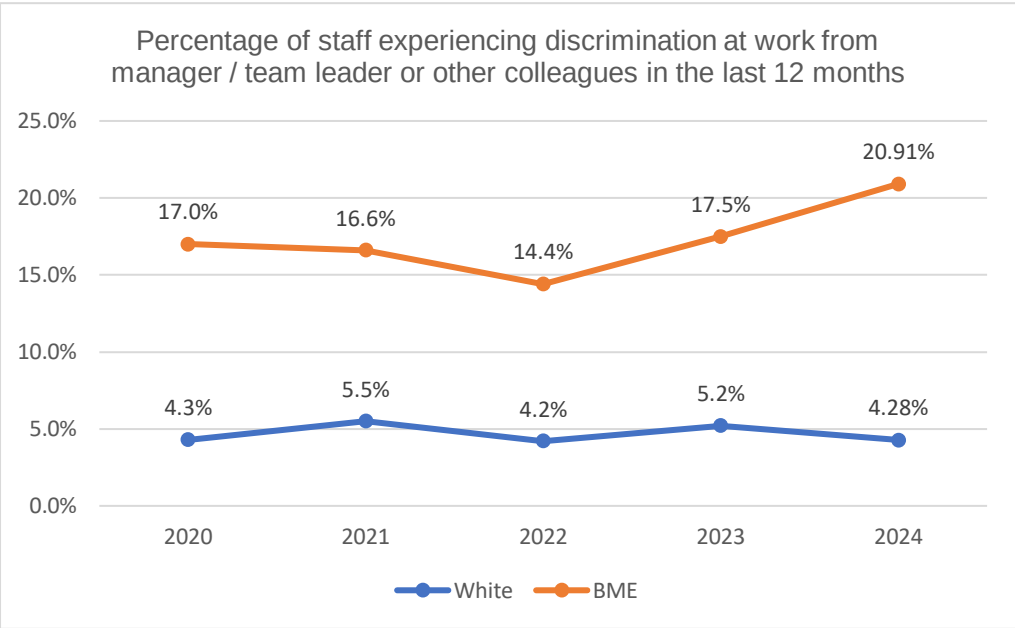


7. The percentage of BME staff who believe the Trust provides equal opportunities for career progression has declined from **58% to 56.3%**. White staff perceptions have also declined slightly from **70% to 68.79%**. This reflects a disparity gap of **12.49** percentage points for BME staff highlighting the need for continued focus on career development. Although several initiatives have been implemented to support BME staff, barriers to career progression persist.

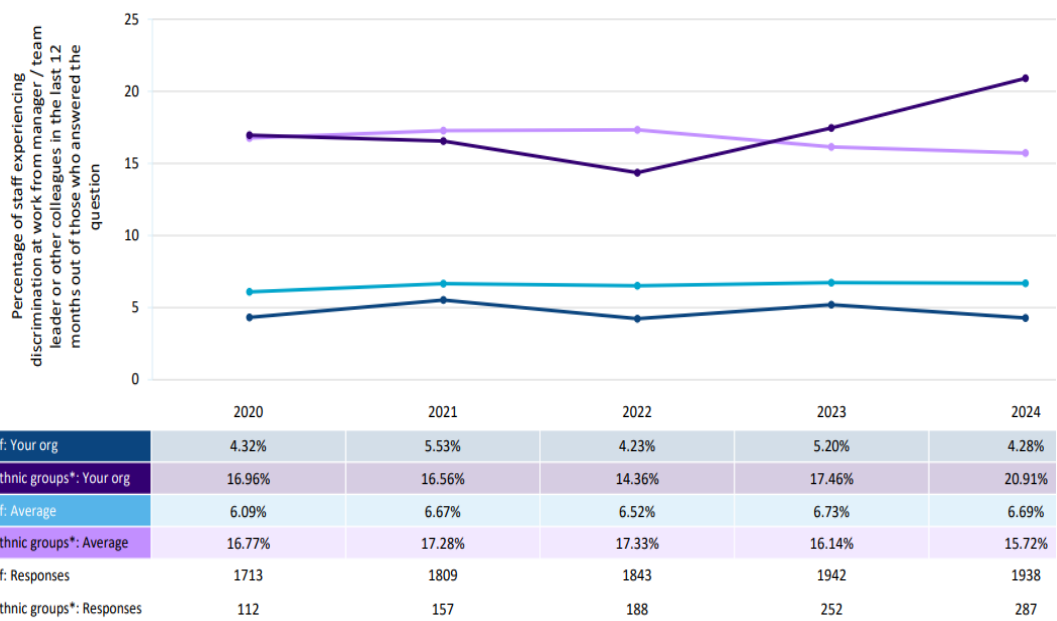
Interventions taken and planned:

- **Reciprocal Mentoring Programme:** has been successfully delivered with two of the six BME aspiring leaders achieving career progression. The programme provides mutual learning partnership between senior leaders and aspiring BME leaders to help to share insights and experiences to promote an inclusive culture and career development
- **Nursing Careers clinics:** ongoing initiative with increased engagement from the international recruited nurses offering tailored guidance and support for navigating clinical career pathways
- **Career Progression Action Learning Peer Support group:** Initiative was launched in March 2025 and will be running until January 2026. This group provides BME staff with a reflective and empowering space to build confidence, resourcefulness, and clarity in their career goals. Early feedback indicates increased self-belief and readiness to progress their careers
- **Inclusive Recruitment:** The Inclusive Recruitment Task & Finish Group is undertaking a full overhaul of recruitment practices covering all stages from advertising and shortlisting to selection and onboarding to improve fairness, consistency and candidate experience
- **Inclusive Nurse Progression:** A regional project led by the ICB engaged over 20 nurses across SY to identify barriers to progression. Recommendations include improving interview feedback, coaching on application forms, and increasing access to development opportunities. These are being piloted and aligned with recruitment reform efforts. Further work is underway to support implementation
- **Thrive Together Conference:** Provided a platform for staff to engage, share lived experiences and access development opportunities through workshops and networking

Metric 8 – Discrimination (Obtained from NHS Staff Survey)



Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



8. The percentage of BME staff reporting discrimination from manager/team leader/ other staff has risen sharply from **17.5%** to **20.91%**. In contrast, White staff reports have declined slightly from **5.2%** to **4.28%**. This reflects a widening disparity, with BME staff nearly five times more likely to face discrimination compared to white staff. The increase in reporting may reflect greater confidence in BME staff reporting their experiences. The sharp rise also suggests that discriminatory behaviours persist and may be escalating.

Interventions taken and planned:

- **Staff network support:** provides a safe space for BME staff to share concerns and receive peer support
- **Lived Experiences:** BME staff is being encouraged to share their lived experiences to influence change, shape culture and inclusive behaviours
- **Anti-racist framework** – comprehensive framework will be launched to embed anti-racist principles into our work practice and culture
- **Anonymous Reporting platform** – a new platform is being created for staff to report incidents confidentially to gain deeper insights into discrimination trends and staff experiences
- **Monitor trends and Targeted interventions** – patterns will be monitored, hotspots identified and targeted interventions to address specific issues to prevent recurrence
- **Support from PMAs, PNAs, Inclusion & Wellbeing Champions:** are available to offer support and guidance for staff encountering negative experiences
- **Oversight by Proud to Care Cultural Leadership Group:** This group, supported by subgroups including the Diversity Subgroup, is responsible for driving progress on cultural goals, ensuring alignment with the NHS People Promise and Trust values.
- **Promotion of a Just and Learning Culture:** Continued emphasis on promoting a focus on just and learning culture where staff feel safe to speak up, mistakes are treated as learning opportunities and accountability is upheld.
- **Leadership Accountability:** Ensure leaders are equipped and held accountable for fostering inclusive behaviours and addressing discrimination

Metric 9 – Percentage Difference between BME on the board minus percentage of BME workforce (as of 31 March 2025) (Gap in BME representation at board level compared to the BME workforce)

Board membership (as at March 2025)		
Percentage of the Overall Board members	Percentage of Voting BME Board members	Percentage of Executive BME Board members
17.65%	7.14%	7.14%

(A value of 0.0 – Equity)

- Positive value – percentage of BME board members is higher than the workforce
- Negative value – percentage of BME members on the board is lower than in the workforce

*Please note that the information previously submitted to the national team indicated that the Trust Board comprised **15 voting members and 2 non-voting members**. However, the current composition is **14 voting members and 3 non-voting members**. This correction is reflected in this report and should be incorporated into future reporting to ensure accuracy and alignment with governance records.

Board Representation Compared to BME Workforce

This indicator shows how well BME staff are represented at board level compared to the overall BME workforce, which is 15.2%

Overall Board Representation (Including Non-Voting Members)

Current Percentage: 17.65%
Gap vs Workforce: +2.45%

This gives a broad view of diversity across the board, including members who don't have voting rights. It shows that BME representation at this level is slightly higher than the workforce average, which is a positive sign of inclusivity.

Voting BME Board Members

Current Percentage: 7.14%
Gap vs Workforce: –8.06%

This focuses on BME members who have voting rights and therefore influence over decisions. The gap shows that BME staff are underrepresented in decision-making roles. This is an area to improve so that leadership better reflects the workforce

Executive BME Board Members

Current Percentage: 7.14%
Gap vs Workforce: –8.06%

The same gap shows that BME staff are also underrepresented in senior leadership roles which affects how the Trust leadership represents the diversity of its workforce

Conclusions and Strategic Direction for 2025 / 2026:

The 2024/25 WRES data highlights meaningful progress in early and mid-career representation, particularly among international recruits. However, persistent gaps in senior-level representation and widening disparities in staff experience especially around bullying, harassment, abuse, and discrimination reinforce the need for sustained cultural transformation.

Of particular concern is the sharp increase in disparity in appointment from shortlisting, with BME applicants now four times less likely to be appointed compared to white applicants. This is the highest level of disparity recorded to date and reinforces the urgent need for inclusive recruitment reform and leadership accountability.

The Trust is embedding the Anti-Racist Framework as a strategic priority, supported by data-driven insight, inclusive recruitment, and staff-led initiatives. These efforts aim to build a respectful, inclusive, and accountable culture where equity is embedded in leadership behaviours and operational delivery.

A detailed action plan will accompany this report, focusing on the priority metrics where performance has not met the standard:

Next Steps and Future Priorities for 2025/26

The Trust's focus for 2025/26 will concentrate on the WRES metrics showing the greatest disparity and requiring urgent attention. These priorities are informed by the 2024/25 data and will be supported by a detailed action plan included within this report.

1. Appointment from Shortlisting

- Address the significant disparity in appointment outcomes, with BME applicants currently four times less likely to be appointed than white applicants
- Review recruitment processes to improve fairness, transparency, and consistency at every stage, enhancing candidate experience

2. Bullying, Harassment, Abuse, and Discrimination

- Address the rising reports of negative experiences from both staff and patients.
- Strengthen preventative approaches, embed lived experience to inform action, launch an anonymous reporting platform and deliver cultural interventions

3. Career Progression

- Improve representation of BME staff at senior levels and explore consultant grades.
- Support targeted development pathways and leadership pipelines.

4. Anti-Racist Practice and Culture

- Embed anti-racist principles across policies, leadership behaviours, and operational delivery.
- Co-produce a Trust-wide Anti-Racist Commitment Statement and promote allyship through staff-led campaigns.

5. Data Insight and Accountability

- Use workforce and experience data to identify disparities, monitor progress and inform targeted action.

Through its anti-racist and inclusive recruitment efforts, the Trust will continue to strengthen progress across all key Workforce Race Equality Standard (WRES) metrics, ensuring that equity is not only a strategic priority but a lived reality for all staff.

The Trust remains firmly committed to advancing race equality and fostering a workplace where every individual feels safe, valued, and empowered to thrive. The findings from the 2024/25 WRES report highlight areas of concern that require focused, sustained, and collaborative action. The priorities outlined above will guide the Trust's efforts throughout 2025/26, supported by a detailed action plan that provides a clear framework for delivery.

The Board is asked to:

- Endorse this report,
- Support the implementation of the Anti-Racist Framework, a
- Champion inclusive recruitment and cultural transformation initiatives.

Leadership accountability, staff empowerment, and data-driven action will be essential to embedding equity and inclusion across all staff groups, roles, and levels of the organisation.

Workforce Race Equality Standard (WRES) Action Plan Progress – 2024/2025

Introduction

Supporting Information for WRES Action Plan

As part of our ongoing commitment to fostering an inclusive and supportive workplace, we have conducted a comprehensive review of our Workforce Race Equality Standard (WRES) actions. In collaboration with the Race Equality Staff Network, we have agreed to streamline our WRES actions to ensure they are both realistic and achievable. This strategic approach will allow us to focus our efforts on key priority areas that will have the most significant impact.

The following WRES priority areas have been identified.

- **Metric 2 - Relative likelihood of White applicants being appointed from shortlisting compared to BME applicants**
- **Metric 5, 6 & 8 - Harassment, Bullying & Abuse from: Patients / relatives/public, Discrimination from manager/team leader/colleagues**
- **Metric 7 – Equal opportunities for career progression or promotion**

By focusing on these priority areas, we can make meaningful progress towards a more inclusive and supportive workplace for our colleagues

Metric	WRES Indicators	Objective	Actions	Lead	Timescale	Update	RAG
2.	Relative likelihood of White applicants being appointed from shortlisting compared to BME applicants Value of 1:00 is equity Ratio increased  4.36 Aligns with: NHS EDI Improvement Plan: High Impact Action 2: Overhaul recruitment processes, embed talent management strategies that target under-representation & lack of diversity People Promise – We are compassionate and inclusive, We are learning, We each have a voice that counts, We are a team	Continued focus to ensure recruitment & selection processes are inclusive	➤ Deliver the expectations of line managers people management training including unconscious bias and inclusive recruitment & selection practices	Head of inclusion & wellbeing/ Inclusion & Wellbeing Lead	31 January 2025 – 31 August 2025	Proud to Manage Training delivery is ongoing	Amber
		Embed fair and inclusive recruitment processes and talent management strategies that target under representation and lack of diversity	➤ Establish a working group to review and refresh recruitment & selection and strengthen inclusive recruitment to ensure the process is consistently fair, reliable and free from debias	Deputy director of People/HR Resourcing Manager/ Head of I&WB	31 March 2025	Task & Finish Group is established – work is underway to review and overhaul recruitment	Amber

5,6 &8	Percentage of staff experiencing bullying, harassment & abuse, discrimination from: a. Patients/ relatives/public in the last 12 months (BME staff increased  25.6 to 29.2%) White staff – 15.6% b. Staff (BME staff increased from 26.8%to 30. 82%) White staff – 17.8% Indicator 8	To commence our journey to become an Anti-racist organisation and actively scope the work to undertake a self-assessment and goals aligned to the Bronze status of the North West approach BAME assembly anti-racist framework (ARF) To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or	➤ Collaborate with the staff network and Proud to Care Diversity subgroup in scoping and undertaking the self-assessment anti-racist framework	Head of I&WB/I&WB lead	1 October 2024 – 31 August 2025	Initial scoping self-assessment completed	Green
			➤ Create a working group to look at the ARF deliverables		1 October 2024 – 31 August 2025	Working group is established through the Diversity subgroup. ARF is being promoted	Green
			➤ Collaborate with the Executive Sponsor		1 October 2024 – 31 August 2025	Collaboration with Executive sponsor and roles and responsibilities have been shared	Green

c. Discrimination from manager/team leader/colleagues (BME staff – Increased  17.5% to 20.9%) White staff – 5.2% High Impact Action 6 and High impact Action 5 Comprehensive Induction and on-boarding programme for International recruited staff, People Promise ambitions: We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are safe and healthy, We are a team Indicator 8	public, managers and colleagues To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Feedback the gap analysis and produce an action plan in delivery of our commitment in being an anti-racist Trust	Head of I&WB/I&WB lead	1 October 2024 – 31 August 2025	Completed and shared at various key groups e.g. Executive Team, People Committee	Green
		➤ Promote and launch the Anti-racist framework		1 October 2024 – 31 August 2025	Initial scoping self-assessment completed. Plans are in place for launch of ARF	Amber
		➤ Collaborate with key staff and about raising the profile of Race Equality across the Trust including the development of Allies		31 December 2024	Attended a range of meetings e.g. Senior leaders meeting, Nursing & Midwifery Professional council and further plans are in place to raise the profile of the race equality agenda	Green

Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – Increased ↑17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Collaborate with ICS partners in delivering the ARF framework collectively and sharing practices		30 November – August 2025	ARF self-assessment ad deliverables shared with the Proud to Care Diversity subgroup and Race Equality Staff Network	Green
		➤ Continue with ongoing Respect Campaign to encourage a focus on respectful behaviours	Comms Manager	30 November – August 2025	Range of campaigns have been undertaken	Green
		➤ Posters to be displayed across the Trust	Head of I&WB / I&WB lead	30 November – August 2025	Posters distributed to ED department. Other departments can request posters. Campaigns also included Facebook stories, pulse screens	Green
		➤ Encourage staff to speak up and report harassment, bullying or abuse	Head of I&WB / I&WB lead Freedom to Speak up Guardian	30 November – August 2025	Awareness sessions held, reporting channels promoted through various sources	Green

Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – Increased ↑17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Collaboration with Race Equality staff network, Champions, Freedom to Speak up, Health & Wellbeing	Head of I&WB / I&WB lead Freedom to Speak up Guardian Champions (Inclusion & Wellbeing & FTSU)	30 November – August 2025	Staff encouraged to speak up and share any incidents or lived experiences	Green
		➤ Promote and raise awareness on how to report hate crime	I&WB lead	30 October 2024	Black History Month event – raised awareness Two Hate crime awareness sessions delivered Hate Crime Coordinator attended different staff network events	Green
		➤ Regular reporting through Violence and Aggression Management Group (VAMG) highlighting any themes, trends and hotspots	I & W Lead, Freedom to Speak Up Head of Inclusion & Wellbeing	1 October 2024 – 31 August 2025	Trends shared at VAMG	Green

	Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – Increased  17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Provide support (counselling, debrief, wellbeing conversation) and allow a safe place for voice to be heard	Head of Occupational Health Head of I&W	1 October 2024 – 31 August 2025	<i>Support services promoted</i>	Green
			➤ Stay and Thrive and pastoral programme for international recruited nurses	Associate Director of Professions	1 October 2024 – 31 August 2025	Stay and Thrive Programme delivered Thrive Together Conference held	Green
			➤ Provide support (counselling, debrief, wellbeing conversations, liaising with the PNA/PMAs) and allow safe place for voice to be heard	Head of Occupational Health Head of I&WB Associate Director of Professions	1 September 2024 – 31 August 2025	Ongoing support provided through various mechanisms e.g. counselling	Green
			➤ Recruit more train the trainer to deliver Cultural competence training	Associate Director of Professions	31 January 2025 – August 2025	Amended version being delivered - Cultural Awareness to newly registered practitioners as part of preceptorship	Green

Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – Increased ↑17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Create and promote an inclusive and compassionate culture and respectful behaviours and just culture	Head of I&WB Head of Learning & OD	1 October 2024 – 31 August 2025	Ongoing through Proud to Manage training, courageous conversation, resources on hub for managers	Green
		➤ Deliver the expectations of line managers people management training	Head of EDI / EDI Lead Head of Learning & OD	31 January – 31 August 2025	People management training is being delivered and is ongoing – low number of attendees. Training in June was cancelled due to low numbers	Amber
		➤ Launch and deliver our commitment with progressing the actions related to the Sexual Safety Charter	Deputy Director of People, Head of Head of I&WB/Head Leadership & OD / Head of Occupational Health	31 March 2025	Launched and deliver Sexual Safety, commitments	Green

7.	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (BME staff – declined 58% to 56.3%)  White staff – 68% High Impact Action 2 People Promise – We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are a team, We are recognised and rewarded	To ensure BME staff have equal opportunities for career progression or promotion	➤ Ensure mentorship and development plans are in place for aspirant BME nurses and midwives	Head of I&WB/Head of Leadership & OD	1 October 2024 – 31 August 2025	A range of initiatives are available e.g. coaching & mentoring, careers clinic, reciprocal mentoring, action learning. Being supported to navigate career pathways and positive feedback from career clinics, reciprocal mentoring programme	Green
			➤ Continue to explore barriers and opportunities for career and personal development	Head of I&WB, I&WB Lead	1 October 2024 – 31 August 2025	Explored lived experiences and barriers during the Diversity subgroup. ICB Inclusion nurse Progression findings shared and key recommendations to support and enhance inclusive recruitment	Amber
			➤ Work with the staff network and	Head of I&WB / I&W	1 October 2024 – 31	Completed	Green

	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	To ensure BME staff have equal opportunities for career progression or promotion	promote targeted resources for development / training programmes / skills and competencies, coaching/mentoring shadowing	Lead, L&OD Manager	August 2025		
	Aligns with: High Impact Action 2 and 6		➤ Continue with delivery of nursing career clinic, stay and thrive and consider longer-term career development needs of International nurses at Band 5 to ensure retention and further development	Associate Director of Professions	1 October 2024 – 31 August 2025	Clinic sessions ongoing; feedback shows positive impact on retention.	Green
	People Promise – We are compassionate and inclusive, We are always learning, We each have a voice that counts, we are a team, We are recognised and rewarded		➤ Delivery of the Reciprocal mentoring programme – second cohort	Head of I&WB	18 September 2024 –	Reciprocal mentoring completed with reports of positive outcomes	Green

		To ensure BME staff have equal opportunities for career progression or promotion	commenced in September 2023. Identify and share key learning as necessary for the Trust		31 August 2025		

KEY RAG Rating

GREEN

Complete

AMBER

On track for delivery

RED

Behind plan and action needed to bring back on target

Workforce Race Equality Standard (WRES) Action Plan – 2025 / 2026

Introduction

Supporting Information for WRES Action Plan

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By focusing on these priority areas, we can make meaningful progress towards a more inclusive and supportive workplace for our colleagues

Metric	WRES Indicators	Objective	Actions	Lead	Timescale	Status
2.	Relative likelihood of White applicants being appointed from shortlisting compared to BME applicants Ratio increased  4.36 Aligns with: NHS EDI Improvement Plan: High Impact Action 2: Overhaul recruitment processes, embed talent management strategies that target under-representation & lack of diversity People Promise – We are compassionate and inclusive, We are learning, We each have a voice that counts, We are a team	Continued focus to ensure recruitment & selection processes are inclusive	➤ Continue to deliver the expectations of line managers people management training including unconscious bias and inclusive recruitment & selection practices	Head of EDI & EDI Lead HR Resourcing manager	1 October 2025 – 31 August 2026	
		Embed fair and inclusive recruitment processes and talent management strategies that target under representation and lack of diversity	➤ Task & Finish group to continue to review and refresh recruitment & selection and strengthen inclusive recruitment to ensure the process is consistently fair, reliable and free from debias	Deputy director of People/HR Resourcing Manager/ Head of EDI	1 October 2025 - 31 March 2026	
5,6 & 8	Percentage of staff experiencing bullying, harassment & abuse (HBA), discrimination from:	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or	➤ Implement a zero-tolerance campaign on bullying, harassment, and abuse, including sharing lived	Head of EDI/I&WB lead	1 October 2025 – 31 August 2026	

	d. Patients/ relatives/public in the last 12 months (BME staff increased ↑24.1 to 29.2%) White staff – 24.7%	public, managers and colleagues. To launch the Anti-racist framework aligned and achieve Bronze status by Spring 2026.	experiences and leadership visibility.			
	e. Indicator 6 Staff – Harassment, Bullying/Abuse (BME staff increased ↑ 25.1 to 31.8%) White staff – 15.6%		➤ Promote and launch the Anti-racist framework		1 October 2025 – 30 August 2026	
	Indicator 8 f. Discrimination from manager/team leader/colleagues (BME staff – ↑ 17.5% to 20.9%) White staff – 5.2% Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – ↑ 17.5% to 20.9%) White staff – 5.2% High Impact Action 5 and High impact Action 6 Comprehensive Induction and on-boarding programme for International recruited staff,	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues. To launch the Anti-racist framework aligned and achieve Bronze status by Spring 2026.	➤ Launch an anonymous reporting platform for HBA and discrimination	Head of EDI/I&WB lead	1 October 2025 – 10 January 2026	
			➤ Facilitate listening sessions and focus groups to gather lived experiences and inform cultural interventions	Head of EDI/I&WB lead	1 November 2025 – June 2026	
			➤ Continue with ongoing Respect Campaign to encourage a focus on respectful behaviours	Comms Manager	1 October 2025 – 30 June 2026	

People Promise ambitions: We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are safe and healthy, We are a team Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff –  17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues. To launch the Anti-racist framework aligned and achieve Bronze status by Spring 2026.	➤ Posters to be displayed across the Trust and collaborate with comms for anonymous lived experiences to be added to posters	Comms Manager	1 October 2025 – 30 Jan 2026	
		➤ Encourage staff to speak up and report harassment, bullying or abuse	Head of EDI / I&WB lead	October 2025 – 31 August 2026	
		➤ Collaboration with Race Equality staff network, Champions, Freedom to Speak up, Health & Wellbeing Champions	Freedom to Speak up Guardian		
		➤ Promote and raise awareness on how to report hate crime	Champions (Inclusion & Wellbeing & FTSU)		
		➤ Regular reporting through Violence and Aggression	I&WB lead	1 October 2025 – June 2026	
			EDI Lead, Freedom to Speak Up	1 October 2025 – 31 August 2026	

Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – ↑ 17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	Management Group highlighting any themes, trends and hotspots	Head of EDI		
		➤ Provide support (counselling, debrief, wellbeing conversation) and allow a safe place for voice to be heard	Head of Occupational Health & Wellbeing & Wellbeing Head of EDI	1 October 2025 – 31 August 2026	
		➤ Provide range of support: Mediation	Head of EDI Associate Director of Professions	1 October 2025 – 31 August 2026	
		➤ Liaise with PNA/PMAs) Chaplain to allow safe place for voice to be heard	Head of Occupational Health & Wellbeing & Wellbeing		

Indicator 8 c. Discrimination from manager/team leader/colleagues (BME staff – 📈 17.5% to 20.9%) White staff – 5.2%	To reduce the conditions in which harassment, bullying or abuse (HBA) or discrimination from patients, relatives or public, managers and colleagues	➤ Create and promote an inclusive and compassionate culture and respectful behaviours and just culture	Head of EDI Head of Learning & OD	1 October 2025 – 31 August 2026		
		➤ Deliver the expectations of line managers training	Head of EDI Head of Learning & OD		1 October 2025 – 31 August 2026	
		➤ Promote the range of resources available on the hub to support managers				
	Launch and Promote Allyship campaigns	➤ Explore allyship training and collaborate with key staff and partners	Head of EDI / EDI Lead	1 October – August 2026		
		➤ Use the Allyship survey to assess behaviours and barriers				

			➤ Encourage the sharing of lived experiences			
			➤ Align Allyship with key events e.g. Black history month, Disability month			
			➤ Collaborate with the staff networks and key staff to be involved in shaping Allyship initiative			
7.	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (BME staff – declined ↓ 58% to 56.3%) White staff – 68% High Impact Action 2 People Promise – We are compassionate and inclusive, We are always learning, We each have a voice	To ensure BME staff have equal opportunities for career progression or promotion	➤ Ensure mentorship and development plans are in place for aspirant BME nurses and midwives	Head of EDI/Head of Leadership & OD	1 October 2025 – 31 August 2026	

	that counts, We are a team, We are recognised and rewarded					
7.	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (BME staff – declined ↓ 58% to 56.3%) White staff – 68% High Impact Action 2 People Promise – We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are a team, We are recognised and rewarded	To ensure BME staff have equal opportunities for career progression or promotion	➤ Continue to explore barriers and opportunities for career and personal development	Head of EDI/Head of Leadership & OD	1 October 2025 – 31 August 2026	
			➤ Work with the staff network and promote targeted resources for development / training programmes / skills and competencies, coaching/mentoring shadowing	Head of EDI / EDI Lead, L&OD Manager	1 October 2025 – 31 August 2026	
			➤ Continue with delivery of nursing career clinic and evaluate outcomes	Associate Director of Professions	1 October 2025 – 31 August 2026	

7.	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (BME staff – declined ↓ 58% to 56.3%) White staff – 68% High Impact Action 2 People Promise – We are compassionate and inclusive, we are always learning, we each have a voice that counts, we are a team, We are recognised and rewarded	To ensure BME staff have equal opportunities for career progression or promotion	➤ Continue with BME Action learning Group and peer support and evaluate its impact	Head of Leadership & OD / Staff Network Chair	1 October 2025 – 31 March 2026	

KEY RAG Rating



Complete



On track for delivery



Behind plan and action needed to bring back on target

5.5. Annual Workforce Disability Equality Standard: Pauline Garnett in Attendance

For Assurance/Approval

Presented by Steve Ned



REPORT TO THE BOARD OF DIRECTORS

REF:

BoD: 25/10/02/5.5

SUBJECT: **WDES ANNUAL REPORT AND ACTION PLAN 2025**

DATE: 2 October 2025

PURPOSE:		Tick as applicable			Tick as applicable
	For decision/approval	✓		Assurance	✓
	For review			Governance	✓
	For information	✓		Strategy	

PREPARED BY: Pauline Garnett, Head of Equality, Diversity & Inclusion, Leeann Newsome, Inclusion & Wellbeing Administration Support Officer
Roya Pourali, Equality, Diversity & Inclusion Lead

SPONSORED BY: Steven Ned, Director of People

PRESENTED BY: Steven Ned, Director of People

STRATEGIC CONTEXT

This report supports the strategic aims of the National People Plan and the Trust Strategic objectives and goals (2022-2027)

Best for People

We will make our Trust the best place to work by:

- Ensuring a caring, supportive, fair and equitable culture for all
- Creating an organisational climate that supports Equality, Diversity and Inclusion

EXECUTIVE SUMMARY

Key Highlights:

- **Workforce Representation:** Disabled workforce representation increased from **5.16% to 5.99%**, reflecting progress across clinical and non-clinical bands
- **Presenteeism:** Reduced from **27% to 21.6%**, indicating improved wellbeing support.
- **Workplace Adjustments:** Remain strong despite a slight decline from **85.4% to 84.5%**.
- **Staff Engagement:** Disabled staff engagement score remains stable at **6.8**.
- **Capability:** No disabled staff entered formal capability processes

Persistent Challenges:

- **Recruitment:** Disabled applicants are **1.38** times less likely to be appointed from shortlisting compared to non-disabled staff.
- **Harassment and Bullying:** Disabled staff continue to report higher rates of abuse from patients, managers, and colleagues than non-disabled staff.
- **Feeling Valued:** Only **42.3%** of disabled staff feel valued, compared to **51%** of non-disabled staff.
- **Board Representation:** There continues to be **no** disabled representation at board level, with a consistent **-6%** gap compared to the overall workforce.

- **Workplace Adjustments:** Although strong scores, staff network feedback highlights inconsistency in the implementation of workplace adjustments.

Key Priorities for 2025/26:

Informed by the 2024/25 findings and aligned with the Trust's strategic objectives, the following priorities will guide our efforts to strengthen equality, diversity and inclusion and enhance staff experience. These are supported by a detailed action plan included within this report.

- **Workforce Representation & Disability Declaration:** Although declared representation has increased from **5.16% to 5.99%**, anonymous staff survey data indicates that **24.9%** of respondents identified as having a disability or long-term condition (broadly in line with national NHS survey findings). This significant gap highlights the need to build confidence in disability disclosure and improve data quality through inclusive engagement and collaboration with staff networks.
- **Bullying, Harassment & Abuse:** Strengthen preventative approaches and embed lived experience into training and support, ensuring staff feel safe and respected in the workplace
- **Workplace Adjustments:** Improve consistency and timeliness through close collaboration with staff networks and support teams including Occupational Health & Wellbeing and Human Resource Business Partners (HRBPs)
- **Board Representation:** Increase visibility and representation of disabled staff at senior levels

Inclusive recruitment work is currently actively underway via the Inclusive recruitment Task & Finish Group. WDES key priorities have been streamlined to ensure they are both realistic and achievable.

Summary:

The Trust remains committed to fostering a fair, inclusive, and compassionate workplace where disabled staff are not only supported but empowered to thrive. The accompanying action plan outlines the next phase of this work, ensuring that equity is embedded in every aspect of the Trust's culture

RECOMMENDATION

The Board of Directors is requested to acknowledge the contents of this report for ratification, ahead of it's submission to the NHSE National Mandated Standards team. Upon approval, the report will be published on the Trust's website by the deadline 31 October 2025.



WORKFORCE DISABILITY EQUALITY STANDARD



WDES Annual Report and Action Plan 2025

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Background

The Workforce Disability Equality Standard (WDES) is a key national framework because research consistently shows that a motivated, included, and valued workforce is essential for delivering high-quality patient care, improving patient safety, and enhancing patient satisfaction.

Retaining experienced and skilled employees who acquire an impairment offers significant benefits compared to recruiting and training new staff. This approach not only supports the individual but also helps create a workforce that reflects the diverse communities and patients we serve.

The Trust’s strategic objectives, underpinned by the People Plan, aim to make Barnsley Hospital NHS Foundation Trust the best place to work by fostering a caring, supportive, fair, and equitable culture for all. We are committed to creating an organisational climate that champions equality, diversity, and inclusion, positioning us as an employer of choice. Our focus is on maintaining a compassionate and inclusive culture where diversity is valued and celebrated, while prioritising staff health and wellbeing.

In line with our Public Sector Equality Duty, the Trust is dedicated to embedding equality, diversity, and inclusion across all areas. This includes eliminating unlawful discrimination, harassment, and victimisation; advancing equality of opportunity; and fostering good relations.

Disabled staff bring invaluable lived experience and expertise of healthcare services and health conditions into the NHS workforce. Building and sustaining the NHS as a disability-inclusive employer delivers multiple benefits for patients, service users, and staff alike.

The WDES comprises of ten specific metrics that enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. These metrics allow us to measure progress year-on-year, identify good practice, and benchmark performance regionally, nationally, and by Trust type. The data informs an action plan that builds on the high-impact actions within the EDI improvement plan.

Similar to the Workforce Race Equality Standard (WRES), WDES is included in the NHS Standard Contract, and performance outcomes may be considered during Care Quality Commission (CQC) inspections under the ‘Well-Led’ domain. There is a statutory requirement to publish our WDES metrics and action plan internally and externally on the Trust’s website by 31 October 2025

The following three high priority areas below were identified for improvement from the national WDES team based on the WDES 2024 data returns. These areas are among the lowest percentile rankings compared to other Trusts.

WDES Key progress in 2024/25

High priority areas for improvement within the Trust (to a maximum of three): 2023	Status

Indicator 4c: Harassment, Bullying or Abuse from other colleagues in last 12 months	BME staff 23.2%  21.7% White staff 13.9%
Indicator 6: Presenteeism – Feeling pressure to come to work despite not feeling well to perform their duties	Improved from 27% to 21.6% 
Indicator 10: Board representation	Unchanged None 

Interventions have been incorporated under each relevant metric within the WDES report, highlighting both progress and the specific actions taken or planned.

Where applicable, previously outlined initiatives are referenced to avoid duplication and ensure consistency across the report.

WDES Metrics – 2024/2025

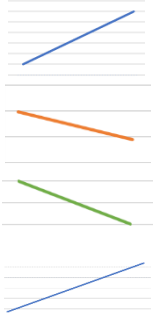
WDES METRICS 2024/2025

Workforce indicators

For each of these four workforce indicators, compare the data for disabled and non-disabled staff

1. Workforce Representation – Overall staff with a disability 5.99% ▲ (positive increase) previous year 5.16%		Trend
2. Relative likelihood of disabled applicants being appointed from shortlisting across all posts compared to non-disabled applicants	1.38 ▲ (negative increase) previously 1.14 showing equity of opportunity for applicants being shortlisting across all posts	
3. Relative likelihood of disabled staff entering formal capability processes compared to non-disabled staff	0.0 (unchanged) Disabled staff more likely entering formal capability. This has stayed the same as in previous years 0.0 2024 and 0.0 2023	

National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for disabled and non-disabled staff

4. Percentage of disabled staff experiencing bullying, harassment & abuse from: - Patients/Service users/Relatives/Public - Managers - Colleagues - Reporting Incidents	28.98% ▲ Non-disabled 22.71% (negative increase) Previously 27.8% 10.2% ▼ Non-disabled 4.7% (improvement) Previously 10.5% 21.7% ▼ Non-disabled 13.1% (Improved) Previously 23.2% 60.5% ▲ Non-disabled 51.8% (improvement) Previously 56%	
5. Percentage believing the Trust provides equal opportunities for career progression and promotion	Disabled 63.7% ▼ (Negative decrease) Previously 64.4% - Non-disabled 67.8%	
6. Pressure to come to work despite not feeling well enough to perform duties	Disabled 21.6% ▼ (improvement) Previously 27% - Non-disabled 18%	
7. Feeling valued – Extent to which organisation values their work	Disabled 42.3% ▼ (slight decline) Previously 42.7% - Non-disabled 51%	
8. Workplace adjustments to enable Disabled staff to carry out their work.	84.5% ▼ (slight decline) Previously 85.4%	
9. Staff engagement	6.8 ➡ (no change) Previously 6.8 - Non-disabled 7.2	
10. Board representation	Exec = 0.0% Non-exec = 0.0% Voting = 0.0% Non-voting = 0.0%	

WDES Metrics

Metric 1 – Workforce representation – Percentage of disabled staff in each Agenda for Change Bands 1-9 and VSM compared with percentage of non-disabled staff

Non-Clinical Band Clusters	2023		2024		2025	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Bands 1 - 4	5.4%	90.8%	5.7%	91.1%	↑ 6.90%	90.60%
Bands 5 - 7	5.7%	90.9%	7.0%	88.2%	↑ 8.40%	86.60%
Bands 8a – 8b	6.7%	93.3%	7.5%	92.5%	↑ 8.20%	91.80%
Bands 8c – 9 & VSM	0.0%	85%	0.0%	84%	↑ 3.10%	90.60%

Clinical Band Clusters	2023		2024		2025	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Bands 1 - 4	3.0%	91.3%	4.0%	91.6%	↑ 5.60%	90.20%
Bands 5 - 7	5.3%	90.8%	6.0%	90.0%	↑ 6.40%	87.20%
Bands 8a – 8b	5.2%	94.8%	8.1%	89.5%	↑ 10.90%	87.60%
Bands 8c – 9 & VSM	0.0%	100%	0.0%	100%	↑ 7.70%	84.60%
Medical, Dental staff, Consultants	0.55%	97.27%	0.54%	96.8%	↑ 1.03%	96.41%
Medical, Dental staff, Non-Consultant career grade	0.0%	98.8%	0.0%	98.7%	→ 0.00%	98%
Medical, Dental staff, Medical and Dental trainee	5.6%	92.8%	3.6%	90.8%	↓ 2.09%	93.19%

Across both clinical and non-clinical clusters, there has been a positive shift in disabled staff representation, reflecting growing awareness and action on workplace inclusion at the Trust.

Non-Clinical Band Clusters

All non-clinical bands showed improvement, with the highest proportion found in Bands 5–7, rising from **7.0% in 2024 to 8.4% in 2025**.

The most significant rise occurred in Bands 8c–9 & VSM, jumping from **0.0% to 3.1%**, indicating a breakthrough in senior-level inclusion.

Notably, Bands 5–7 also saw a **1.4 percentage point** increase, reinforcing mid-level progress.

Clinical Band Clusters

Bands 8a–8b rose from **8.1% to 10.9%**, a **2.8 percentage point** improvement.

Bands 8c–9 & VSM reflected the same upward trend seen in the non-clinical cluster, Dramatic increase in this clinical band from **0.0% to 7.7%**.

Medical & Dental Consultants improved from **0.54% to 1.03%**, showing progress in senior clinical roles.

However, Medical & Dental trainees declined from **3.6% to 2.09%**, highlighting an area for further investigation and targeted support.

Staff Survey vs ESR Records

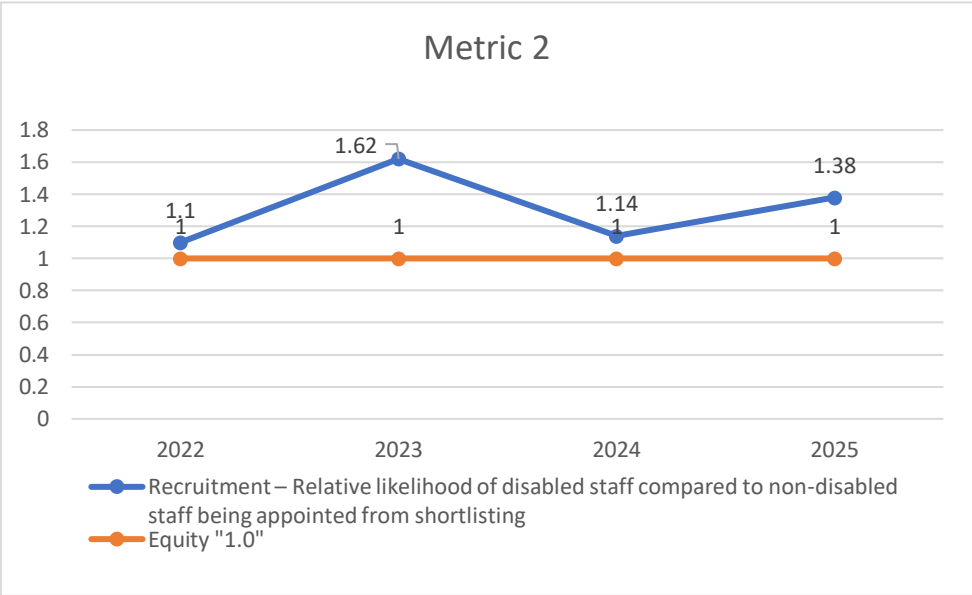
In the 2024 anonymised NHS Staff Survey, **560 out of 2,253** respondents declared a disability equating to **24.86%**.

This contrasts sharply with the overall workforce representation of **5.99%**, which is an increase from **5.16%** in the previous reporting period.

The gap between the staff survey declarations and ESR records highlights the importance of encouraging staff to update their disability status in ESR. Ensuring accurate and complete data enables the development of equitable inclusion strategies that genuinely reflects the needs and lived experiences of disabled staff.

Metric 2 – (Data source: Trust’s HR data)

Relative likelihood of disabled applicants being appointed from shortlisting across all posts compared to non- disabled applicants

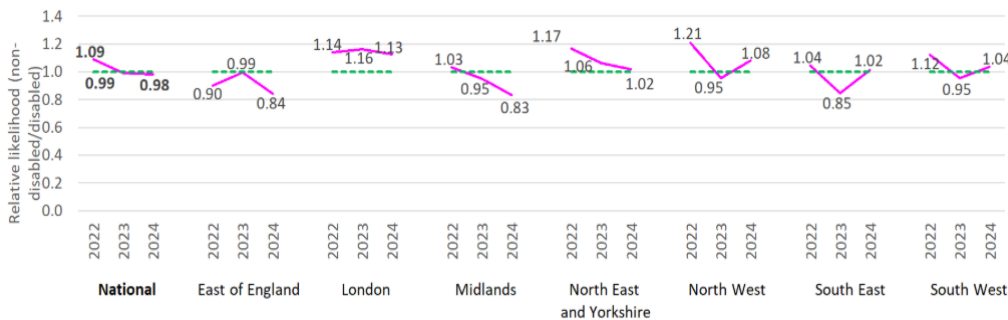


2.The data shows a shift in the relative likelihood of appointment from shortlisting, with non-disabled applicants being **1.38** times more likely to be appointed than disabled applicants, an increase from **1.14** the previous year. It indicates a disparity in recruitment outcomes. A value of **1.0** represents equity, and the current figure highlights the need for continued focus on inclusive recruitment practices.

Interventions taken:

- **Inclusive Recruitment Training:** The ongoing refreshed Proud to Manage and former Passport to Management programme includes inclusive recruitment and selection practices, ensuring managers are equipped to make fair and objective decisions.
- **Disability Confident Employer Status:** This accreditation is actively promoted in recruitment campaigns, showing the Trust’s commitment to being an inclusive employer.
- **Guaranteed Interview Scheme:** Applicants who meet the minimum criteria and declare a disability continue to be offered guaranteed interviews, helping to remove barriers at the shortlisting stage.
- **Task and Finish Group:** A dedicated Inclusive Recruitment Task and Finish Group has been established to review recruitment data, identify gaps, and recommend improvements

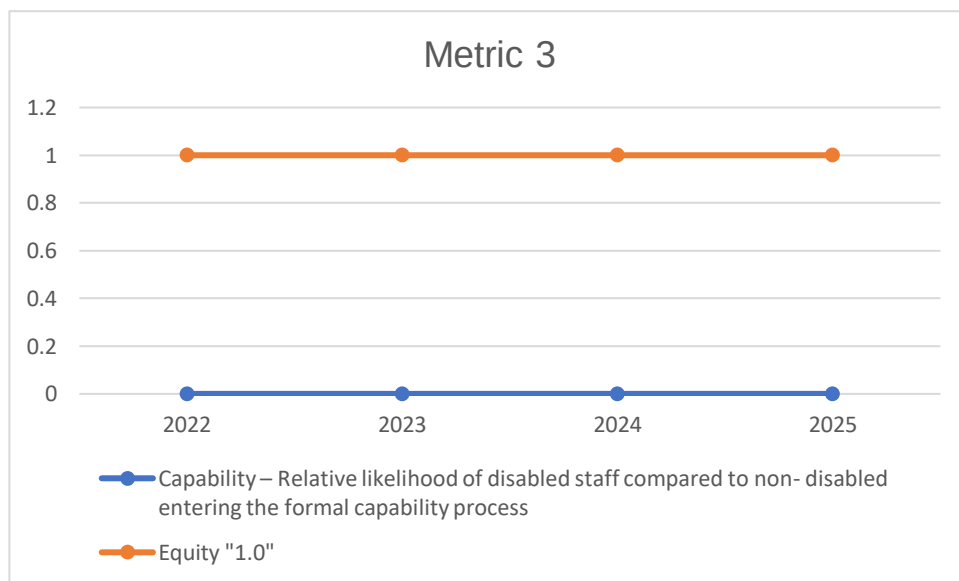
National Data



Metric 3 – Capability (Data source: Trust's HR data)

A figure above 1.00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process (on grounds of performance).

This metric is based on data from a two-year rolling average of the current year and the previous year.



3. The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process has remained consistent at **0.0%**. This sustained trend reflects the Trust's proactive and preventative approach to performance management, ensuring that staff are supported early and equitably.

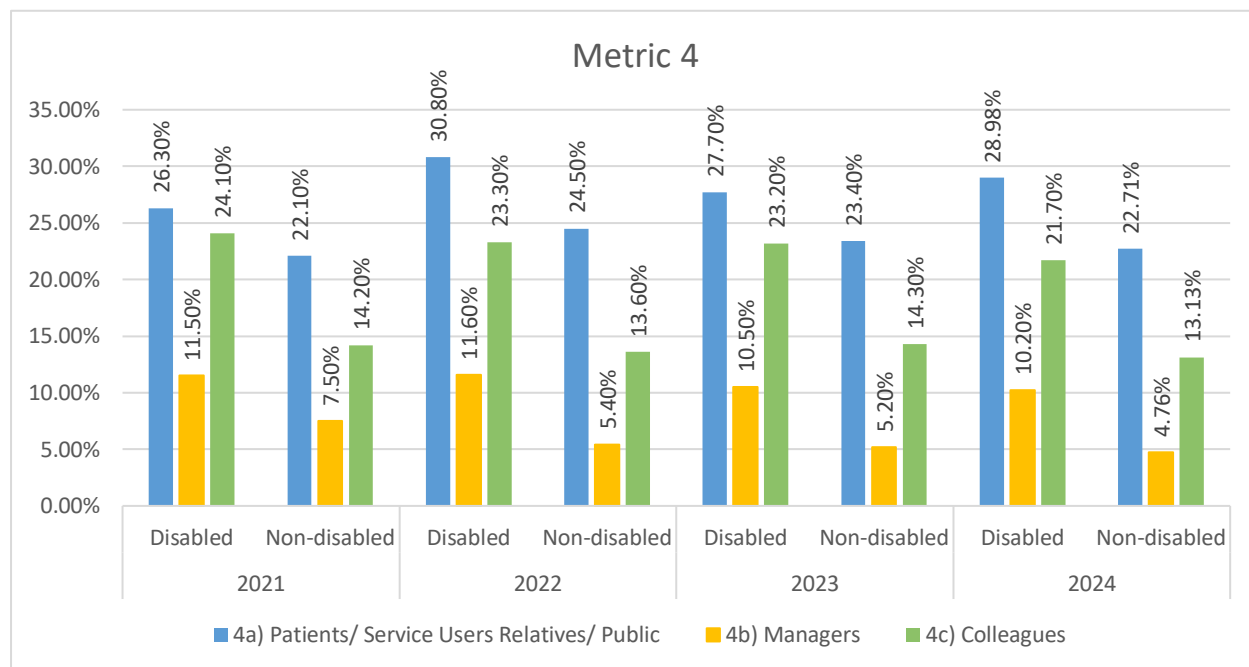
Interventions taken:

- **Early Resolution Focus:** Managers are trained to identify and address performance concerns informally, reducing the need for formal capability processes.
- **Proud to manage training:** This programme equip staff in managing performance, grievances, and disciplinary procedures with an emphasis on equity and disability awareness.
- **Monitoring and Assurance:** Capability figures are regularly reviewed to ensure consistency and fairness across departments, with a focus on continuous improvement.
- **Mediation Support:** Available to support staff with workplace disputes or conflict to see informal resolution and prevent escalation of workplace matters

National Data



Metric 4 - Harassment, bullying or abuse from patients/service users/ public (Obtained from the staff survey)

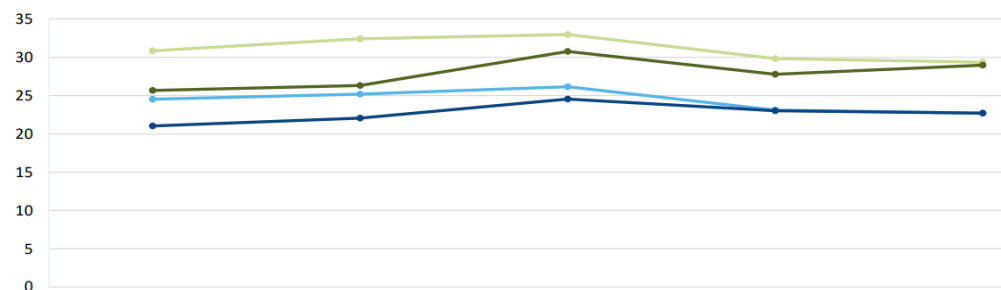


Staff Survey Result

4a

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	25.67%	26.33%	30.77%	27.78%	28.98%
Staff without a LTC or illness: Your org	21.03%	22.05%	24.55%	23.01%	22.71%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
Staff with a LTC or illness: Responses	409	471	494	525	559
Staff without a LTC or illness: Responses	1431	1501	1552	1610	1678

4a. Patients/Relatives/Public –

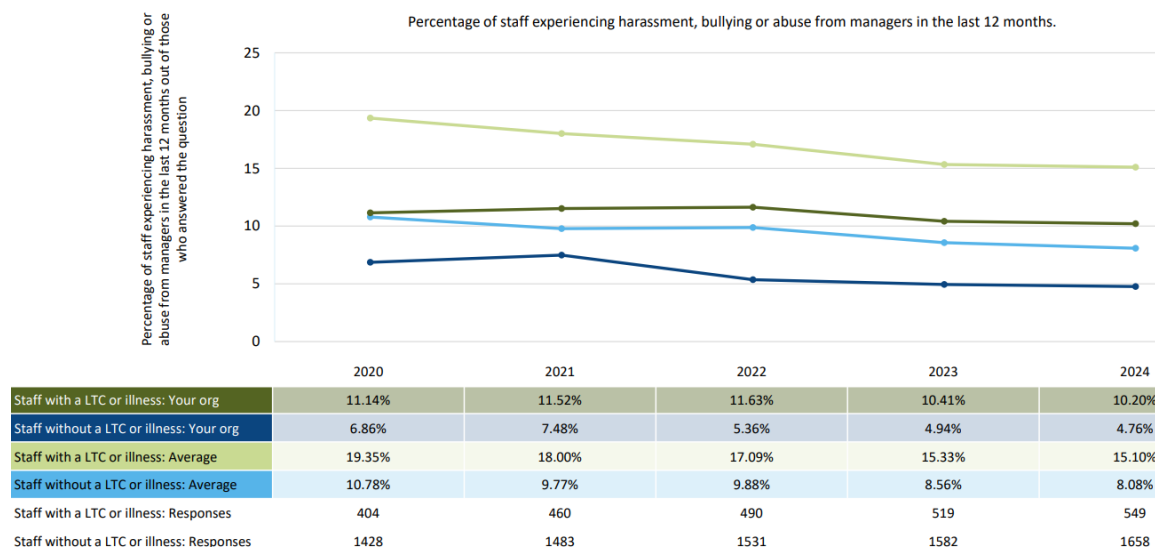
The percentage of disabled staff experiencing harassment, bullying, or abuse from patients, relatives, or members of the public has increased by **1.2 percentage points**, rising from **27.7% in 2023 to 28.9% in 2024**. In contrast, the figure for non-disabled staff has improved, decreasing from **23.4% to 22.7%** over the same period. This persistent gap highlights that disabled staff continue to be disproportionately affected by negative behaviours from patients/relatives/public

Interventions taken and planned:

- **Ongoing Respect campaigns:** Supported by the Violence & Aggression Management Group aim to raise awareness and promote respectful behaviours across the Trust.
- **Incident Analysis:** Reported incidents are regularly reviewed to identify trends, themes, and hotspot areas for targeted action.
- **Body Camera:** In high-risk departments, body are used to deter aggression and support staff safety.
- **Staff Network Engagement:** The Disability Staff Network, known as the Ability staff network provides a safe space for staff to share experiences and access peer support.
- **Courageous Conversations Training:** Available to all staff to build confidence in addressing inappropriate behaviours.
- **Freedom to Speak Up:** The guardian continues to engage with staff and encourage reporting of incidents, ensuring concerns are heard and acted upon.
- **Promote Allyship behaviours –** Empower staff to speak up and support staff who may be experiencing negative behaviours

Metric 4 – Harassment, bullying or abuse from managers (Obtained from the Staff survey results)

4



4b. Managers: The percentage of disabled staff experiencing harassment, bullying, or abuse from managers has slightly improved, decreasing from **10.5% in 2023** to **10.2% in 2024**. For non-disabled staff, the figure also declined from **5.2% to 4.7%**. These improvements are encouraging but the data reveals a persistent gap: disabled staff are **5.5 percentage points** more likely to report negative experiences with managers than their non-disabled colleagues.

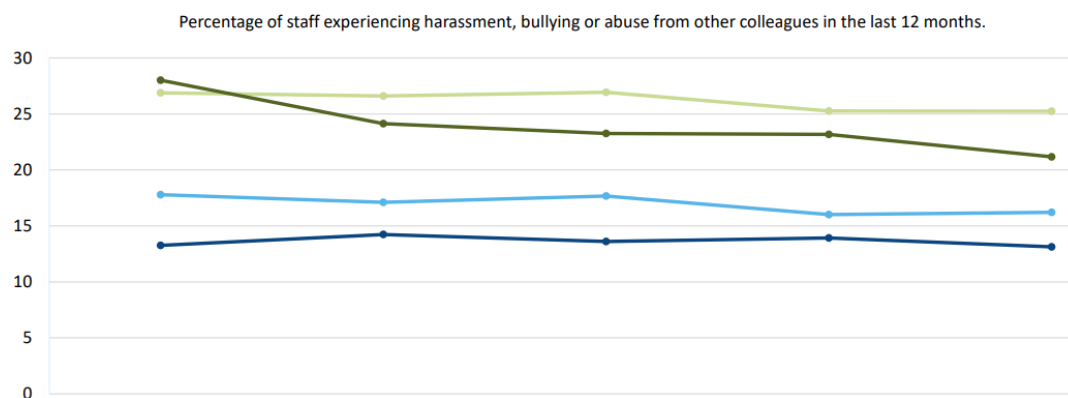
Interventions taken and planned:

- **Ability staff network:** The staff network continues to provide a confidential and supportive environment for disabled staff to share concerns and access peer support.
- **Freedom to Speak Up:** The Guardian actively engages with staff across the Trust, encouraging open dialogue and ensuring concerns are addressed.
- **EDI Mandatory Training:** Virtual training was introduced last year to complement the existing e-learning training and improve accessibility. The training has been well received by staff and positive feedback highlighting its relevance in raising awareness and promoting inclusive workplace behaviours
- **Inclusive Leadership Development:** The Proud to Manage and the former Passport to Management programme equip managers with inclusive leadership skills
- **Allyship campaigns** – Empowering staff to speak up and support colleagues who may be experiencing negative behaviours. Further campaigns are planned to encourage staff engagement and raise awareness
- **Neurodiversity, Workplace adjustment guides:** Managers have access to practical guides that support neurodivergent and outline workplace adjustment. These resources help ensure staff function effectively and feel valued, contributing to an inclusive culture.

Metric 4 – Harassment, bullying or abuse from colleagues (Obtained from the Staff survey results)

4c)

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



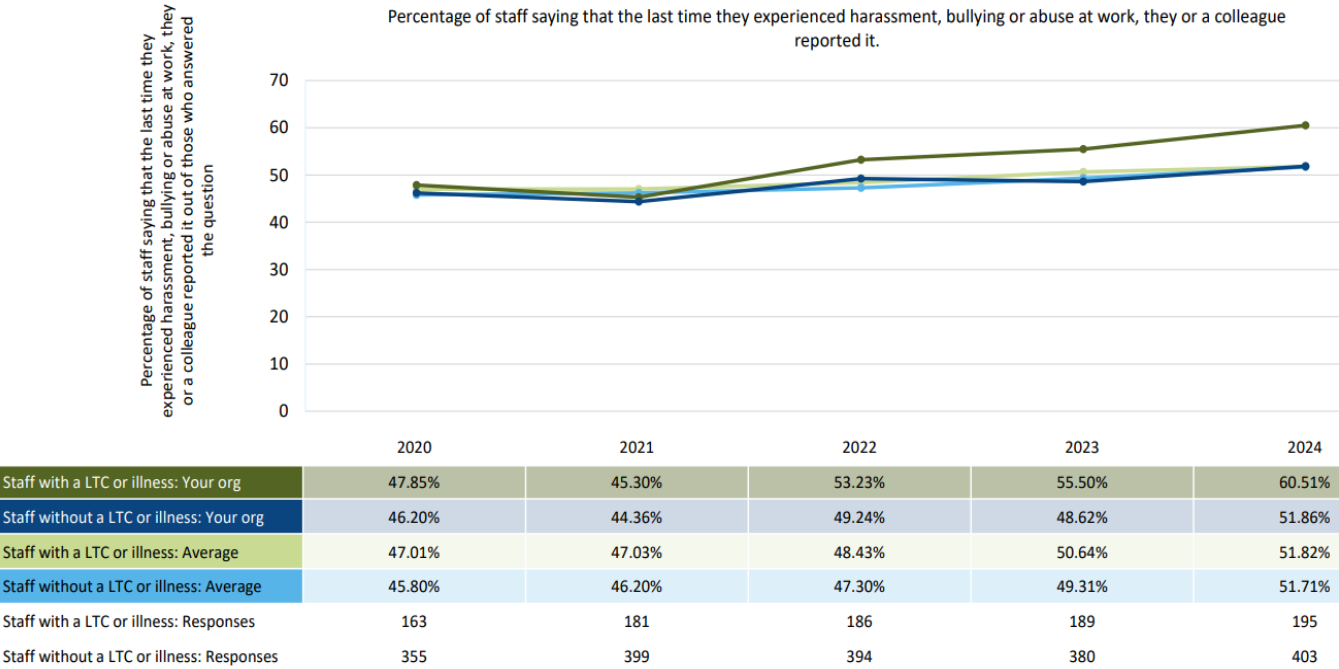
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	28.01%	24.13%	23.25%	23.17%	21.17%
Staff without a LTC or illness: Your org	13.25%	14.23%	13.60%	13.92%	13.13%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	407	460	486	518	548
Staff without a LTC or illness: Responses	1426	1483	1529	1581	1653

4c. Colleagues: The percentage of disabled staff experiencing harassment, bullying, or abuse from colleagues has improved, decreasing from **23.2% in 2023 to 21.7% in 2024**. For non-disabled staff, the figure also declined from **14.3% to 13.1%**. Despite this progress, disabled staff remain **8.6 percentage points** more likely to report such experiences compared to non-disabled staff. The disparity highlights the need for continued focus on fostering respectful compassionate and inclusive culture.

Interventions taken: (As outlined in Metric 4b)

- **Ability Staff Network:** Continues to provide a safe space for staff to raise concerns and access peer support.
- **Freedom to Speak Up initiatives and mandatory training:** Strengthened efforts to encourage open reporting, trust and ensure accountability across all levels of the Trust
- **Inclusive leadership training and cultural engagement events,** Initiatives such as the Proud to Care Conference, reinforce expectations around respectful workplace behaviours.
- **Allyship campaigns** – Empowering staff to speak up and support staff who may be experiencing negative behaviours

Metric 4 – Harassment, bullying or abuse - Reporting Incidents (Obtained from the Staff survey results)



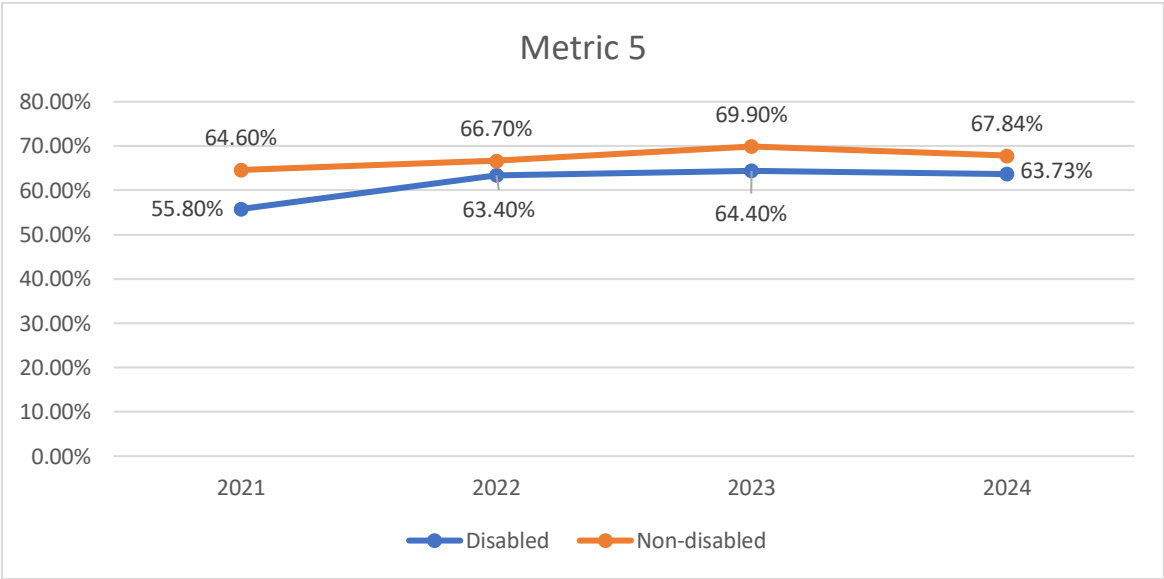
4d. Reporting Incidents:

The percentage of disabled staff reporting incidents of harassment, bullying, or abuse at work has increased from **55.5% in 2023 to 60.5% in 2024**, indicating a positive shift in confidence to speak up. For non-disabled staff, the reporting rate also improved from **49% to 51.8%**. These increases reflect the Trust’s efforts to foster a culture of openness and psychological safety. Although progress is evident, disabled staff remain more likely to report such incidents, which may reflect both a higher prevalence of negative experiences and a stronger engagement with support mechanisms.

Interventions taken:

- **Freedom to Speak Up Guardian:** Actively engages with staff across the Trust, promoting awareness and accessibility of reporting channels.
- **Ability Staff Network:** Reinforcing the importance of speaking out sharing lived experiences and promoting reporting pathways.
- **Courageous Conversations Training:** Equip staff and managers with the skills to address difficult issues constructively.
- **Counselling Support:** Available through in-house services and the Vivup Employee Assistance Programme, ensuring staff have access to emotional and psychological support.

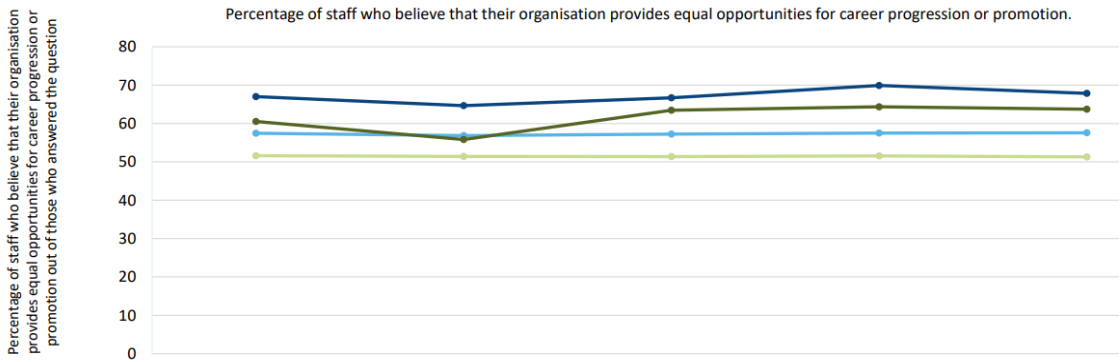
Metric 5 – Career Progression (Metric obtained from the Staff survey)



5. The data shows **63.7%** of disabled staff believed they had equal opportunities for career progression or promotion, a slight decrease from **64.4% in 2023**. In comparison, **67.8%** of non-disabled staff reported the same, highlighting a **4.1 percentage point** gap in perception between the two groups.

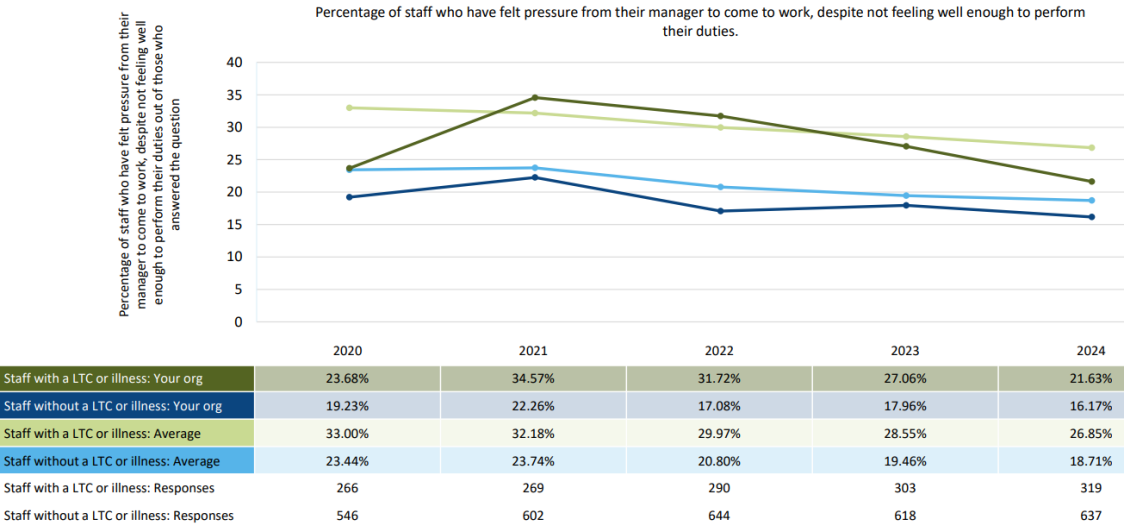
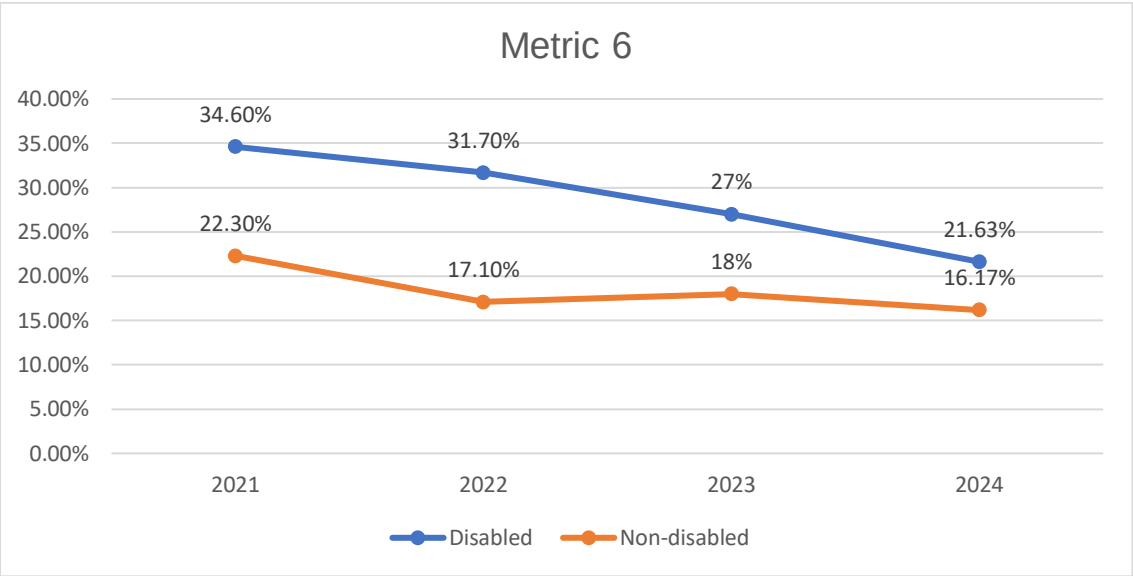
Interventions taken and planned:

- **Ability Staff Network:** Continues to provide a safe space to share concerns and access peer support related to career development
- **Collaboration with Learning & OD:** The Learning and Organisational Development team has engaged with the staff network to promote development opportunities, including coaching, mentoring, and talent management programmes.
- **Professional development opportunities:** Key resources and opportunities are shared directly with network members to improve awareness and participation



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	60.54%	55.82%	63.45%	64.35%	63.73%
Staff without a LTC or illness: Your org	67.01%	64.64%	66.69%	69.91%	67.84%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	408	464	487	533	557
Staff without a LTC or illness: Responses	1437	1482	1531	1655	1651

Metric 6 – Presenteeism (Metric obtained from the Staff survey)

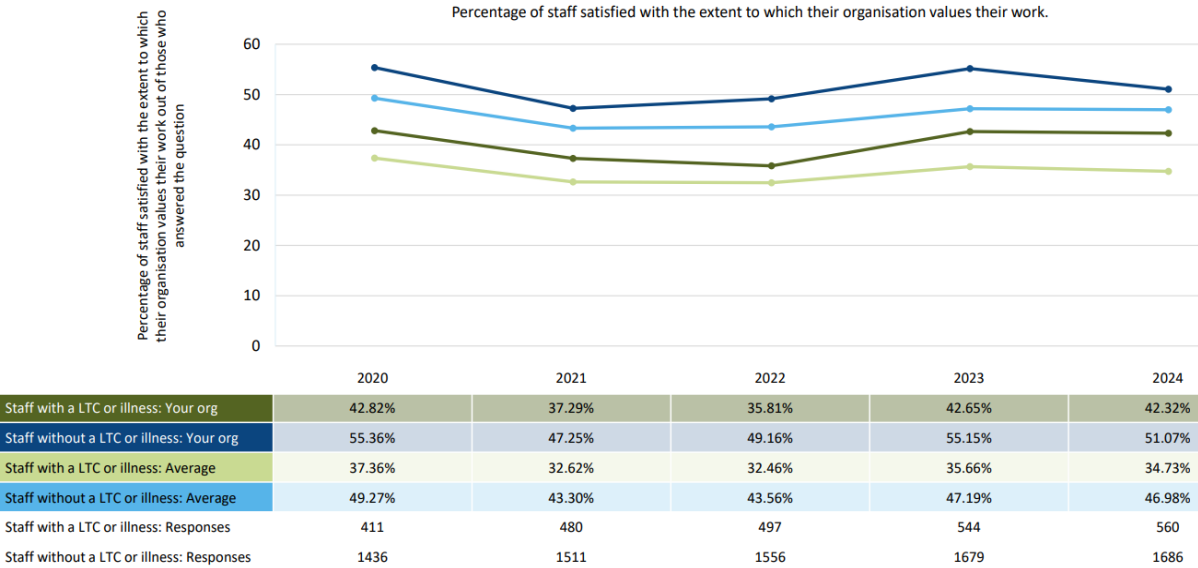
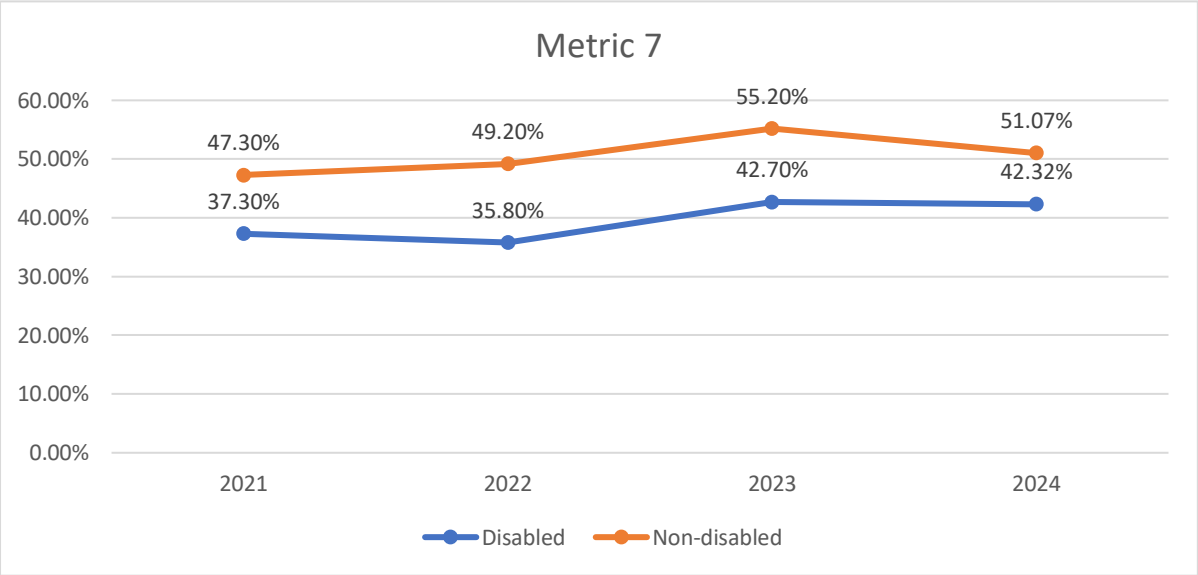


6. There has been an improvement in the percentage of disabled staff feeling pressure to attend work despite not feeling well enough to perform their duties, decreased from **27% to 21.6%**, a **5.4 percentage point** improvement. This reduction reflects the positive impact of targeted wellbeing interventions. However, disabled staff remain **5.5 percentage points** more likely than non-disabled staff to report this experience (**21.6% vs 16.1%**), indicating further progress is needed to close the gap.

Interventions taken and planned:

- **Proud to Manage Training:** Covers performance, discipline, grievance, and sickness absence, with emphasis on disability-related considerations and early support.
- **Neurodiversity Guide:** Developed to support neurodivergent colleagues and raise awareness. Further promotion is planned
- **Lived Experience Sharing:** Stories and insights from neurodivergent staff have been shared to build empathy and understanding.
- **Workplace Adjustment Guide:** Created in response to staff feedback to support managers and staff implement reasonable adjustments.
- **Health & Wellbeing Passport:** Embedded across departments to facilitate open conversations between staff and managers about health needs and workplace support.
- **Supporting Staff Attendance Policy:** Implemented for line managers to enable compassionate and effective attendance conversations.
- **Flexible Working Policy:** Developed to improve work-life balance and reduce pressure on staff to attend work when unwell.

Metric 7 Feeling Valued (Metric obtained from the staff survey)

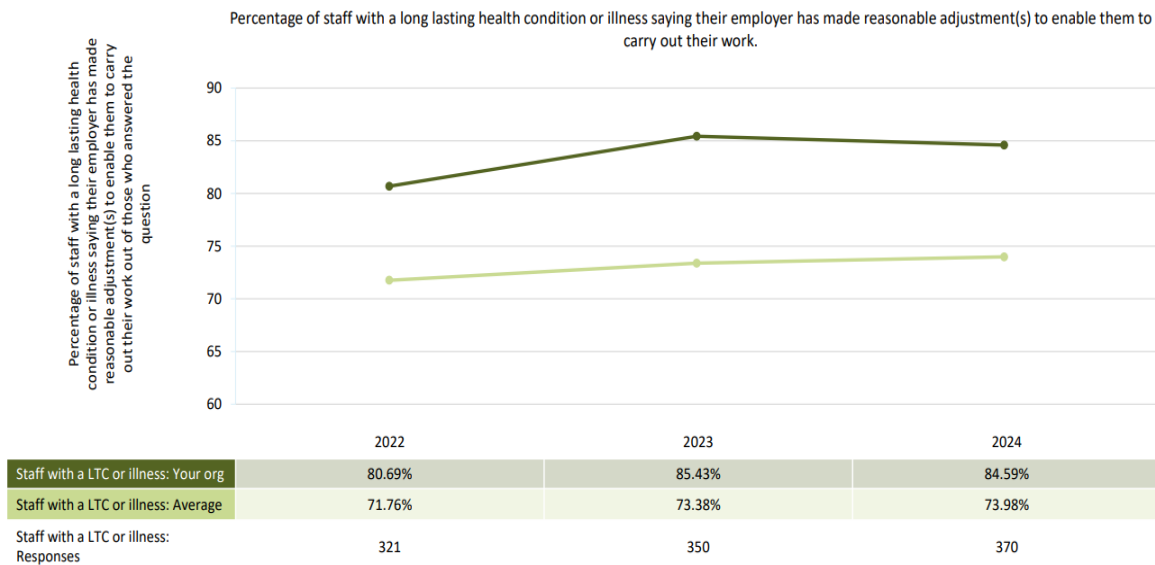
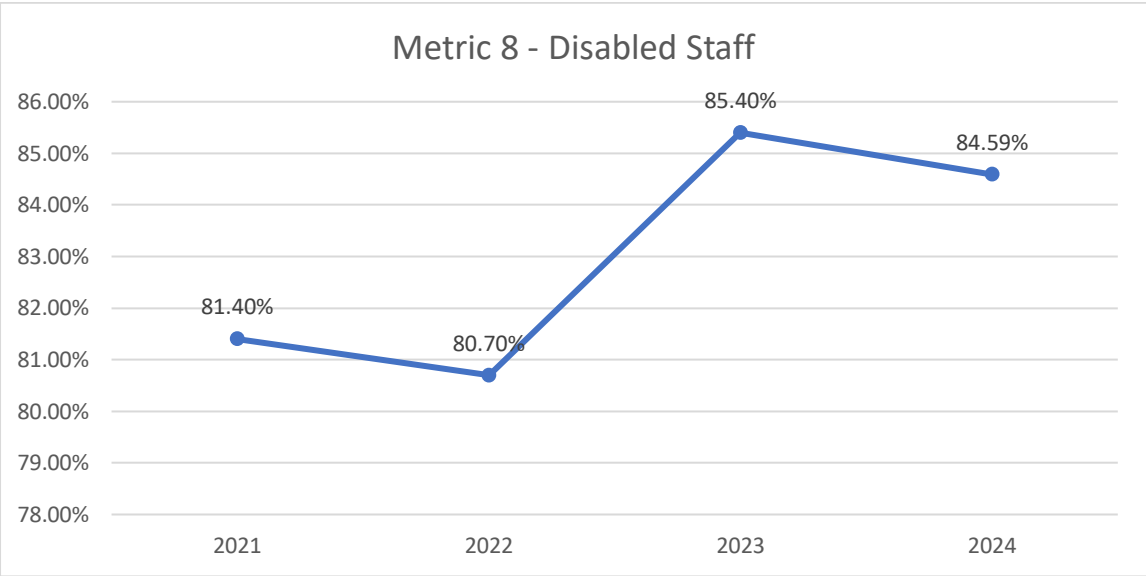


7. Disabled staff are **8.7 percentage points** less likely to say that they feel their organisation values their work when compared to non-disabled staff (**42.3% vs 51%**). This disparity highlights the continuing need for targeted interventions to foster inclusion and wellbeing.

Interventions taken and planned:

- **Staff network:** Disabled and neurodivergent staff network are actively encouraged to participate in related network events and share experiences to influence change
- **Trust Chair:** Regular meetings are held with the with the Trust Chair and staff network members to maintain open dialogue and influence key decisions
- **Thriving Together conference:** was held to promote the staff networks, engage with members, share information and celebrate achievements and drive change
- **Health & Wellbeing Strategy:** The newly developed strategy will be launched, implemented and embedded to create a safe, inclusive culture, where staff feel heard and supported and valued through targeted wellbeing initiatives
- **Human Library:** Creating a safe space where staff felt empowered to openly share their lived experiences with senior leaders to increase understanding and promote inclusive leadership

Metric 8 - Workplace adjustments to enable disabled staff to carry out their work (Metric obtained from the staff survey)

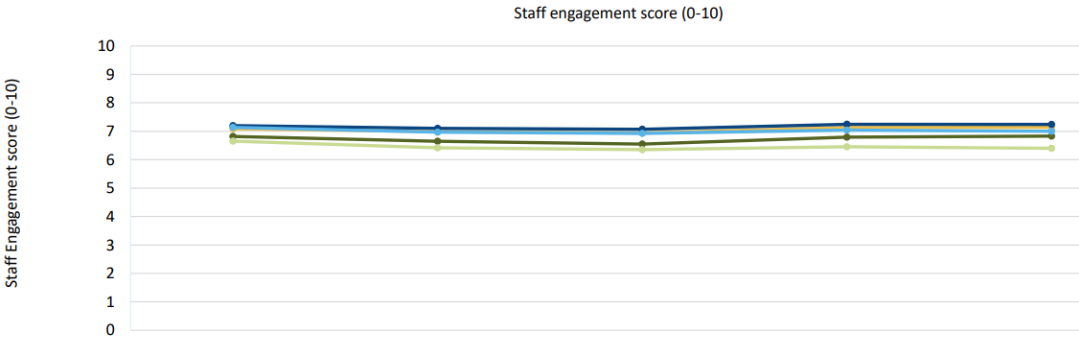
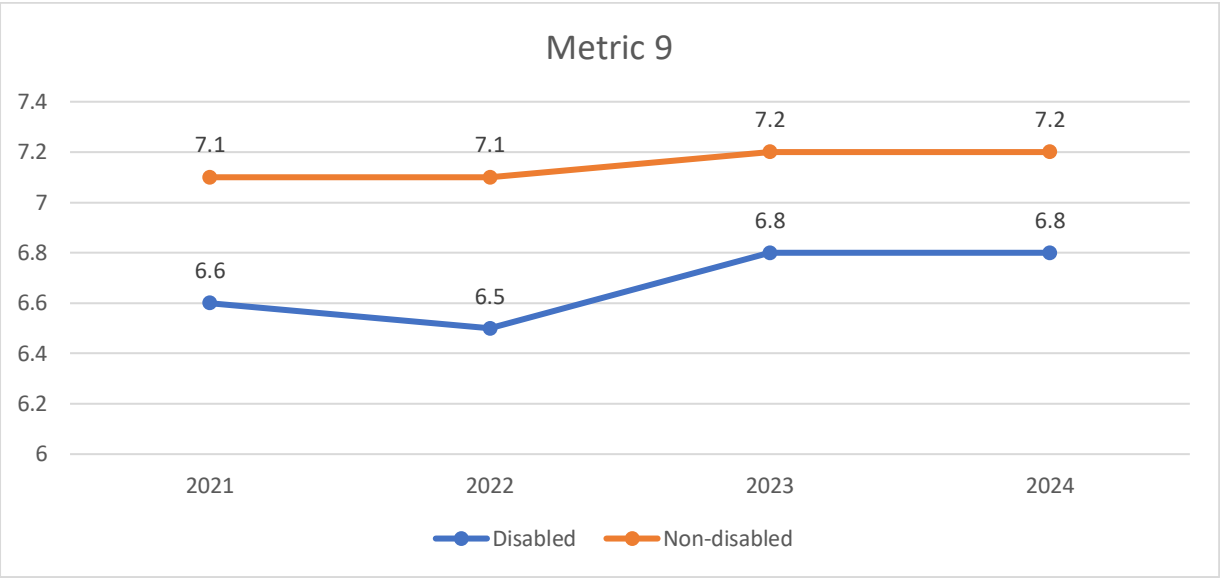


8. **84.5%** of disabled staff reported they had adequate adjustments to enable them to perform their duties. This shows a slight decrease of **0.9 percentage point** increase from 2023.

Interventions taken and planned:

- **Health & Wellbeing Passport:** Embedded across departments to facilitates open conversations between staff and managers about health needs and workplace support
- **Flexible policy:** Promotes work-life balance and is integrated with the wellbeing passport process. Adjustments are tracked and reviewed in line with policy guidance
- **Staff with Disabilities Guidance for Managers:** Provide Access to work guidance to equip managers to advise staff on grants and support available for workplace adjustments
- **Neurodiversity guide:** Created to support neurodivergent colleagues and will be promoted further
- **Health & Wellbeing Strategy:** To be launched and embedded, mapping wellbeing interventions across the employee lifecycle, including work design and psycho-social risk management

Metric 9 – Disabled staff engagement - (Data source: NHS Staff Survey)



	2020	2021	2022	2023	2024
Organisation average	7.09	6.99	6.94	7.13	7.14
Staff with a LTC or illness: Your org	6.82	6.65	6.55	6.79	6.83
Staff without a LTC or illness: Your org	7.20	7.10	7.07	7.24	7.24
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	414	479	497	545	560
Staff without a LTC or illness: Responses	1447	1515	1558	1687	1690

9a. The overall staff engagement score remains at **6.8**, unchanged from the previous year. However, disabled staff report a lower engagement score compared to **7.2** for non-disabled staff, reflecting a **0.4** point gap.

Interventions taken and planned:

- **Ability Staff network:** Provides a safe, supportive platform for disabled staff to connect, share experiences and influence change
- **Trust Chair, Executive Sponsor:** Regular meetings with the Trust Chair and Executive Sponsor, Michael Wright to ensure that disabled staff concerns are heard and acted upon at senior levels
- **Thriving Together conference:** Celebrated achievements, promoted the staff networks and an opportunity to engage with a wide range of staff groups
- **Engagement events:** The network is expanding its reach through events like Disability History Month, Learning Disability Week, and ESR drop-in sessions, which promote visibility and encourage staff to disclose their disability status
- **Policy & Data Influence:** The network contributes to data collection, policy development, and staff survey analysis, ensuring that disabled staff perspectives shape organisational priorities and the WDES actions
- **Allyship Campaign:** A new campaign is being developed to promote allyship across the Trust, encouraging staff to support disabled colleagues and foster inclusive behaviours
- **Executive sponsorship** – Reinforce the strategic importance of inclusion and wellbeing. Supports the Staff Network including the range of events and activities

Metric 10 - Disabled representation at board level

Gap in disabled representation at board level (as at March 2025)	
Overall board	-6
Executive board members	-6
Non-executive board members	-6
Voting board members	-6
Non-voting board members	-6

Disabled Board representation	Disabled 2022	Disabled 2023	Disabled 2024	Disabled 2025
Exec Board Members	0%	0%	0%	0%
Non-Exec Board Members	0%	0%	0%	0%
Voting	0%	0%	0%	0%
Non-voting	0%	0%	0%	0%

No board members have identified as having a disability in 2025 compared to 6% of the overall workforce with a disability

Difference between disabled representation on the board and in the workforce:

Overall Board representation: -6%, Disabled members are underrepresented on the board by one member in terms of headcount

Executive Board membership: -6%

Voting Board membership: -5.16%

Non-voting: -6%, **National average in 2024:** 6.1%

There is an overall consistent gap of -6% in representation for executive, non-executive, voting, and non-voting board members indicating underrepresentation of disabled staff at senior levels

Interventions taken and planned:

This indicator has been prioritised within the Trust’s WDES action plan, with a combination of completed and planned initiatives aimed at closing the representation gap.

Disclosure Support: ESR drop-ins, wellbeing conversations, and visibility campaigns have been actively delivered to foster psychologically safe environments and encourage voluntary disclosure of disability status across all levels.

Leadership Engagement: Collaboration with the Executive Sponsor and Trust Chair has begun to raise awareness and promote inclusive practices. This partnership will continue as part of an ongoing commitment to champion disability inclusion.

Expanded Disclosure Campaigns: Further campaigns are scheduled to strengthen engagement with senior leaders and encourage more staff to voluntarily share their disability status.

Allyship Campaign: Initiative will promote inclusive leadership by equipping senior leaders to actively support disabled colleagues, challenge stigma, and model allyship behaviours across the organisation.

These combined efforts aim to close the representation gap and ensure that board composition better reflects the diversity of the workforce.

Conclusion and next steps for 2025/2026

The Trust remains committed to fostering an inclusive and equitable workplace where disabled staff feel valued, supported and empowered to thrive. The 2024/25 Workplace Disability Equality Standard (WDES) data provides valuable insight into the experiences of disabled staff at the Trust. It reflects encouraging progress in several areas but also highlights persistent challenges that require targeted intervention and sustained leadership commitment and system-wide accountability.

Key Highlights

- **Representation** of disabled staff has increased to **5.99%**, with improvement across both clinical and non-clinical roles.
- **Presenteeism** has reduced to **21.6%**, reflecting a more supportive wellbeing culture.
- **Harassment and bullying**, a priority area in 2023 has shown a slight improvement, though it remains a concern requiring continued focus
- **Workplace adjustments** remain high at **84.5%** indicating a strong uptake, however consistency in delivery remains an area for development.
- **Staff engagement** remains stable at **6.8**, highlighting the need to strengthen inclusion efforts and ensure all staff feel connected and heard.

Ongoing Challenges

- **Recruitment outcomes:** show a widening gap, with disabled applicants **1.38** times less likely to be appointed reinforcing the need to overhaul recruitment practices
- **Feeling valued:** remains lower for disabled staff (**42.3%**) compared to non-disabled peers (**51%**) indicating that work needs to continue with strengthening staff recognition
- **Board representation:** remains at **2024** with a consistent **-6% gap** highlighting the need to diversify leadership and decision-making structures

Work Undertaken: (Based on 2023/24 WDES priorities)

In response to the previous year's WDES priorities, the Trust has taken the following actions;

- **Embedded the Health & Wellbeing Passport:** to enable meaningful conversations between staff and managers about health & wellbeing and reasonable adjustments
- **Established a Recruitment & Selection Task & Finish Group:** active work underway to overhaul recruitment practices, reduce bias and embed inclusive recruitment processes
- **Delivered inclusive recruitment training:** through the refreshed Proud to Manage programme and the former Passport to Management Programme, both of which includes modules on unconscious bias and inclusive practices

- **Rolled out Virtual EDI Mandatory Training:** to complement the existing EDI e-learning, improving accessibility and engagement. The training has been received positively, with excellent feedback from staff across departments
- **Strengthened the Ability Staff Network:** through engagement events, strategic involvement in policy development and active feedback on lived experiences and enhancing visibility and inclusion for disabled staff
- **Promoted disability visibility** through targeted campaigns, engagement events, encouraging staff to share lived experiences and encouraging staff to update their disability status to improve data quality and representation

Next Steps and Future Priorities for 2025/26

The Trust will continue to build on the progress made in 2024/25 by focusing on four key priority areas aligned with the WDES metrics. These will be supported by a detailed action plan included within this report. A strong emphasis will also be placed on embedding inclusive culture through Allyship, peer support and leadership visibility.

Workforce Representation and Disability Declaration

- Promote confidence in sharing disability status and improve data quality through inclusive engagement and collaboration with staff networks.

Harassment, Bullying, and Abuse

- Strengthen preventative approaches, promote inclusive behaviours and embed lived experience into training and support pathways.

Workplace Adjustments

- Improve consistency, timeliness of adjustments through collaboration with the Ability staff network, Occupational health and HR Business partners

. Board Representation

- Increase disabled representation at senior leadership levels, educate leaders on disability inclusion and promote visibility through lived experiences

These priorities reflect the Trust's ongoing commitment to creating an inclusive and compassionate workplace and embedding equality, diversity and inclusion at every level of the organisation. Through the delivery of the 2025/26 action plan, the Trust will ensure that inclusive values are not only recognised but actively demonstrated throughout across all services and departments and foster a culture where difference is respected and all staff are empowered to contribute meaningfully.

The accompanying action plan outlines the specific activities that will support delivery throughout 2025/26 to ensure that equity is embedded in every aspect of the Trust's culture and operations.

The People Committee is asked to note and support the WDES Annual Report and Action Plan 2025 prior to its submission to the Trust Board on 2nd October 2025 for ratification. Following approval, the report will be submitted to the national mandated standards team and be published on the Trust website by the deadline of 31st October 2025.

Workforce Disability Equality Standard (WDES) Action Plan – 2025/2026 Progress

As part of our continued commitment to fostering an inclusive and supportive workplace, we have conducted a comprehensive review of our Workforce Disability Equality Standard (WDES) actions. In collaboration with the Ability Staff Network, we have streamlined our WDES action plan to ensure it remains both realistic and achievable. This focused approach will enable us to concentrate our efforts on key priority areas that will deliver the greatest impact.

Priority Metrics:

- **Metric 1 - Workforce Representation and Sharing Disability Status**
- **Metric 4 - Harassment, Bullying, and Abuse**
- **Metric 8 – Reasonable Adjustments** – Based on the NHS Staff Survey 2024, **84.5%** of disabled staff reported receiving adequate adjustments, a slight decline from **85.4%** (previous year), yet still a strong result. In partnership with the Ability Staff Network, we recognise the importance of consistency and timeliness in implementing workplace adjustments. We will continue to raise awareness and provide targeted guidance to managers and colleagues to ensure all necessary adjustments are made to support disabled staff in performing their roles effectively.
- **Metric 10 - Board Representation**

By focusing on these priority areas, we can make meaningful progress towards a more inclusive and supportive workplace for our colleagues

Metric	WRES indicator Objective	Action/s	Timescale	Lead/s	Progress review	Status
1	Workforce Representation and sharing disability status Increase the number of staff sharing their disability during employment at the Trust Aligns with: People Promise – We are compassionate and inclusive, We are learning, We each have a voice that counts, We are a team (5.2% staff recorded disability on ESR compared to 10.1% of staff survey responds who identified) Workforce Representation and sharing disability status	➤ Work with colleagues to create a safe environment for sharing disability/ long-term condition and respecting those who do not feel comfortable in sharing their status Collaborate with the Ability staff network and the Workforce Information team to launch a communication campaign:	30 November 2024 – August 2025	Ability staff Network, Head of EDI /EDI Lead, HRBP	Ongoing ESR Drop-in session delivered. Workforce representation increased from 5.2 to  5.99%	Amber

	Increase the number of staff sharing their disability during employment at the Trust Aligns with: People Promise – We are compassionate and inclusive, We are learning, We each have a voice that counts, We are a team (5.2% staff recorded disability on ESR compared to 10.1% of staff survey responds who identified)	➤ Promote the benefits of sharing disability status	30 November 2024 – August 2025	Workforce Information Manager /EDI Lead Communications Manager	Further work to be undertaken for staff to share their employment experiences	Amber
	Workforce Representation and sharing disability status	➤ Explain how the data will be used and who will have access to it	30 November 2024 – August 2025	Workforce Information Manager, EDI Lead / I&W Comms Engagement Officer, Comms manager	Increase in Disability Data – Improving ESR Updates	Amber

	Workforce Representation and sharing disability status	➤ Host drop in sessions for colleagues to update their disability data	30 November 2024 – August 2025	Workforce Information Manager, EDI Lead / I&W Comms Engagement Officer, Comms manager	Further work to be undertaken for this to be carried out consistently	Green
		➤ Provide guidance and support on using and updating MyESR through various communications channels			Completed and ongoing Reminders sent via ESR	Green
		➤ Include quarterly reminders through internal communication channels e.g. intranet, emails and appraisals	30 November 2024 – August 2025	Workforce Information Manager /EDI Lead Communications Manager	Message to be reinforced consistently	Amber
		➤ Encourage line managers to remind new starters and existing staff to update ESR during one to one meeting, appraisals, and return to work interviews	30 November 2024 – 31 August 2025	Workforce Information Manager, Head of Leadership & OD, HRBP	Message to be reinforced consistently	Amber
		➤ Encourage managers when having a conversation with staff about reasonable adjustments, give staff the opportunity to talk openly about disability and encourage to record on ESR / through health &	30 November 2024 – 31 August 2025	HRBP, Head of Occupational Health	Health & Wellbeing Passport implemented and supporting attendance training or managers. Further work to be undertaken to reinforce message consistently	Amber

	Workforce Representation and sharing disability status	wellbeing passport conversations				
		➤ Reinforce message during Corporate induction	30 November – August 2025	EDI Team	Message to be reinforced consistently	Amber
		➤ Promote and celebrate disability and encourage staff to share their disability status at Disability History Month event	30 November 2024	EDI Lead, I&W Comms Engagement Officer, Ability Staff Network	Completed and ongoing	Green
		➤ Work with the Executive Sponsor to promote the benefits of updating disability status and champion disability equality	30 November 2024 – 31 March 2025	Head of EDI / EDI Lead	Lived experiences shared at various events e.g. Schwartz rounds, Board meeting	Amber
		➤ Create opportunities to share lived experiences, achievements e.g. using quotes and short case studies from disabled colleagues talking about their experience of working in the Trust	1 October 2024 – 31 August 2025	Head of EDI / EDI Lead, Ability Staff Network	Disability Confident Employer information shared, Information about the staff network shared.	Green
		➤ Share information in recruitment materials	30 November 2024 – August 2025	HR Resourcing Manager	Further work to be undertaken and	Amber

		about how the Trust supports disabled people and what they can expect when they join			also as part of the inclusive recruitment work underway	
4	Reduce the incidence of Disabled colleagues experiencing harassment, bullying and abuse (HBA) from patients, managers and colleagues	➤ Violence & Aggression management Group to look at incidence, trends, themes and hotpots areas	1 October 2024 – 31 August 2025	Violence & Aggression Management group Chair	WDES Information shared and incidents discussed at VAMG to look at patterns, trends and reporting	Green
4a	Patients/relatives/ Public: reduced from 30.8% to 27.8% for disabled, 23.6% for non-disabled				↑ Increased from 27.8 to 28.98%	
4b	Managers: reduced from 11.6% to 10.5% for disabled staff and 5.2% for non-disabled	➤ Evaluate the effectiveness of the Equality & Diversity, Passport to Management Training course to deliver the required manager skills and capabilities	31 March 2025	Learning & OD Manager	4b ↓ Decreased slightly from 10.5 to 10.2% Training was evaluated periodically sometimes low response rates	Amber
4c	Colleagues: slightly reduced from 23.3% to 23.2% for disabled staff, 14.3% for non-disabled				4c ↓ Decreased from 23.2 to 21.7%	
4d	Reporting HBA incidents (Increased from 53.2% to 56% for disabled staff, disabled 49.2%)	➤ Continue promoting the ongoing Respect Campaigns, Hashtag #NoPlaceForHateInBarnsley being adopted in partnership with Barnsley Council	1 October 2024 – 31 August 2025	Communication Manager	4d ↑ Increased from 27.8 to 28.98% Posters refreshed across the hospital and work is ongoing	Green

	High Impact Action 2 People Promise ambitions: We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are safe and healthy, We are a team	➤ Signpost and promote Freedom to Speak Up Guardian, Champions and Staff networks and create a Psychological safety approach where staff can feel able to speak up and raise concerns	1 October 2024 / August 2025	EDI Lead / Head of EDI/FTSU	Freedom to Speak up attends the staff network	Green
		➤ Promote the internal mediation support service and opportunities to expand the pool of mediators to encourage informal resolution for workplace issues	1 October 2024 / August 2025	Head of EDI	Mediation promoted and further work is underway to relaunch the support service and raise awareness	Amber
		➤ Embed and promote the Inclusion & Wellbeing Champions	1 October 2024 / August 2025	Head of EDI	Inclusion & Wellbeing Champions role reviewed as part of an exercise scope the effectiveness of the champions	Amber
		➤ Continue to promote and embed the Health & Wellbeing Passport	1 October 2024 / March 2025	HRBP	HWB passport promoted and appears to be embedded	Green

		➤ Launch the newly developed Stress Policy	01 2025	Head of Occupational Health	Stress policy has been launched	Green
		➤ Offer the opportunity to Debrief following incidents	1 October 2024 / August 2025	Head of Occupational Health	Debrief sessions are taking place. unsure how Further work is needed to ensure they are being offered and conducted consistently	Amber
		➤ Proud to Care Culture Group looking at the Trust values and work to create a culture of civility and respect and share key learning	1 October 2024 / August 2025	Head of Learning & OD / Head of EDI	Various initiatives have been undertaken through the Proud to Care Cultural Leadership Group and subgroup initiatives	Green
		➤ Work to eliminate the risk of sexual harassment in the workplace, launch and implement the sexual safety charter	31 March 2025	Deputy Director of People/Head of EDI, Head of Occupational Health	Sexual Safety Charter & supporting work launched, policy & e-learning training	Green
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	➤ Deliver the expectations of line managers people management training ➤ Include reasonable adjustment information on the line managers	31 January 2025 - 31 August 2025	Head of EDI, EDI Lead, HRBP	 Declined from 85.4 to 84.5% Information available on the line managers expectations hub, training	Green

	(Increased from 80.7% to 85.4%) High Impact action 4 Develop and implement an improvement plan to address workforce health inequalities	expectations hub and signpost ➤ Support Staff Attendance Management training to line managers, which includes raising awareness and advice surrounding reasonable adjustments and supporting staff			undertaken at Proud to manage and Support staff attendance training promoting the policy	
		➤ Promote the Workplace adjustment guide, toolkit and infographic	30 November 2024 – August 2025 30 November 2024 – August 2025	I&WB lead, Head of Occupational health, Head of EDI	Promoted, Further work is planned to promote the guides further.	Green
		➤ Promote the neurodiversity guide		HRBP, Head of Occupational health	Health & Wellbeing Passport is launched and is being embedded	
		➤ Continue to promote and launch the Health & wellbeing passport		HRBP, Head of Occupational health		
		➤ Educate and seek opportunities to engage managers and staff to increase understanding and awareness around the provision of reasonable adjustments including access to work	1 October 2024 - August 2025	HRBP, Head of Occupational health, Head of EDI /EDI Lead	Further work to be undertaken to educate and engage with managers to ensure timely response to workplace adjustments	Amber

		➤ Include clear statements in recruitment pack how accessible materials can be obtained in different formats e.g. braille, large print	30 November 2024	HR Resourcing Manager – August 2025	Recruitment pack is being enhanced.	Amber
10	Reduce the gap between Board representation and overall representation of disabled staff in the workforce No disabled board member High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable People Promise – We are compassionate and inclusive, We are always learning, We are a team,	Launch a range of campaigns on updating Disability data monitoring Campaigns will include: ➤ Raising awareness about the importance of updating personal details	30 November 2024 – 31 August 2025	Workforce Information Manager /EDI Lead Communications Manager, Managing Director	➡ No change -No board members ESR Drop-in session delivered.	Green
		➤ guidance on how to update MyESR				
		➤ Invite board members to check and refresh their disability data	30 November 2024 – 31 August 2025	Workforce Information Manager /EDI Lead Communications Manager, Managing Director	Reminders sent to staff across the Trust to update their disability status	Green
		➤ Hosting drop in sessions for colleagues to update their status				

	We each have a voice that counts	➤ Involve board members and Executive board sponsor in the communication campaigns around this topic		Managing Director	Further work to be undertaken to strengthen approach	Amber
		➤ Maintain strong relationships with the Board and the Ability Staff Network	1 October 2024 – 31 August 2025	Head of EDI/EDI Lead, Ability Staff Network	Regular meetings take place with the Trust chairs and the network chairs/member	Green
		➤ Consider recruitment strategies to attract diverse Board candidates with disabilities to ensure the Board reflects the diversity of the workforce	30 November 2023 – 31 August 2025	Director of Corporate Affairs	To collaborate with the Executive sponsor about board disability inclusion	Amber

KEY RAG Rating



Complete



On track for delivery



Behind plan and action needed to bring back on target

Trust	Priority 1	Priority 2
Barnsley Hospital NHS Foundation Trust	Metric 6: Presenteeism	Metric 10: Board Representation

Workforce Disability Equality Standard (WDES) Action Plan – 2025/2026

In our ongoing commitment to fostering an inclusive and supportive workplace, we have undertaken a thorough review of our Workforce Disability Equality Standard (WDES) actions. In collaboration with the Ability Staff Network, we have agreed to streamline our WDES actions to ensure they are both realistic and achievable. This strategic approach will allow us to focus our efforts on key priority areas that will have the most significant impact.

- **Metric 1 - Workforce Representation and Sharing Disability Status**
- **Metric 4 - Harassment, Bullying, and Abuse**
- **Metric 8 – Reasonable Adjustments** - Our 2023 results indicated a positive score in the percentage of disabled staff who reported they had adequate adjustments to enable them to perform their duties (85.4%), however, we recognise the need to continue to raise awareness and provide additional advice to managers and colleagues to ensure that all necessary adjustments are made to support our disabled staff effectively.
- **Metric 10 - Board Representation**

By focusing on these priority areas, we can make meaningful progress towards a more inclusive and supportive workplace for our colleagues

Metric	WRES indicator Objective	Action/s	Timescale	Lead/s	Update	RAG Status
1	Workforce Representation and sharing disability status Increase the number of staff sharing their disability during employment at the Trust Aligns with: People Promise – We are compassionate and inclusive, We are learning, We each have a voice that counts, We are a team (5.99% staff recorded disability on ESR compared to 24.86% of staff survey responds who identified) Workforce Representation and sharing disability status	➤ Work with colleagues to create a safe environment for sharing disability/ long-term condition and respecting those who do not feel comfortable in sharing their status	30 November 2025 – August 2026	Ability staff Network, Head of EDI / EDI Lead, HRBP		
		Collaborate with the Ability staff network and Workforce Information team to launch a communication campaign:	30 November 2025 – August 2026	Workforce Information Manager / EDI Lead Communications Manager		
		➤ Promote benefits of sharing disability status ➤ Explain how data will be used and who will have access to it				
		➤ Provide guidance and support on using and updating MyESR				
		➤ Encourage line managers to remind new starters and existing staff to update ESR during one to one meetings, appraisals, and return to work interviews	30 November 2025 – 31 August 2026	Workforce Information Manager, Head of Leadership & OD, HRBP		

	Workforce Representation and sharing disability status	➤ Encourage managers when starting a conversation with staff about reasonable adjustments, give staff the opportunity to talk openly about disability and encourage to record on ESR / through health & wellbeing passport conversations	30 November 2025 – 31 August 2026	HRBP, Head of Occupational health & Wellbeing		
		➤ Reinforce message during Corporate induction	30 November – August 2025	Head of EDI		
		➤ Promote and celebrate disability and encourage staff to share their disability status at Disability History Month event	30 November 2025	EDI Lead, I&W Comms Engagement Officer, Ability Staff Network		
		➤ Work with the Executive Sponsor to promote the benefits of updating disability status and champion disability equality	30 November 2025 – 31 March 2026	Head of EDI / EDI Lead		
		➤ Share information in recruitment materials about how the Trust supports disabled people and what they	30 November 2025 – August 2026	HR Resourcing Manager		

		can expect when they join				
4	Reduce the incidence of Disabled colleagues experiencing harassment, bullying and abuse (HBA) from patients, managers and colleagues	➤ Violence & Aggression management Group to look at incidence, trends, themes and hotpots areas	1 October 2025– 31 August 2026	Violence & Aggression Management group Chair		
4a	Patients/relatives/ Public: increased from 27.8% to 28.98% for disabled, 22.71% for non-disabled	➤ Continue promoting the ongoing Respect Campaigns	1 October 2025– 31 August 2026	Communication Manager		
4b	Managers: reduced from 10.5% to 10.2% for disabled staff and 4.7% for non-disabled	➤ Signpost and promote Freedom to Speak Up Guardian, Champions and Staff networks and create a Psychological safety approach where staff can feel able to speak up and raise concerns	1 October 2025/ August 2026	EDI Lead/ Head of EDI		
4c	Colleagues: slightly reduced from 23.2% to 21.7% for disabled staff, 13.1% for non-disabled	➤ Promote the internal mediation support service and opportunities to expand the pool of mediators to encourage informal resolution for workplace issues	1 October 2025/ August 2026	Head of EDI		
4d	Reporting HBA incidents	➤ Offer the opportunity to Debrief following incidents	1 October 2025/ August 2026	Head of Occupational health & Wellbeing		
	(Increased from 56% to 60.5% for disabled staff, non-disabled 51.8%)					

	High Impact Action 2 People Promise ambitions: We are compassionate and inclusive, We are always learning, We each have a voice that counts, We are safe and healthy, We are a team					
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Decreased from 84.5% to 85.4%)	➤ Continue to deliver the expectations of line managers people management training	1 October 2025 - 31 August 2026	Head of EDI, EDI Lead, HRBP		
		➤ Include reasonable adjustment information on the line managers expectations hub and signpost				
	High Impact action 4 Develop and implement an improvement plan to address workforce health inequalities	➤ Promote the Workplace adjustment guide, toolkit and infographic	30 November 2025 – August 2026	EDI Lead, Head of Occupational health & Wellbeing, Head of EDI		
		➤ Promote the neurodiversity guide				
		➤ Continue to promote and launch the Health & wellbeing passport		HRBP, Head of Occupational health & Wellbeing		

	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Decreased from 84.5% to 85.4%)	➤ Educate and seek opportunities to engage managers and staff to increase understanding and awareness around the provision of workplace adjustments including access to work	1 October 2025- August 2026	HRBP, Head of Occupational health & Wellbeing, Head of EDI / EDI Lead		
		➤ Include clear statements in recruitment pack how accessible materials can be obtained in different formats e.g. braille, large print	30 November 2025 - August 2026	HR Resourcing Manager – August 2025		
10	Reduce the gap between Board representation and overall representation of disabled staff in the workforce No disabled board member High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI	Launch a range of campaigns on updating Disability data monitoring Campaigns will include: ➤ Raising awareness about the importance of updating personal details	30 November 2025 – 31 August 2026	Workforce Information Manager / EDI Lead Communications Manager, Managing Director		
		➤ guidance on how to update MyESR				
		➤ Invite board members to check and refresh their disability data				
		➤ Involve board members and Executive board sponsor in the communication				

	objectives to which they will be individually and collectively accountable	campaigns around this topic				
	People Promise – We are compassionate and inclusive, We are always learning, We are a team, We each have a voice that counts	➤ Maintain strong relationships with the Board and the Ability Staff Network	1 October 2025– 31 August 2026	Head of EDI/EDI Lead, Ability Staff Network		
		➤ Consider recruitment strategies to attract diverse Board candidates with disabilities to ensure the Board reflects the diversity of the workforce ➤ Collaborate with Ability Staff Network Executive Sponsor and Trust Chair	30 November 2025 – 31 August 2026	Director of Corporate Affairs Ability Staff Network Executive Sponsor (Managing Director) Trust Chair		

KEY RAG Rating



Complete



On track for delivery



Behind plan and action needed to bring back on target

5.6. Annual Doctors Appraisal & Revalidation Report: Jeremy Bannister in attendance

For Assurance

Presented by Simon Enright



REPORT TO THE BOARD OF DIRECTORS		REF:	BoD: 25/10/02/5.6	
SUBJECT:	DOCTOR'S APPRAISAL & REVALIDATION – ANNUAL REPORT			
DATE:	2 October 2025			
	<i>For decision/approval</i>	✓	<i>Assurance</i>	✓
	<i>For review</i>	✓	<i>Governance</i>	✓
	<i>For information</i>	✓	<i>Strategy</i>	
PREPARED BY:	Sally Flint, Appraisal, Revalidation and Job Planning Manager Jeremy Bannister, Deputy Medical Director & Appraisal Lead			
SPONSORED BY:	Simon Enright, Medical Director and Responsible Officer			
PRESENTED BY:	Jeremy Bannister, Deputy Medical Director & Appraisal Lead			
STRATEGIC CONTEXT				
This Annual Appraisal and Revalidation Report (Annex D of NHS England Framework of Quality Assurance) provides the required assurance to Barnsley NHS Foundation Trust and NHS England that the Responsible Officer, Dr Simon Enright, is fulfilling their statutory duty and provides the means to demonstrate the effectiveness of all the systems they oversee in relation to; recommendations made to the General Medical Council (GMC) on doctors' fitness to practice and arrangements for medical appraisal.				
EXECUTIVE SUMMARY				
Aim and objectives				
- Provide an understanding of the progress that the Trust has made during 2024/2025 - Provide a tool to help Responsible Officers assure themselves and their Board/Management bodies that robust Trust systems are in place. - Provide a mechanism for assuring NHS England (as the Senior Responsible Owner for medical revalidation in England), England Revalidation Implementation Board (ERIB) and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective & consistent.				
Key findings				
• Appraisal and Revalidation processes are working well and performing at high levels. Of 360 doctors connected to us via the GMC, 349 were appraised and 7 had "agreed missed" appraisal, therefore 356, 98.9%, of doctors were successfully managed for appraisal within the agreed Appraisal year. Of 4 doctors "unapproved missed" for appraisal 3 have since appraised and 1 has retired. • The 2024/2025 Appraisal year was the first full year on the new on-line appraisal system, L2P, which went live in October 2023. The success of migration on to the new system is evident as we exited the appraisal year with 98.9% of doctors having their appraisal successfully managed. • Of 71 doctors scheduled to revalidate by the GMC, 65 successfully revalidated and 6 were deferred due to lack of supporting information - 4 were due to having only recently				

commenced in post, 1 due to ongoing investigations and 1 due to ongoing long-term sickness. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.

- Our process of repeating the MSF report every 3 years meant we did not have to defer any Revalidations due to an incomplete MSF, GMC guidance is one MSF/5-year cycle.
- Three Appraiser Update Meetings were held to ensure our appraisers are up to date, maintaining and building on their skills and current issues are addressed, with focus on the new L2P Appraisal System.

Conclusions

This report confirms our Appraisal and Revalidation processes continue to be a success following the migration onto the new L2P system. We continue to provide good quality, robust medical appraisals which underpin recommendations made to the General Medical Council (GMC), doctors' fitness to practice, arrangements for medical appraisal and responding to concerns.

RECOMMENDATION

The Board of Directors is asked to accept and approve this report, for sign-off of the Statement of Compliance confirming that Barnsley NHS Foundation Trust, as a Designated Body, is compliant with the regulations.

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Subject:	DOCTORS' APPRAISAL AND REVALIDATION ANNUAL REPORT	Ref:	PC: 23/09/25

1. INTRODUCTION

This paper provides information and reassurance that Appraisal and Revalidation is being carried out to a high standard at Barnsley NHS Foundation Trust.

2. EXECUTIVE SUMMARY

This was the first full appraisal year on the new on-line appraisal system, L2P, which went live in October 2023. Throughout 2024/2025 all appraisals have taken place on the L2P system.

Feedback from both Appraisers and Appraisees regarding L2P has been very positive. The success of the migration on to the new system is evident as we exited the appraisal year with 96.9% of our doctors who were eligible for appraisal in date, rising to 98.9% when 7 approved missed appraisals are including. Therefore, switching to the new appraisal system has had zero negative impact on maintaining our high level of doctors in date for appraisal. The Trust and NHSEI targets are for 90% of doctors to be in date with the appraisal, both were exceeded.

BHNFT, as at 31st March 2025 (the end of the reporting period for 2024/2025 appraisal year) had 360 doctors for whom we are the Designated Body (DB). This makes us responsible for their annual Appraisal and, if they are working here at the time of their General Medical Council (GMC) scheduled Revalidation, responsible for making a recommendation to the GMC regarding their suitability for Revalidation.

From Appraisal Office Data: during the 2024/2025 appraisal year, 349 appraisal meetings were conducted with an additional seven appraisals categorised as "agreed exceptions" (these did not take place due to "approved" reasons of; sick leave, maternity leave, sabbatical leave and family issues). Therefore 98.9% (356) of the 360 doctors connected to us as their Designated Body were successfully managed for appraisal.

Four appraisals did not occur which were "unapproved missed"; two of these appraised by the end of the following month, April 2025 and a third appraised in May 2025.

Of the remaining doctor with unapproved missed appraisal; they have since retired.

As in all appraisal years since the start of the pandemic, appraisers have been encouraged to be supportive, give guidance, conduct "a light touch appraisal", de-brief doctors and signpost help when required. The L2P appraisal system encourages and builds on Wellbeing and we have reinforced this message at the three Appraiser Update Meetings held during the 2024/2025 appraisal year.

Appraisal Summary for 2023/-2024 Appraisal Year:

Number of doctors connected to Barnsley NHS FT = 360

Appraisals conducted = 349

Appraisal agreed exceptions 31/03/2025 = 7

356 or 98.9% of doctors eligible for appraisal

Appraisals not agreed exceptions = 4 or 1.1%

Revalidation Summary:

During the 2024/2025 year we had 65 doctors successfully revalidate as per GMC schedule. An additional six doctors had their revalidation deferred due to lack of supporting information – four who had recently commenced in post, one due to ongoing investigations and one due to ongoing long-term sickness. All submissions were in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

3. PURPOSE OF THE PAPER

The purpose of this paper is to provide information to the Board of Directors to confirm that the Appraisal and Revalidation process is being carried out to a high standard and demonstrate our processes are continually evolving and improving and we share best practice amongst other Trusts.

4. BACKGROUND

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Doctors are scheduled to revalidate every five years by the GMC. The Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations¹, and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

5. GOVERNANCE ARRANGEMENTS

The Responsible Officer has statutory responsibility for performing the roles set out in the relevant legislation.

Quality Assurance Framework Hierarchy

1. Department of Health
2. NHS E&I Medical Director and Responsible Officer Professor Sir Stephen Powis, Level 3
3. NHS E&I North East and Yorkshire Region Medical Director and Responsible Officer Dr Yvette Oade, Level 2
4. Designated Body (BHNFT) Medical Director and Responsible Officer Dr Simon Enright, Level 1

Level 1 users are responsible for making recommendations to the GMC for the revalidation Cycle of all doctors who have a prescribed connection to their designated body.

At BHNFT Level 1 users are supported by a decision support group, the “Appraisal and Revalidation Support Group” (ARSG), comprising the Medical Director (MD) /RO, Deputy Medical Director (DMD) and Appraisal, Revalidation and Job Planning Manager. The ARSG meets every 4 weeks and has formalised Terms of reference. Other colleagues are invited e.g. Head of Medical Staffing or Human Resources representation to these meetings on an adhoc basis as required. The Deputy Medical Director and Appraisal, Revalidation and Job Planning Manager

meet on a weekly basis.

For Responding to Doctors with Concerns we have a Responsible Officer Advisory Group (ROAG) comprising the Medical Director/RO, Deputy Medical Director, Joint Associate Director of HR and OD, General Manager for Medical Directorate and Appraisal, Revalidation and Job Planning Manager as core members. Other attendees will be co-opted to provide professional advice as required. ROAG provides advice and support and meet every 4 weeks.

Level 2 users are responsible for making recommendations to the GMC for the revalidation Cycle of all level 1 Responsible Officers within their designated body. They ensure that the Responsible Officer attends 75% of all training programmes on an annual basis, has undertaken Continuing Professional Development (CPD), MSF, Reflection of Serious Incident (SI), Investigations and Complaints/compliments and they are delivering their responsibilities as a Responsible Officer.

The Appraisal, Revalidation and Job Planning Manager monitors the GMC Connect Website on a daily basis to ensure that the list of doctors for whom we are the DB is accurate and up to date.

Confidentiality: In addition to the appraisee and appraiser the; AL, Head of Medical Staffing, Appraisal, Revalidation and Job Planning Manager and Appraisal, Revalidation and Job Planning Officer are the only four people with access to L2P appraisal forms. The RO has access only when there are concerns. Appraisers who are supporting the AL with QA of appraisal forms will also have access to named appraisal forms only. The doctor need only provide the PDP section for job planning purposes.

Whole scope of practice appraisal: to fulfill this GMC requirement, doctors must include all internal and external roles e.g. Educational Supervisors (ES), Medical Examiners (ME) and Clinical Leads (CL) etc. and any external private work must be entered in the Scope of Practice Section of their appraisal form to prompt a full review of these roles by their appraiser.

ES's must complete the Medical Educator Section in the appraisal form. ME's must complete the Trust Medical Examiner Review Framework and CL's must complete the Clinical Lead Framework; links to both for downloading are within the resource section of the appraisal form. They should be completed and uploaded to the appraisal form for discussion.

Any Medical Practice outside of Barnsley should also be included in the doctor's declaration of scope of work.

The Trusts Framework for Appraisal and Revalidation Policy was renewed, agreed and uploaded to TAD on 18/01/2024.

The Trusts' Remediation, Reskilling & Rehabilitation Policy for Medical and Dental Staff was renewed in January 2025.

Appraisal and MSF (Multi Source Feedback) Documentation is stored on both a secure Trust server (R Drive) and the L2P on-line system. In both cases access is limited to AL, Head of Medical Staffing, MARSM and Administration Assistant

Appraisal and MSF Systems are provided on-line by L2P with processes detailed in our Standard Operating Procedures (SOP's) Documentation. These are updated on an ad-hoc basis in line with NHS England and GMC guidance alongside internal continuous review and streamlining. The SOP's are stored on Trust internal G drive. All processes are paper free.

Regular updates on appraisal and revalidation are provided monthly at ARSG meetings and in a Half Yearly Medical Director's Report. A more detailed report, this Annual Doctors Revalidation

Report, will be presented to Board as per guidance.

6. MEDICAL APPRAISAL

6.1 Appraisal and Revalidation Performance Data

See page 2, point 2 Executive Summary.

This was the first full appraisal year on the new on-line appraisal system, L2P, which went live in October 2023. Throughout 2024/2025 all appraisals have taken place on the L2P system.

Feedback from both Appraisers and Appraisees regarding L2P has been very positive. The success of the migration on to the new system is evident as we exited the appraisal year with 96.9% of our doctors who were eligible for appraisal in date, rising to 98.9% when seven approved missed appraisals are including. Therefore, switching to the new appraisal system has had zero negative impact on maintaining our high level of doctors in date for appraisal. The Trust and NHSEI targets are for 90% of doctors to be in date with the appraisal, both were exceeded.

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From Appraisal Office Data: during the 2024/2025 appraisal year, 349 appraisal meetings were conducted with an additional seven appraisals categorised as “agreed exceptions” (these did not take place due to “approved” reasons of; sick leave, maternity leave, sabbatical leave and family issues). Therefore 96.9% (356) of the 360 doctors connected to us as their Designated Body were successfully managed for appraisal.

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As in all appraisal years since the start of the pandemic, appraisers have been encouraged to be supportive, give guidance, conduct “a light touch appraisal”, de-brief doctors and signpost help when required. The L2P appraisal system encourages and builds on Wellbeing and we have reinforced this message at the three Appraiser Update Meetings held during 2024/2025 appraisal year.

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6.2 Revalidation Summary

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Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

6.3 Appraisers

We commenced 2024/2025 with 36 appraisers in place which equates to one appraiser: eight doctors which is in line with Trust and NHSEI recommended requirements. We ended the appraisal year with 33 appraisers in place as one had retired and the other two have stood down from the role, still maintaining recommended requirements. Each appraiser is expected to undertake a minimum of five appraisals with the average being eight appraised during the appraisal year.

We run three Appraiser Update Meetings (AUM)/appraisal year with all three 2024/2025 meetings progressing via video link. Topics included Learning Styles, Antimicrobial Stewardship – C Diff RCA's and Summary of New GMP Domains.

We plan to hold three AUM meetings in the 2025/2026 appraisal year.

A round of recruitment and training is underway to increase the number of trained, available appraisers.

6.4 Quality Assurance

For the 2024-2025 appraisal year formal QA of Appraisal Outputs (new L2P Form) will be undertaken.

The main focus on Quality Assurance of Appraisal Outputs for 2024/2025 has been internal via the Deputy Medical Director and Appraisal Lead (DMD) reviewing Revalidation portfolios, including approx. 150 appraisal forms (L2P), for preparation of a summary to inform the Medical Director/RO's revalidation submission to the GMC. The Revalidation Manager (trained Medical Appraiser) checks all appraisal forms to ensure the required documentation is present; including over the 5-year revalidation cycle all six areas of supporting information have been covered as per GMC mandatory requirements. The quality of the write up is checked before finalising the appraisal process; the DMD is requested to review any appraisal forms that may be below our required, acceptable standards.

Following a survey on L2P with information provided by our Medics, 85.1% found the L2P appraisal form easy to use and populate and 92.45% found L2P easy to navigate.

6.5 Access, Security and Confidentiality

For all doctors, their Appraisal and MSF data is stored on L2P. This cohort's revalidation data is stored on a secure Trust hard drive with access limited to the DMD, Head of Medical Staffing, Appraisal, Revalidation and Job Planning Manager and Administration Assistant. The RO has access to specific data if concerns arise.

6.6 Clinical Governance

There are six key pieces of information that are mandatory for Appraisal and Revalidation; Adequate evidence of Continuing Professional Development, Quality Improvement Activities, Colleague Feedback and Patient Feedback (MSF report), Reflection on any Complaints and Reflection on any serious incidents and/or Patient Safety Incident Investigations.

Evidence of CPD must be provided by the appraisee, including their Royal College CPD log (or similar) where available and include reflection.

The Quality Improvement data requires evidence of performance, outcomes and audit. This information will be provided in part by the information analyst employed by each Clinical

Business Unit (CBU), the outcomes of Local or National Audits and information gathered by the doctor. Each College/Faculty has a data set which it recommends should be included over a cycle of appraisal/revalidation. It is the responsibility of the Appraiser and Appraisee to cover these areas.

The colleague and patient feedback report is provided by L2P and the timeline for repeat is 36 months. The appraisee appraiser must discuss and reflect on the MSF report at appraisal.

The appraisee is responsible for contacting Risk (SI/PSII) and Complaints departments to ascertain if they have been involved in either/both of these. Emails from Risk and Complaints are part of the supporting documentation that must be uploaded to the appraisal form by the appraisee with any involvement being discussed and reflected on.

7. Revalidation Recommendations

During the 2024/2025 year we had 65 doctors successfully revalidate as per GMC schedule. An additional six doctors had their revalidation deferred due to lack of supporting information – four who had recently commenced in post, one due to ongoing investigations and one due to ongoing long-term sickness. All submissions were in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete one MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

8. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

8.1 Substantive or fixed term recruitment checks

Prior to any appointment being made, provisional offer letters are sent out subject to the following:

- Checks being made: Proof of Identification Checks, GMC Registration, Occupational Health Clearance, Disclosure and Barring Service (DBS), Clinical References from previous employment, and Salary information from Electronic Staff Record (ESR) or via proof of last pay slip.
- If the doctor has been registered with a Designated Body prior to being offered a Post, the applicant will be requested to provide the name of their previous responsible officer and designated body, in addition to their last date of appraisal and then be entered into the appraisal and revalidation system at Barnsley.

8.2 Locums via agency

All agency workers are supplied via Holt Doctors Ltd via a Master Vendor Arrangement, (we have no off-framework agencies that supply to the Trust), who have been assessed by the Crown Commercial Services (Previously GPS). As an agency they have to comply with strict pre-employment checks that cover GMC registration, right to work, DBS clearance, Occupational Health Clearance, References, Qualifications and Experience.

In addition, they must also provide access to a responsible officer, who can make recommendations on their fitness to practice if they are not substantively employed elsewhere. Their Agency is responsible for their appraisal and revalidation.

9. MONITORING PERFORMANCE

2024/2025 Appraisal Year: Via the Annual Job Planning Cycle, Clinical Directors/Leads are required to ensure that each consultant and SAS grade doctor is performing to the standards and expectations required for their position.

In addition to the annual job plan cycle each Consultant and SAS grade doctor must participate in an annual appraisal as do all doctors in the Trust who are not in training. Utilising the L2P appraisal system the appraiser will assess the performance of the doctor against specific

standards; this is to ensure that the individual is able to perform his or her duties safely, in line with best practice.

The appraisee participates in quality improvements and supports effective service delivery that offers the most appropriate care for our patients. In addition, the performance of the appraisee is assessed via a Multi-Source Feedback questionnaire by their peers and patients, as well as the discussion and reflection of any Complaints and/or SI/PSIIS which enables the Practitioner and the appraiser to develop a personal development plan for the following year.

2025/2026 Appraisal Year: This will be the second full year that all appraisals will be conducted in L2P; in addition, this is also the second year L2P is being used as our Job Planning provider.

Both Appraisal/MSF and Job Planning are provided on-line by L2P in the same account for Consultants and SAS doctors meaning greater ease of use and linked functionality.

10. RESPONDING TO CONCERNS AND REMEDIATION

Concerns, identified from any source are the responsibility of all health professionals and managers. Once identified, they will be reported to the appropriate line manager, reviewed by ROAG (Responsible Office Advisory Group) and investigated under the Trust's Policies including Maintaining High Professional Standards (MHPS), Raising Concerns and Capability Policy.

11. RISK AND ISSUES

Due to staffing pressures we are unable to gather RO to RO information transfer (MPIT - Medical Personnel Information Transfer, NHSE form) on all new doctors entering the Trust within 1 month of their starting date. Resources are focused on new doctors approaching revalidation to provide the RO with the most comprehensive portfolio of evidence for review in order to make an informed revalidation recommendation.

12. CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS:

CORRECTIVE ACTIONS:

Peer Review between BHNFT and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

IMPROVEMENT PLAN:

Review the MSF within L2P in line with their current software development to ensure the level of detail provided is sufficient and the MSF and appraisal form are linked to provide easier access to this report.

NEXT STEPS:

Ensure Peer Review and QA of appraisal occurs during the 2025/2026 appraisal year now the new appraisal system has had time to bed in.

13. CONCLUSION

The Trust Appraisal and Revalidation processes are working well and this was the first full appraisal year on the new on-line appraisal system L2P. We exited 2024/2025 appraisal year with 96.9% of our doctors who were eligible for appraisal in date, rising to 98.9% when seven approved missed appraisals are included.

All revalidations were actioned in good time prior to their due date.

Appendix 1

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at [NHS England » Quality assurance](#) before completing.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The Board of Barnsley Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Dr Simon Enright, Medical Director, is the Trust Responsible Officer, appropriately trained and attends NHS England RO Networks
Comments:	Mr Jeremy Bannister, Deputy Medical Director and Appraisal Lead is RO trained and deputises for Dr Enright in his absence. We have a reciprocal alternative RO arrangement with Mid Yorkshire Hospital NHS Trust
Action for next year:	Maintain

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	The Trust purchases an online Appraisal System procured from L2P in October of the 2023/2024 appraisal year. The current year is the first full year of implementation of the new system. Feedback from users and appraisers has been overwhelmingly positive. Resources are made available for 3 x half day, Appraiser Update meetings per annum. These meetings are organised and facilitated by the Medical Appraisal Lead and Appraisal and Revalidation Manager. Appraisers are freed from clinical duties to attend at least 2 out of 3 of these meetings per annum. Attendance is monitored.
Comments:	The Trust provides funding as required
Action for next year:	Maintain provision of resources

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Working within the Medical Staffing Department means we have access to information on all starters/leavers, additionally access to Workforce Information Reports on starters/leavers means our databases are accurate and robust. This allows us to maintain an accurate record of medical practitioners with a prescribed to Barnsley in conjunction with amendments by the GMC on GMC Connect.
Comments:	We ensure Bank Doctors linked to us as their Designated Body are delivering the majority of their sessions at Barnsley, otherwise the Trust/Organisation they perform most of their sessions at are responsible for their appraisal & revalidation and they must link to them accordingly.
Action for next year:	Closely monitor and maintain

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	The Trusts' Framework for Medical Appraisal and Revalidation Policy was renewed, agreed and uploaded to TAD on 18/01/2024.
Comments:	The Framework for Medical Appraisal and Revalidation Policy is next due for review 18/01/2027
Action for next year:	All current policies in date.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Calderdale and Huddersfield Trust conducted a Peer Review at Barnsley 18/05/2017. Peer review has not occurred since March 2020 due to Covid.
Comments:	Peer Review was planned for 2024-2025 Appraisal Year but the implementation and roll out of the new on-line Appraisal System, L2P, will take time to "bed in" therefore it was agreed Peer Review should be put back to the 2025-2026 Appraisal Year allowing the new system to run for the course of the next full appraisal year. We have arranged a reciprocal arrangement with the appraisal team at Doncaster Royal Infirmary for this to be undertaken. The agreed standards are in the final stage of preparation.
Action for next year:	Plan for Peer Review in 2025-2026 Appraisal Year

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	All doctors new to the Trust are required to meet with the Revalidation Manager as part of their Induction, including Bank and LED doctors. All new bank doctors are contacted and their correct Designated Body status identified. Once established that we are the correct Designated Body for the short-term placement or locum doctor a Trust "New Starter Form" (NSF) is issued to gather information to allow the Revalidation Manager to plan their next/first appraisal and MSF in readiness for revalidation. This is communicated to the doctor and a face to face induction meeting is organised. All new doctors are provided with support and guidance in line with their level of appraisal experience.
Comments:	If correctly assigned to us as their designated body, a plan for revalidation is agreed and their next/first appraisal and MSF are scheduled. Previous appraisal documentation is requested as appropriate to commence collation of their supporting evidence in a revalidation portfolio, including the doctor contacting their previous organisation/s for information regarding SI's/PSII's and Complaints. If the doctor is new to appraisal an Induction Appraisal will be conducted by the Revalidation Manager.
Action for next year	Maintain

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC license to practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Appraisers have been trained to focus on the wellbeing of the appraisee and signpost to support as relevant. Our appraisers ensure the appraisal covers the whole scope of practice of the doctor. There are specific templates and documents for Medical Educators, Medical Examiners and Clinical Leads to complete/upload within the new appraisal form for discussion with their appraiser. Appraisers and Appraisees are reminded by the Appraisal office to ensure any external work is included within the Scope of Practice section.
Comments:	Our doctors are aware of their responsibility in providing us with supporting information on activities carried out at Barnsley and in any other organisation during their appraisal year. Doctors joining us from other Trusts during the appraisal year are made aware of these requirements at Appraisal Induction.

	The Revalidation Manager will continue to ensure all new doctors are aware of their responsibility in gathering and providing supporting information during their appraisal year, including that from any other organisation they worked at during that appraisal year. The Revalidation Manager provides face to face, phone, email and video link support and guidance to all doctors as and when required
Action for next year:	Maintain

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Yes. Whole practice appraisal and relevant information gathering: our processes have been in place for a number of years and our doctors are familiar with this. New doctors undergo Appraisal Induction and are made aware of the requirements. Gaps in supporting information usually occur due the new doctor's unfamiliarity with our requirements or them having insufficient time to gather the required information.
Comments:	The doctor is required to provide any missing information to the Appraiser and/or Revalidation Manager who checks all appraisal documentation prior to finalising the Appraisal and issuing the Certificate of Successful Appraisal. The Revalidation Manager uses the process of information gathering from new starters via the NSF and will put a plan in place for their next/first appraisal and MSF in line with their revalidation date. Appraisal Inductions are usually conducted to face or by video link if a doctor request this.
Action for next year:	Maintain

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The Trusts' Framework for Medical Appraisal and Revalidation Policy was renewed, agreed and uploaded to TAD on 18/01/2024. This is compliant with the last NHSEI guidance issued in June 2022.
Comments:	This policy is next due for renewal 18/01/2027
Action for next year:	Maintain and renew if any significant changes.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	We commenced 2024-2025 with 36 appraisers in place which equates to approximately 1 appraiser:8 doctors, in line with Trust and NHSEI recommended requirements. We ended the appraisal year with 33 appraisers in place as 3 had retired from the post.
Comments:	The reduction in reliance on Locum Agency doctors and the commensurate increase in Locally Employed Doctors (LEDs) has led to a significant increase in the number of doctors requiring appraisal. A round of recruitment and training is underway to increase the number of trained, available appraisers in light of this
Action for next year:	Monitor numbers and organise additional training with MIAD (external company) as required.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Action from last year:	We run 3 Appraiser Update Meetings (AUM)/appraisal year. L2P training videos for appraisers and appraisees are available from the company. The outputs from appraisals are reviewed on a regular basis by the Medical appraisal lead and the Medical Appraisal Manager and .Feedback is given on basic metrics and suggestions for improvement in performance.
Comments:	However, additional topics included Whole Scope of Work, Antibiotic Stewardship, Updated GMC Good Medical Practice, Communication with Private Sector and Outputs of Appraisal.
Action for next year:	To continue developing and updating Appraisers and Appraisees.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	The main focus on Quality Assurance of Appraisal Outputs for 2024-2025 has been internal review via the Deputy Medical Director and Appraisal Lead (DMD) reviewing Revalidation portfolios, approx. 150 Appraisal Forms, for preparation of a summary to inform the Medical Director/RO's revalidation submission to the GMC. The Revalidation Manager (trained Medical Appraiser) checks all Appraisal Forms to ensure the required documentation is present. The AL checks that all six areas of supporting information have been covered as per GMC mandatory requirements. As part of the process the quality of the write up is checked. Feedback is provided to the appraiser if standards need improvement. Also, following a survey on L2P with information provided by our Medics, 85.1% found the L2P appraisal form easy to use and populate and 92.45% found L2P easy to navigate.
Comments:	High standards of appraisal have been maintained.
Action for next year:	Formal QA will be conducted in the 2025-2026 appraisal year.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	All recommendations for 2024/2025 were submitted in good time, 65 doctors were successfully revalidated and 6 deferrals were submitted. The deferrals included 4 doctors recently appointed to Barnsley who came with inadequate supporting information. A plan was made with all 4 to rectify this deficit over a fixed time period (6 months to 1 year). 1 doctor was not recommended for revalidation due to ongoing investigation into their performance. 1 doctor was on long term sick leave and has been unable to accrue adequate supporting information. They will be supported on their return to work. We have a Responsible Officer Advisory Group (ROAG) comprised of the MD/RO, DMD, Revalidation Manager, Joint Associate Director of HR and OD, Business Manager for the Medical Directorate and the Medical Staffing Manager who meet every calendar month for responding to doctors with concerns. Other attendees are co-opted to provide professional advice as required. The ROAG group meet regularly with and are updated by our GMC Employer Liaison Advisor.
Comments:	If necessary ad-hoc meetings are held and recommendations submitted to the GMC as required.
Action for next year:	Maintain

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	In 2024/2025 we had 65 doctors successfully revalidate with 5 deferrals due to insufficient supporting evidence, 1 due to ongoing investigation. With all deferred doctors, the Revalidation Manager explained why this was necessary, the neutral impact on their practice and put personalised plans in place (with the doctor's agreement) to work towards revalidation.
Comments:	We proceeded with the GMC revalidation schedule as given and all submissions were made in good time. Our process of repeating the Colleague and Patient MSF report every 3 years, a mandatory GMC requirement for revalidation, meant we did not need to defer any revalidations due to an incomplete report. The GMC requires a minimum of 1 MSF in every 5-year cycle.
Action for next year:	Continued forward planning to allow adherence to GMC revalidation schedule.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	The Trust has many sensitive tools in place to identify/pick up any issues including: Complaints and SI/PSII, Datixes, Litigation, Coroners Inquests, Freedom to Speak up Guardian, Concerns from Staff Members, colleague feedback and patient feedback and results of local and national audit reports.
Comments:	Discussion at monthly ROAG meetings, see 1C(i). Or ad-hoc as required.
Action for next year:	Maintain.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	See above, 1D(i).
Comments:	Doctors are required to discuss and reflect on their SI/PSII and Complaints or upload to their appraisal form email evidence from Risk and Complaints that they have not been named in any. The MSF (colleague and patient feedback) report must be discussed and reflected on with an appraiser – this is a mandatory requirement by the GMC for revalidation. Other conduct and performance issues are expected to be discussed, reflected on and learnt from.
Action for next year:	Maintain.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	The new on-line appraisal system provides the doctor with easy access links to all required information and the form is pre-populated with information and PDP's which automatically carry over from the previous year.
Comments:	Information gathering is significantly easier and pre-population saves the doctors re-entering information from scratch each year.
Action for next year:	Maintain and review to improves access to information as new software is developed by L2P.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	This is reviewed monthly by ROAG, see 1C(i) and supported by Barnsley's MHPS policy (approved in November 2021) leading to appropriate arrangements being made.
Comments:	The local GMC Employer Liaison Advisor (ELA) is kept updated.
Action for next year:	Maintain.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Currently the Medical Director reports any exclusions of medical staff at the monthly Board meeting. There are very few individual cases requiring reporting. All concerns are reviewed and discussed monthly by ROAG and measures are promptly put in place to respond at a local level to prevent escalation of issues/concerns where possible.
Comments:	Maintaining High Professional Standards policy, Practitioner Performance Advice and GMC-ELA involvement will be invoked.
Action for next year:	Maintain.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	RO to RO information is shared as appropriate via the GMC Medical Practice Information Transfer (MPIT) form or similar document that other Trusts may have adopted.
Comments:	Barnsley uses the MPIT form to request information from Trust(s) where the doctor was previously employed.
Action for next year:	Maintain

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Action from last year:	ROAG, GMC Governance Handbook and Barnsley's MHPS policy, November 2021, are employed to ensure arrangements are fair and free from bias and discrimination
Comments:	Continue
Action for next year:	Maintain

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Systems are in place: National Reports e.g. National Heart Failure Audit, National Joint Registry, National Emergency Laparotomy Audit and other national reports are reviewed monthly at the Clinical Effectiveness Group (CEG) chaired by either the Medical Director or the Deputy Medical Director. Relevant Specialties present these reports at CEG and detail their action plans informed by these reports.
Comments:	Continue
Action for next year:	Maintain

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Systems are in place: Trust MHPS Policy, Clinical Capability Policy, – a specific policy for doctors & dentists. Supporting Positive Staff Behaviour, Conduct at Work policy. Trust Clinical Registration Policy for Nursing Staff.
Comments:	Continue
Action for next year:	Maintain

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Systems are in place for pre-employment checks; Proof of ID, GMC Registration, Occupational Health clearance, DBS, Clinical References, Salary Information and transfer of ESR data in addition to MPIT RO to RO information transfer as relevant.
Comments:	Continue
Action for next year:	Maintain

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Many different processes, e.g. Audit, QIA, CPD and Appraisal feed into this system. GIRFT – Getting it Right First-Time group identifies good performance and encourages sharing of best practice through the oversight groups reporting to the Clinical Effectiveness Group (CEG). CEG provides support for individual outliers.
Comments:	Continue
Action for next year:	Maintain

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	The Trust has systems in place which are closely followed and monitored: Equality, Diversity, Inclusion and Human Rights Policy, Trans Equality and Inclusion Policy and a Workplace Adjustment Guide. All Policies have to have a DPIA and all Trust documents and processes are monitored.
Comments:	Continue
Action for next year:	Maintain

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	The Trust has systems in place which are closely followed and monitored: Freedom to Speak up Guardian and Duty of Candour. We encourage instant reporting via DATIX Learning is encouraged in all areas of reviewed performance, e.g. mortality, litigation, datix, PSII etc.
Comments:	Continue
Action for next year:	Maintain

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Incidents, SI/PSII, Complaints, Litigation, Mortality Oversight Group, Inquests are discussed at the Weekly Patient Safety Group. Where any concerns are raised a prompt response is issued. Formal feedback from all of these inputs is shared throughout the organisation.
Comments:	Continue
Action for next year:	Maintain

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Action from last year:	Regular review of Concerns and MHPS is undertaken at ROAG (see 1C(i)). We had 5 doctors with ongoing MHPS or Concerns during the 2024-2025 appraisal year. 1 of these doctors were from BAME backgrounds and obtained their primary medical qualification outside of the UK.
Comments:	Continue
Action for next year:	Maintain and keep under close scrutiny, continual review of support required for new doctors.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	The Responsible Officer (RO), Deputy Medical Director and Appraisal Lead (DMD) and Appraisal and Revalidation Support manager (ARSM) attend relevant network meetings and engage outside of formal network with their peers to review processes. DMD attended a Disciplinary Panel in a neighbouring Trust, partly to ensure consistency. The Trust has engaged with peer review, pre-Covid.
Comments:	Next peer review planned for 2025/2026 appraisal year after the new appraisal system has had a full appraisal year to bed-in.
Action for next year:	Maintain relationships with peer groups and review processes.

Section 2 – metrics

Year covered by this report and statement: 1st April 2024 – 31st March 2025

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2025	360

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	349
Total number of appraisals approved missed	7
Total number of unapproved missed	4

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	71
Total number of late recommendations	0
Total number of positive recommendations	65
Total number of deferrals made	6
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	5
Total number of trained case managers	3
Total number of new concerns registered	5
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March 2025	7 months and 23 days
Median duration of concerns processes closed	4.5 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0 formal referrals to the GMC

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	182
Number of new employment checks completed before commencement of employment	182

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
<u>New Appraisal System, L2P</u> First full year pf new appraisal system. Appraisal rates maintained. Feedback for doctors and appraisers overwhelmingly positive. <u>Appraisal:</u> BHNFT, as at 31st March 2025 (the end of the reporting period for 2024/2025 appraisal year) had 360 doctors for whom we were the Designated Body (DB). This makes us responsible for their annual Appraisal and, if they are working here at the time of their General Medical Council (GMC) scheduled Revalidation, responsible for making a submission to the GMC regarding their suitability for Revalidation. During this timeframe 349 appraisal meetings were conducted with an additional seven appraisals categorized as approved missed (these did not take place due to “approved” reasons of; Sick leave, MAT leave, Sabbatical Leave and family issues). Therefore 98.9% (356) of the 360 doctors connected to us as their Designated Body had their appraisal successfully managed. Four appraisals did not occur which were categorised as unapproved missed appraisals; of these four doctors who had unapproved missed appraisals; one has retired, two have successfully appraised in April and one successfully appraised in May 2025. <u>Revalidation:</u> During the 2025/2025 year we had 65 doctors successfully revalidate as per GMC schedule. An additional six doctors had their revalidation deferred four due to lack of supporting information all of whom had recently commenced in post. one doctor on long term sick leave had not had the opportunity to collect supporting information. One doctor was under formal investigation. All submissions were in good time and prior to their GMC scheduled dates.
Actions still outstanding

<u>Appraiser End of Appraisal Year Reports</u>

We issue End of Appraisal Year Reports to our appraisers which details their metrics and includes anonymised feedback from their appraisees.
Current issues
Actions for next year): See list of “Actions for next year” identified in Section 1
<u>Appraiser Recruitment:</u> Increasing number of LED doctors has increased the number of appraisals required (up by 40 in 2 years). Three appraisers have retired from active service. A current round of appraiser recruitment and training is underway to ensure that doctors have a wide choice of appraiser and that the appraisers are not excessively challenged.
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
<u>Achievements</u> Despite industrial action and the demands of the NHS, the Trust Medical Appraisal and Revalidation processes are working well. We continued to deliver high-quality appraisal while maintaining above target levels of doctors in date for appraisal, Trust and NHSEI targets for in date appraisal are both 90% and were exceeded. We ended the 2024/2025 appraisal year with 96.9% in date for appraisal rising to 98.9% when approved missed appraisals are included.
<u>Challenges</u> The MSF provision within L2P is satisfactory but we hope to improve this when the company rolls out new software later in the current appraisal year.
<u>Aspirations</u> To conduct QA of Appraisal and Peer Review in the 2025-2026 appraisal year after the L2P system has had a full appraisal year (2024/2025) to “bed-in”. Also to recruit another 10 Appraisers to support our increasing Medical workforce.

Section 4 – Statement of Compliance

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of the designated body:	Barnsley Hospital NHS Foundation Trust

Name:	Dr Mike Richmond
Role:	Chair of the Board
Signed:	
Date:	

5.7. Communications Strategy

For Approval

Presented by Emma Parkes



REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD:25/10/02/5.7

SUBJECT:	Communications Strategy

Date	2 October 2025

PURPOSE:		<i>Tick as ✓ applicable</i>		<i>Tick as ✓ applicable</i>
	<i>For decision/approval</i>	X	<i>Assurance</i>	
	<i>For review</i>		<i>Governance</i>	
	<i>For information</i>		<i>Strategy</i>	X

PREPARED BY:	Emma Parkes & Liz Close, Deputy Director of Communications

SPONSORED BY:	Dr Richard Jenkins, Chief Executive

PRESENTED BY:	Emma Parkes, Director of Communications

STRATEGIC CONTEXT

Our organisational strategy and narrative are aligned to Barnsley Hospital's six Trust objectives. Our corresponding messages underline the Trust's commitment to making the most of our available resource in the challenging years ahead, as we take another step on our journey towards our longer-term goals.

EXECUTIVE SUMMARY

As we build this strategy, the NHS is facing the highest demand since its inception. The population is growing while finances and resources are decreasing. Attracting and retaining the right people into our organisation is essential for us to rise to these challenges. Without good communication with our current and future workforce, this will not be possible.

Our Trust is in a stronger position than many other healthcare organisations. We have an abundance of inspiring and pioneering stories to tell about our colleagues and the work they do.

This strategy acknowledges the current challenges facing the NHS nationally, including lower patient satisfaction, rapid technological and demographic changes, and increasing operational pressures. It is also designed with agility in mind, enabling us to flex and adapt to evolving national landscape.

It will:

- Support organisational priorities and values, prioritising our patients, performance and people
- Enhance internal engagement and team building, engendering a well-informed workforce
- Bolster our already strong external reputation and public perception
- Uphold partnership working, showcasing shared goals and messaging aligned with our partners
- Support recruitment and retention
- Enable crisis and risk-communication readiness, supporting business continuity

RECOMMENDATION

The Executive Team are asked to support and approve the Trust's new 5 year Communications Strategy.



Barnsley Hospital
NHS Foundation Trust

Communications Strategy

2025-2030



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Foreword by Dr Richard Jenkins, Chief Executive of Barnsley Hospital



In the complex world of healthcare, effective communication is not just a function – it is a key element of compassionate care, patient safety, clinical excellence, and operational effectiveness. When communication is strong and well delivered, it builds mutual understanding, trust, and coordinated action, all of which are essential for delivering high-quality care.

In our organisation, we are committed to fostering a culture where communication is important at every level. This helps us engage with our colleagues, stakeholders and partners – all of which are vital in delivering our Trust priorities and caring for the communities and patients we serve.

Effective communications are even more important over the next five years, with the NHS facing significant challenge, pressure and fast-paced change. Patient satisfaction with the NHS is low, and at the same time, technology is innovating and the demographic landscape is evolving. The UK government is reprioritising public money at a time when the economy is struggling. This isn't going to be a short-term issue and consequently public services, such as the NHS, have to manage their finances better and become more efficient at using the tax payers' money that we are given.

At Barnsley Hospital, we have great colleagues who are committed to delivering excellent services and we will need to utilise everyone's ideas about how to deliver these changes. Communication plays an ever-more important role in this.

Barnsley continues to have a strong community identity throughout our geographical area. We are proactive in our role as an 'anchor institution,' working with partner organisations across Barnsley, South Yorkshire and nationally, to harness our collective influence and have an even greater impact on the health and wellbeing of our community.

This strategy will help us align our messages and narrative, and inform how we communicate with our wide range of internal and external stakeholders locally, regionally and nationally. It is a guide to the most appropriate, effective, and inclusive ways to engage and build teams and partnerships now and for the future.

Barnsley Hospital is Proud to Care and I am proud to support this approach to underpin our services over the next few years.

A message from Emma Parkes, Director of Communications



I'm really proud to present this communications strategy for Barnsley Hospital. I joined Barnsley Hospital in 2013 after working in communications and marketing for around 20 years. In that time, I have been truly honoured to work with some of the most inspiring people I've ever met.

Every day when I walk through the hospital doors, I'm reminded of the huge array of extraordinary stories of dedication, innovation and resilience that happen here.

From our award-winning portering team who move thousands of patients each year with precision and a smile, to our nurses who receive heartfelt tributes from patients, carers and visitors, our army of selfless volunteers, or a team supporting a family through end-of-life-care – every role matters.

When people ask me why hospital workers are inspiring, I say it's because they remind us what it means to be human, to care deeply and never stop striving to give our patients the best care they can.

Our communications team work hard each day to seek out and share these stories. They understand why this is important:

- that if we are to continue to recruit the best people, we need to demonstrate we are the best
- and why it's essential to scrutinise our own communications closely, to ensure the right messages reach our patients, the public and our stakeholders as clearly as possible in a timely, and well-managed way.

What I value most about working here is the professionalism and the unity: From receptionists who welcome people into our hospital, our laboratory colleagues providing a 24/7 service, our security teams working to keep everyone safe, a therapist providing life changing treatment, or a clinical team implementing cutting-edge new technology – Barnsley Hospital comes together across roles, disciplines and departments to support each another and our patients.

Being communications director here is a privilege, because I get both witness, and tell these stories.

Please reach out to our team and tell us about your news, and your successes, however big or small they seem, so we can really reflect who we are as a whole hospital team

And keep an eye on the communications page of our Hub, for our policies and processes.

Our strategic priorities

Our mission is simple: To provide the best possible care for the people of Barnsley and beyond at all stages of their life.



The Government’s [10 Year Health Plan for England](#) seizes the opportunities provided by new technologies, medicines, and innovations to deliver better care for all patients – wherever they live and whatever they earn. It is making three big shifts to how the NHS works:

- from hospital to community: more care will be available on people’s doorsteps and in their homes
- from analogue to digital: new technology will liberate staff from admin and allow people to manage their care as easily as they bank or shop online
- from sickness to prevention: we’ll reach patients earlier and make the healthy choice the easy choice



Our organisational strategy and narrative are aligned to Barnsley Hospital’s six Trust objectives. Data, insight and feedback from patients, teams across our Trust, and our executive team and Board, as well as national drivers and the priorities of the ICB and Acute Federation all contribute

to these priorities. Our corresponding messages underline the Trust’s commitment to making the most of our available resource in the challenging years ahead, as we take another big step on our journey towards our ambitious longer-term goals by 2028/29:



Best for Patients and the Public

We will achieve quality of care consistent with a CQC ‘good’ rating and perform in the top quartile of patient experience surveys by 2028/29.

Best for People

We will achieve a top staff survey result and have the necessary workforce in place by reducing absence and improving our vacancy and retention rates.

Best for Performance
(operational and financial)

We will deliver national planning guidance priorities and develop plans to meet constitutional standards, including cancer care standards and 92% of patients waiting no longer than 18 weeks for elective treatment. We will work towards a top 10 performance goal for Urgent and Emergency Care by 2028/29. Services will be delivered in line with our financial plan, aiming to return to a recurrent sustainable balanced break-even position by 2028/29.

Best for Place

We will achieve quality of care consistent with a CQC ‘good’ rating and perform in the top quartile of patient experience surveys by 2028/29

Best for Partners

We will work with our partners to deliver the Integrated Care Partnership Strategy and Joint Forward Plan across South Yorkshire including an increased collaboration with The Rotherham Foundation Trust.

Best for Planet

We will deliver energy efficiencies and refine plans to enable a platform for meaningful progress against the ambition of an 80% reduction in direct emissions between 2028 and 2032.



Why do we need a Communications Strategy for Barnsley Hospital?

As we build this strategy, the NHS is facing the highest demand since its inception. The population is growing while finances and resources are decreasing. Attracting and retaining the right people into our organisation is essential for us to rise to these challenges. Without good communication with our current and future workforce, this will not be possible.

Barnsley Hospital is a great place to work, as proven in the results of the annual NHS Staff Survey. Our Trust is in a stronger position than many other healthcare organisations.

We have an abundance of amazing, inspiring and pioneering stories to tell about our colleagues and the work they do.

This strategy acknowledges the current challenges facing the NHS nationally, including lower patient satisfaction, rapid technological and demographic changes, and increasing operational pressures. It is also designed with agility in mind, enabling us to flex and adapt to evolving national landscape. It will:

- Support organisational priorities and values, prioritising our patients, performance and people
- Enhance internal engagement and team building, engendering a well-informed and motivated workforce
- Bolster our already strong external reputation and public perception honestly, openly, clearly and proactively
- Uphold partnership working, showcasing shared goals and messaging aligned with our partners
- Support recruitment and retention
- Enable crisis and risk-communication readiness, supporting business continuity through timely and accurate information flow



Our Proud to Care content themes

In an acute NHS Trust, teamwork, compassion and respect are more than values – they change lives. Across wards and CBUs, our shared purpose unites us: to provide high quality person-centred care for every person who needs it. No single role, department, or discipline can achieve this alone. Being Proud to Care means looking out for each other. It is only possible when we work together, bringing our diverse skills, perspectives, and experiences to the table.

When clinicians, support teams, and partners collaborate openly and respectfully, we create a culture of trust and continuous improvement. This teamwork strengthens our decision-making, enhances patient outcomes, and supports each other’s wellbeing in the face of daily challenges.

Working together means communicating clearly, listening actively, valuing every voice, and lifting each other up. In doing so, we build systems of care that are resilient, responsive, and inclusive, where innovation thrives and people feel seen and supported. Together, we are stronger. Together, we can achieve more. And together, we will continue to be Proud to Care.



Patients
Person-centred care places the patient at the heart of every decision and action taken in our hospital. There is a direct correlation between highly engaged colleagues and patient outcomes. Our communications play an important role in establishing this approach.

People
We support the Trust’s People Strategy (looking after our people, belonging in the NHS, growing for the future, and new ways of working and delivering care), our Proud to Care Cultural Leadership themes of Respect and Teamwork, and the NHS People Promise. Barnsley has a diverse and changing population and workforce and a clear commitment to inclusivity and equality. These messages are crucial to fulfilling our ambitions.



Partnership
Our communications approach further strengthens our successful partnership with TRFT, as we continue to grow our relationship and connections between our two hospital communities. Building on the best of both Barnsley and Rotherham means both Trusts are in an even better position to continue delivering the best possible care to our patients, and become even better places to work.

We have a close and important working relationship with regional and national NHS organisations, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Council (BMBC), Barnsley Hospice, and Barnsley Community and Voluntary Services (CVS). Our communications teams work together to align and deliver clear messages to our patients and stakeholders, jointly working towards an ambition where everyone in our Borough is able to enjoy a life in good physical and mental health.



“We’re excited to be able to provide more of our services in the heart of Barnsley. Our partnership working has sharpened focus on the needs of our community, and moving a further 90,000 appointments from the hospital to the town centre addresses some of those needs.”

Dr Richard Jenkins
Chief Executive

Performance
Every day, by working together as one team, we make a huge difference. From our emergency care to every ward and department across the hospital, commitment, teamwork, professionalism and skill ensures our patients receive safe, timely, and compassionate care right from the very start of their journey.

Our communications encourages, supports and then celebrates these achievements, showcasing how every individual and every team plays a part.

Place
Barnsley Hospital is one of the Borough’s largest employers. We work closely with Barnsley Council, education institutions and other partners to deliver outcomes that truly improve the town and surrounding areas for those who live and work within it. The introduction of our Community Diagnostic Centre in The Glass Works and plans to move more appointments to the town centre Alhambra are some of our flagship Place projects. We’re proud to share our story as an important and growing ‘anchor institution’ employing more than 4,000 people.

Planet
Barnsley Hospital has specific targets for energy efficiencies, a reduction in direct emissions, and sustainability. Our already established Green Plan will be refined and improved in line with the latest national guidance, and we also contribute to the ICB’s Green Plan regionally. Communicating these improvements helps everyone play their part, however big or small, and move towards the same goal.



Delivering effective brand and service level communications

Barnsley Hospital has a clear and well-established visual brand identity. In an increasingly noisy, information and media-rich world, it is more important than ever to remain on brand and true to our identity. The Communications Team acts as 'brand guardian,' and will deliver activity as such.

Against our content themes, we will plan and develop a full range of high quality campaigns and content, including key message development, human interest stories, infographics, briefings, thought leadership, imagery and video.



Delivering effective stakeholder communications

Our stakeholders are diverse and multi-faceted, requiring the right mix of activities and channels to ensure messages cut through to each. These relationships are managed in different ways throughout the Trust and the Communications Team is responsible for producing targeted key briefings. Broadly, our hospital's stakeholders are:

External

1. Patients, their carers and families, and the community we serve
2. Candidates and the talent pool
3. Our partners
4. Providers
5. Academic partners
6. Industry and research partners
7. Regulatory bodies (CQC, NHS England, Department for Health and Social Care, NMC, GMC, ICB, Healthwatch)
8. Media
9. Political, locally and nationally

Internal

1. Barnsley Hospital colleagues
2. Board of Directors and Executive Team
3. Council of Governors
4. Senior Leaders
5. Staff Side Partners

Proactive stakeholder and partnership bulletins will be developed to shore-up the increase in crucial, need to know information, in addition to successes and celebrations, ensuring everyone is appropriately well-informed, supporting stability and assurance in times of change.





Delivering effective crisis communications

At Barnsley Hospital NHS Foundation Trust, we take a proactive and structured approach to communications crisis planning. Our strategy is built on preparedness, clarity, and cooperation.

We define a crisis as any situation that poses a risk to operational continuity, patient or colleague safety or public trust – ranging from national or local incidents to data breaches or significant media scrutiny.

To ensure readiness, we maintain a crisis communications protocol that includes clear thresholds for escalation, and a checklist of immediate actions. We work closely with senior leaders, security operational teams, and switchboard staff to plan ahead, ensure consistent messaging and rapid deployment of activity.

Our relationships with the full range of emergency services, all our partners, and the media are vital in this work. We regularly participate in training and professional development internally and alongside other organisations to maintain maximum foresight and resilience.

Awards and recognition

Recognising the skills, hard work, support, professionalism and person-centred care our colleagues deliver is key to inclusivity, recruitment and retention, and to employing the people we need to deliver our ambitions.

Barnsley Hospital has a number of well-established recognition mechanisms, including: Shout Out, our monthly peer-to-peer newsletter, monthly Brilliant Awards, Long Service Awards, our annual Heart Awards

ceremony, and a calendar of national and international professional awareness events.

We also champion industry awards, supporting colleagues to enter key health service awards as well as awards in any other sector specialism employed by our Trust.

As a Trust, we want to take our recognitions from great to excellent.



Barnsley Hospital's Communications channels

In building our strategy, we conducted a Trust-wide survey to gather feedback, explore how well current channels engage our people, and understand how they want to receive communications.

We have listened carefully to what the survey told us to build our new strategy, and will continue to do-so. We operate in a changing environment and will continually improve to deliver and engage. Some of the priority channels we will use to communicate and engage with our people and population include:

Team Brief delivers a regular leadership narrative to our people. Broadcast monthly online by our Chief Executive. Guest speakers provide 'deep dives' into important topics as an opportunity for colleagues to knowledge-share. Question and answer sessions provide a space for openness.

The Hub. We will develop the Trust's intranet – 'the Hub' – as a dynamic and agile library of information for all Trust colleagues, building a central repository fit for future changes and challenges.

Proud News is our vibrant weekly online staff magazine, used to celebrate staff stories from our diverse teams. Launched in 2024, the colourful publication is used to acknowledge and promote the work and achievements of our people and provide staff news in an engaging and easily digestible way. Feedback to-date has been overwhelmingly positive and we monitor analytics via the Issu platform to adapt and improve.

iBulletin is our weekly operational newsletter - a snapshot of important operational updates.

Barnsley Hospital Staff App. Our communications survey showed staff were strongly in favour of receiving communications via a Barnsley Hospital staff app. We will develop and launch an app. It will be a central place for easy access to key information while on the move and a way of reaching the large numbers of staff who do not use laptops regularly, delivering information directly to phones. The app will send push notifications (subject to strict criteria) and acts to connect all disciplines, colleagues and teams.

We also want to move towards all communication, including the Hub, to be accessible on mobile to reach all colleagues.

Digital Screens – We will proactively seek to increase our digital communications for public, patients and colleagues.

All-staff emails from our directors provide important operational information and strategic messages.

Partnership Communications – We will proactively communicate with MPs, other NHS organisations, Place, and public sector partners to build strong relationships, share insights, and work together to improve the health and wellbeing of local communities.



Social media

Social media provides a visible public presence and an avenue for key updates in a timely manner to members of the public that is not possible with traditional media.

Social media is seen as an important source of information by both colleagues and patients and we have built a strong following for Barnsley Hospital.

Social media is fast evolving with different channels having different audiences and bespoke style.

We will continue to grow our social media following through organic content on the platforms that provide the best engagement with our intended audiences.

Facebook remains the most popular channel for all our stakeholders. We will focus on people-centred posts on the Trusts' Facebook accounts, including a new Feedback Friday theme in which we will highlight compliments and positive feedback given to our colleagues by our patients.

Instagram is still a growing and leading platform, and we will build our presence here to deliver public messaging.

LinkedIn remains the number one channel for professionals, supporting the goals of our People Strategy. We will continue to grow our following on LinkedIn, utilising messaging to promote career opportunities and support recruitment.

Barnsley Hospital has reduced activity on X and at the time of writing uses X for urgent operational updates to the public only. **BlueSky** is fast-emerging and we will build our presence on this channel and others. We continue to monitor **TikTok** and other platforms for effectiveness and cut through with our target audiences.



Press and broadcast media

- The Communications Team works hard to build and maintain good media relations, through responsiveness and transparency. Recent political narrative will continue to affect Barnsley Hospital with NHS scrutiny at an all-time high. We will continue to build even stronger relationships with local, regional, national and industry journalists, titles and outlets.
- We operate a highly responsive press office, reacting to media enquiries in a timely, open and transparent way. The Communications Team will continue to work with the media and stakeholders to navigate this landscape with the intention of clear messaging for our colleagues, stakeholders, patients and community.
- Press and broadcast media offer a high-profile outlet for person-centred care stories, which we continue to seek out and share.
- We work proactively with producers and documentary makers and have seen success with our Casualty 24/7 and recent Panorama feature about community-based care. We will continue with this approach while remaining mindful of operational pressures and putting patient care first and foremost.
- We will continue to build our calendar of proactive press release stories and pitched story ideas, to clearly inform public and patients about our services, and showcase and applaud our people and their successes.

Barnsley Hospital News is the Trust's quarterly supplement packed with stories about our service and our people, published with the Barnsley Chronicle – a newspaper that continues to have a strong following in our Borough.

Website

We continue to develop our website to respond to user feedback and build opportunities for increased digital interaction, while ensuring accessibility standards are met. Patient information published on our website is subject to a rigorous governance process.

How will we measure?

- Analytics tools for social media, online newsletters and web
- Feedback in our communications surveys
- Listening tools, such as our Team Brief questions
- Media coverage analysis
- Anecdotal feedback from all levels

Fulfilling our strategy: Making it happen

The Communications Team is owner of Barnsley Hospital's Communications Strategy, but it is a collaborative holistic, evolving work plan. Delivery of all the communications activity included in this strategy is dependent on commitment and input from colleagues across our Trust. Our Communications Team are facilitators of information, supporting you to creatively and appropriately share your news, your key information and your updates.

Our service functions as a 'hub and spoke' model. We work with CBUs, Barnsley Facilities Services and the full range of corporate and support teams, and are present on all key Trust and partner committees and steering groups but due to the size and complexity of our whole hospital service, some of the best 'Proud to Care' stories and achievements are often never uncovered.

It is everyone's responsibility to identify opportunities to share and communicate their achievements across and about our hospital, and beyond. Being Proud to Care means everyone sharing a culture of celebration and recognition, that underpins a leading and forward-thinking, positive institution. We work with individuals in every area of our Trust and with partner organisations to achieve this.

- We work to the principles of effective communication at all times:
1. Clarity and timeliness
 2. Accessibility, plain English and inclusivity, using NHS England's style guide
 3. Credibility and trust
 4. Engagement and feedback
 5. Consistency of messaging
 6. Compassion and cultural sensitivity
 7. Transparency and honesty
 8. Alignment with the NHS and Barnsley Hospital Proud to Care brands

We will continue to ensure our communications are accessible to all our stakeholders, utilising a range of communication methods suitable for our diverse audiences.



The Communications Team's Hub page is a central platform and single access point for up-to-date Trust communications processes and procedures, as well as for other resources such as guides and templates. New policies to reflect current and emerging social media trends and partner policies are in development and will be published on this page.

Our delivery calendar reflects our hospital's operational plan, as well as the needs and demographic of our town and national healthcare priorities. We prioritise the following:

- 'Big ticket' launches and events, such as Health on the High Street Alhambra Outpatients, and the opening of our new Education Centre
- Activity that supports our Patients, People, Performance and Partnership themes and the national move towards digital, prevention and care in the community
- Health and wellbeing, equality and diversity, cultural initiatives and celebration
- Business continuity, safeguarding and anti-violence and aggression through our well-established No Place for Hate campaign
- Professional celebratory calendar dates, such as International Nurses Day
- QI (quality improvement) to drive efficiency and best value for money
- Trust-wide strategic activity, for example financial planning, Anti-Racism Framework and People Strategy
- Large events like our Heart Awards and Proud to Care conference and small events such as Armed Forces Day
- Inspections and survey findings, such as the CQC InPatient survey and annual NHS Staff Survey
- National, regional and Barnsley Hospital specific public health, information and awareness campaigns.

The Communications Team deals with a high number of items from all areas of the organisation every day and uses planning tools to ensure these requests can be fulfilled to a high standard. The team is skilled at reacting to demand at short notice but also requests adequate lead time for known activities to maximise each communications activity.

The team will advise on the timing of the release of a success story to ensure it lands at a good time with media.



6. System & Partnership

To Note

6.1. System Partnership Update

To Note

Presented by Michael Wright



REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/10/02/6.1

SUBJECT:	SYSTEM, PLACE AND PARTNERSHIP UPDATE

DATE:	02 OCTOBER 2025

PURPOSE:		<i>Tick as applicable</i>		<i>Tick as applicable</i>
	<i>For decision/approval</i>		Assurance	✓
	<i>For review</i>	✓	Governance	
	<i>For information</i>	✓	Strategy	✓

PREPARED BY:	Michael Wright, Managing Director

SPONSORED BY:	Michael Wright, Managing Director

PRESENTED BY:	Michael Wright, Managing Director

STRATEGIC CONTEXT

We will fulfil our ambition to be at the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health.

EXECUTIVE SUMMARY

This paper provides a summary of key activities happening within the South Yorkshire Integrated Care System, Barnsley Place and the partnership with The Rotherham NHS Foundation Trust. The includes progress to date on new and ongoing initiatives, governance and events that have taken place in the reporting period.

Updates cover: Barnsley place partnership, Barnsley 2030, The South Yorkshire Integrated Care Board and Acute Federation.

RECOMMENDATION(S)

The Board of Directors is asked to receive and note the update on the latest developments at Place.

1. INTRODUCTION

- 1.1 One of the hospital's key strategic aims in Place is: "We will fulfil our ambition to be at the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health".
- 1.2 This paper provides a summary of key activities happening across the South Yorkshire Integrated Care System, within the Place Partnership and progress on the partnership work with The Rotherham NHS Foundation Trust.

2. SOUTH YORKSHIRE INTEGRATED CARE BOARD (SYICB) AND SOUTH YORKSHIRE AND BASSETLAW ACUTE FEDERATION (SYBAF)

- 2.1 Representatives from the Trust have continued to attend several meetings led by the SYICB and the SYBAF. The August 2025 update report from the Chief Executive of the SYICB, which highlights the work of the South Yorkshire ICB and system partners is attached (Appendix 1). Within the update, the SYICB Chief Executive referred to the following:
 - the launch of the 10 Year Health Plan, which sets out how the nation's health will be transformed over the next decade and the role the NHS and care will play in this. The plan is based on the Government's three shifts of hospital to community, analogue to digital and treatment to prevention.
 - the SYICB continue to work through plans following the announcement earlier this year that NHS England (NHSE) will become part of the Department of Health and Social Care (DHSC) over the coming two-year period and that Integrated Care Boards will focus on strategic commissioning of NHS services and system leadership for population health. As part of this reduced focus, the SYICB are also required to reduce operating costs by 51% by December 2025. The formal consultation process start date was however paused following guidance received from NHSE.
- 2.2 The SYBAF continues to meet regularly to coordinate work between the five-member Trusts, with a continued focus on stakeholder workshops relating to fragile services, which were identified following sustainability reviews across all partners. The specific areas of focus include Dermatology, Ophthalmology, Oral and Maxillofacial Surgery, Community Paediatrics and Audiology. Clinical leads have now been appointed, with a number of workshops scheduled to take place from September.
- 2.3 The Chief Executive of the Trust continues to chair specific meetings relating to key workstreams of the South Yorkshire and Bassetlaw (SYB) Acute Federation, these include:
 - The SYB QUIT Oversight Group
 - The Diagnostic Oversight Group
 - The Imaging Network Meeting
 - The UEC Alliance Board

3. BARNSELEY PLACE PARTNERSHIP

- 3.1 The latest available Barnsley Place partnership update is included at Appendix 2. The update makes specific reference to smoking services in Barnsley and the following successes:
 - Over the last 12 years, smoking rate in Barnsley has dropped significantly from 23.7% to 16.1% amongst men, and from 24.3% to 14.0% in females.
 - For the last two years, the overall smoking rate in Barnsley stands at 15%, closely aligning with the England average.
 - The quit rate is notably high, with 65% of people setting a quit date in 2023/24 successfully stopping smoking - well above the 55% target.

3.2 Health on the High Street (Alhambra) continues to progress well, with the Trust's phase one (Ophthalmology) expecting build completion by the end of October 2025. Other partners including the South West Yorkshire Mental Health NHS Foundation Trust are also developing plans to enhance the health service offer in the building, although the start dates are not confirmed at this stage.

3.3 The Barnsley Place Committee and Barnsley Place Partnership Board met on the 25th September. The agenda included the Carers Strategy and Action Plan. It was noted that following an application to be part of the National Neighbourhood Health Implementation Programme (NNHIP) wave one, Barnsley had not been successful.

4. BARNSLEY 2030

4.1 The Barnsley Board meets quarterly and covers 4 key areas: Healthy Barnsley, Growing Barnsley, Learning Barnsley, and Sustainable Barnsley. The Barnsley 2030 Board met on Monday 15th September. This meeting was an away day focused on developing the Barnsley 2040 vision.

5. BARNSLEY HEALTH AND WELL BEING BOARD

5.1 Health and Wellbeing Boards (HWB) are statutory forums where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities.

5.2 Members participated in a workshop session in September which focused on the voluntary sector. The outcomes will be shared with members.

6. BARNSLEY AND ROTHERHAM PARTNERSHIP

During the last two months, work has continued to develop plans for a joint Haematology service, with both Boards previously supporting a business case to take the initiative forward. Patient engagement has continued and a second round of discussions at the local Overview and Scrutiny Committee are scheduled for November, following on from earlier discussions in April 2025.

6.1 The latest Joint Senior Leaders Event took place in September, the agenda focussed on key challenges facing both partners.

7. RECOMMENDATION

7.1 For the Board to note the update on the latest developments at Place, System and Partnership level.

Michael Wright
Managing Director

Barnsley Place update – September 2025



**Barnsley – the place
of possibilities.**

Barnsley Council celebrates 25 years of stop smoking support services



- Over the last 12 years, smoking rate in Barnsley has dropped significantly from 23.7% to 16.1% amongst men, and from 24.3% to 14.0% in females.
- For the last two year, the overall smoking rate in Barnsley stands at 15%, closely aligning with the England average.
- The quit rate is notably high, with 65% of people setting a quit date in 2023/24 successfully stopping smoking - well above the 55% target.

New Wound Care Clinic

A new wound care drop-in clinic has opened in Barnsley to provide vital health services to people experiencing homelessness and rough sleeping. The clinic addresses a critical gap in healthcare provision for this vulnerable population, many of whom face significant challenges in accessing wound care treatment.

The initiative is a collaboration between services provided by South West Yorkshire Partnership NHS Foundation Trust including neighbourhood nursing, health inclusion service, community matrons, and the tissue viability service alongside Barnsley Recovery Steps (formerly Humankind), and Barnsley Council's housing and welfare, town centre warden, and adult safeguarding teams. Homeless individuals often suffer from untreated wounds due to limited access to sanitary facilities, poor nutrition, and harsh living conditions. As many do not seek planned healthcare, untreated wounds can rapidly worsen, leading to emergency medical interventions. Recognising these challenges, the clinic offers specialised, accessible care tailored to the unique needs of rough sleepers.

Since its launch on 14 May 2025, 22 people have received wound treatment at the clinic. Outreach efforts by the health inclusion service from South West Yorkshire Partnership NHS Foundation Trust and town centre wardens help identify individuals with wound care needs and encourage them to attend the clinic. Starting from September 2025, health inclusion service staff will join Barnsley Recovery Step's health workers in delivering the clinic to strengthen relationships with the homeless community and expand health inclusion services.

Investment in a new residential facility for young people in Barnsley

Cabinet members have approved the development of Rock House, a new residential facility for young people aged 16 and above.

This initiative aims to provide short to medium-term accommodation support, helping young people acquire the necessary skills and emotional resilience to transition successfully to adulthood.

The development will see an existing Barnsley Council asset converted into a five-bedroom facility, featuring four self-contained flats and a staff sleep-in area. The conversion of Rock House will allow better support to young people, ensuring they remain closer to their local community, family, and friends. The project is expected to be completed by June 2026, aims to reduce high cost pressures on placement costs.

Barnsley's stop smoking support services were first launched in 1999 as part of the Government's commitment to help smokers quit by investing in local authority led stop smoking services. Starting with just four staff members in a small office, BMBC stop smoking service has grown into a vital community resource offering a range of support to suit varying needs and ensure support is accessible to everyone. The service is now run as part of Yorkshire Smokefree and operates under South West Yorkshire Partnership NHS Foundation Trust. To mark this significant milestone, a Smoke Free celebration will take place on Saturday 30 August, from 10am to 3pm at Glass Works Square. There will also be number of information stalls showcasing support service available to families, including Yorkshire Smokefree and our Smoking in Pregnancy team, providing support and guidance to anyone on or starting their stop smoking journey. The success of Barnsley's stop smoking services over the years is plain to see, with recent data highlighting why this milestone is really worth celebrating:



Urgent and Emergency Care & Flow

In July 2025 Barnsley Hospital’s % A&E patients seen within 4hrs was 72.3% (target 78%). The Category 2 Ambulance Response Time was 26:21 (target 30:00 minutes). Total general and acute bed occupancy for the Trust was 96.% against the 92% standard.

Community Care

South West Yorkshire Partnership Foundation Trust’s target to increase virtual ward utilisation over 80% was achieved at 97% at end of July 2025. Urgent Community Referrals seen within 2 hours also achieved 98.6% against the 70% standard.

Elective

In June 2025 (latest position available) the total of Barnsley place patients waiting over 52 weeks for elective care was 0.3%, meeting the less than 1% standard. The % of patients receiving a diagnostic test within 6 weeks 88.5% missing the 95% standard.

Cancer

In June 2025 (latest position available), the standard of % of Barnsley place patients with a Cancer Diagnosis communicated within 28 Days met the target of 77% at 82.8% The 62 Day Referral to Treatment standard of 70% was not achieved at 58.6%. Cancer Diagnosis for stage 1 and 2 was at 50.5% not meeting the 75% target.

Mental health, Learning Disabilities, Autism and Dementia

In June 2025 (latest position available), an increase in number of 0-17 year olds receiving at least one contact with CYP MH services showed a slow upward trajectory at 4,775 patients in Barnsley Place. There was 0 inappropriate out of area mental health placements in Barnsley.

From 2025/26, as a Partnership we will continue to focus on:

- Neighbourhood approach to health and wellbeing, taking a population health and community development approach to improving outcomes.
- Development of an integrated neurodiversity service offer to meet the needs and improve outcomes for children and young people.
- Developing a coordinated Ageing and Dying Well approach to care in the community.

The Partnership will also continue to focus on the right care at the right time in the right place with a specific focus on:

- **Urgent Care** – Reducing demand on emergency care by proactive alternatives to Emergency Departments and GP practices
- **Intermediate Care** – Implementing a strengthened model of support and care
- **Respiratory and circulatory conditions** – Prevention, early identification, self-management and proactive support
- **Diabetes T2** – Prevention, early identification, self-management and proactive support
- **Optimised discharge pathways** – Ensuring flow through the system and provision of care in the right setting to meet needs
- **Mental Health** – Early help and intervention to prevent people requiring crisis support and inpatient care where appropriate and possible.

The Practice Delivery Agreement (PDA), rolled out 1st April 2025 focuses on early identification, case finding and anticipatory care for Diabetes, CVD and Respiratory. Monthly data demonstrates that this scheme is gaining momentum, with increasing patients being identified and treated earlier.



Chief Executive's Report

NHS South Yorkshire Integrated Care Board meeting

03 September 2025

Author(s)	Gavin Boyle, SY ICB Chief Executive		
Sponsor Director	Gavin Boyle, SY ICB Chief Executive		
This report provides assurance against the following risk(s) on the ICB's Board Assurance Framework, Risk Register or Issues Log:	Not applicable		
Purpose of Paper			
The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.			
Key Issues / Points to Note			
Key issues to note are contained within the attached report from the Chief Executive.			
Is your report for Approval / Consideration / Noting			
To note			
Recommendations / Action Required by the Board			
The Board is asked to note the content of the report			
Board Assurance Framework			
This report provides assurance against the following corporate priorities on the Board Assurance Framework:			
Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals:	
Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓
Are there any Resource Implications (including Financial, Staffing etc)?	
No	
Have you carried out an Equality Impact Assessment and is it attached?	
Not applicable	
Have you involved patients, carers and the public in the preparation of the report?	
Not applicable	



Chief Executive's Report

NHS South Yorkshire Integrated Care Board meeting

03 September 2025

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for July and August 2025.

2. Integrated Care System Update

2.1 10 Year Health Plan

The Government has launched the 10 Year Health Plan (10 YHP), which sets out how the nation's health will be transformed over the next decade and the role the NHS and care will play in this. The plan is based on the Government's three shifts of hospital to community, analogue to digital and treatment to prevention.

The release of the 10 Year Health Plan is a significant moment for the NHS but also for the nation. The Plan places an emphasis on prevention, care closer to home and particularly the importance of integrated neighbourhood health. These are all issues which have been a particular focus for many years in South Yorkshire and particularly in our wider work with system partners.

The plan responds to the challenges articulated in Lord Darzi's report by reimagining the NHS through the three shifts. The predominant focus of the hospital to community shift is neighbourhood health and NHS England have asked for expressions of interest to be part of the National Neighbourhood Health Implementation Programme. The programme will support primary care to lead innovation that will make a difference to their communities, and it is anticipated that the 42 areas that are selected will become coaches for neighbouring areas to lead their own neighbourhood health innovation. Given South Yorkshire's strong foundations we have submitted four expressions of interest, one for each of our Places.

The plan sets out how digital innovation will be harnessed to improve both care and patients' experience. This approach will make access to healthcare more convenient for patients and easier to fit around their day to day lives. The Government's plan will see rapid advances in the use of the NHS App, digital telephony for GP practices and the use of artificial intelligence to streamline services and support clinicians in their roles.

The 10 Year Health plan's focus on prevention includes action to address the modifiable risk factors, such as delivery of the tobacco and vapes bill, and targets unhealthy food and alcohol labelling. It also advocates using digital technology to support genomics and other innovations to make scientific breakthroughs. This will see artificial intelligence tools reducing diagnostic workloads, robotic surgery streamlining complex procedures and smarter use of data.

The three shifts align strongly with our South Yorkshire Integrated Care Strategy and Bold Ambitions. There are significant areas of focus in the National Plan that resonate well with our existing delivery in South Yorkshire, for example our Pathways to Work Programme, or where we are well placed to be at the forefront of delivery, such as neighbourhood health, with each of our Places expressing an interest in the National Programme.

As an ICB we have already started to consider the implications of the National 10 Year Health Plan and the new NHS Operating Model for us in our re-defined role as strategic commissioning and for the South Yorkshire System, including how we develop partnership working arrangements building on our South Yorkshire Integrated Care Partnership and Place Partnerships. South Yorkshire NHS organisations, public sector partners, voluntary, community and social enterprise (VCSE) sector and our Place Partnerships and provider collaboratives and alliances are all starting to consider the National Plan and what it means for them. We intend to consider the implications of the 10 YHP in more detail with our system partners during autumn, with a view to consider in more detail at the November ICB Board.

2.2 National changes to ICBs

We're continuing to work through our plans following the announcement earlier this year that NHS England (NHSE) will become part of the Department of Health and Social Care (DHSC) over the coming two-year period and that Integrated Care Boards will focus on strategic commissioning of NHS services and system leadership for population health.

As part of this reduced focus, we are also required to reduce our operating costs by 51% by December 2025.

In July, the Board endorsed a proposal to start a formal consultation with our staff regarding the organisational change. However, shortly after the Board meeting we received guidance from NHSE requiring us to pause the start of consultation to allow for a national discussion regarding how the redundancy costs of this change would be met. We acknowledge how this hiatus prolongs the period of uncertainty for our people; we have raised this with NHSE and hope that a clear direction is given soon. To be ready to begin consultation as soon as NHSE give approval, we have taken the opportunity of the pause to refine our consultation document and reflect the 10 YHP, which has been published since the original. The updated consultation document, including full people impact and Equality, Quality Impact Assessment (EQIA), has been shared with our Joint Staff Consultative Forum (JSCF).

We're grateful to our partner organisations, particularly the NHS provider trusts, our four local authorities and South Yorkshire Mayoral Combined Authority (SYMCA), for continuing to support us to work through these changes, mitigate the risks and take the opportunities to build on our strong partnerships.

2.3 Financial Position Update

The ICB and system NHS providers continue to work together to deliver a breakeven position for 2025/26. The ICB and South Yorkshire NHS providers need to deliver £270m in efficiencies (6.9% of South Yorkshire allocation) to deliver the plan. The financial plan for the South Yorkshire system also assumed that the ICB and system NHS providers would receive £74.1m of deficit support funding from NHS England to deliver this breakeven position. All 42 Integrated Care Systems now have a breakeven plan, and the South Yorkshire efficiency target is similar to the national average.

At the end of July (Month 4) all NHS organisations in South Yorkshire were on plan after adjusting for deficit support funding still to be received for Quarter 2. NHSE withheld release of deficit support funding in Quarter 2 because the South Yorkshire system was £2.9m off plan (£0.8 ICB/£2.1m NHS providers) at the end of May (Month 2). This position will be reviewed at the end of August for potential receipt in Quarter 3.

The South Yorkshire system continues to strengthen its governance and de-risking of plans for delivery. The ICB has itself adopted a turnaround approach with dedicated leadership and support and strengthened governance to support delivery of the plan.

2.4 Industrial Action

Resident doctors from the British Medical Association have taken their first industrial action since achieving a mandate. The doctors took action between 25-30 July 2025 and have a mandate for strikes valid for up to six months if they wish, until January 2026. In South Yorkshire, the NHS has balanced the right of colleagues to take industrial action with the needs of our patients, with colleagues at NHS South Yorkshire and our providers creating comprehensive mitigation plans.

At the time of writing, it was anticipated that the action had seen most elective and outpatient activity continue, although some patients will have had an outpatient appointment cancelled and a small number of day case procedures rearranged. Partners across South Yorkshire will continue our preparation in case further action is announced. In addition, other trade unions representing NHS staff have taken indicative ballots, and we are waiting to see if this leads to a full ballot for industrial action for staff who are members of those unions.

2.5 Integrated Care Partnership (ICP) Board

Partners from across the ICP are working together to boost sport and physical activity to improve health outcomes across South Yorkshire. South Yorkshire Mayoral Combined Authority, Sport England and NHS South Yorkshire signed a Memorandum of Understanding for an ambitious, collaborative approach to sport, physical activity, prevention and wellbeing aimed at aligning our priorities and working in concert.

In addition, the UK's first Sport Legacy Institute, an innovative £7m private-public partnership between the South Yorkshire Mayoral Combined Authority and Westfield Health that will create a centre of excellence for sport and health innovation within the Olympic Legacy Park in Sheffield. The initiative is aimed at attracting inward investment to improve health outcomes in South Yorkshire.

2.6 Health and Growth Accelerator

A major priority for the SY Integrated Care Partnership is the relationship between good jobs and good health. Our Pathways to Work approach is groundbreaking and we are leading the way nationally. As part of this we have opened applications for the South Yorkshire Health and Growth Accelerator Community Grants. The Grants, each of up to £15,000, will total £585,000, and are part of the £8m Growth Accelerator programme in partnership with South Yorkshire Combined Mayoral Authority Health, with Pathways to Work aiming to support 10,000 people to stay in or return to work over the coming years.

The grants will go to not-for-profit groups that support adults in work who are experiencing

absences from work due to mental health, chronic pain, or musculoskeletal issues to apply. In addition, projects working with 16-24-year-olds with anxiety or depression, including those with neurodiverse needs, who are struggling to stay in education or employment or enter the workplace, are also being supported.

2.7 GP Patient Survey

More than three quarters of patients had a good overall experience of their GP in South Yorkshire. Patients have had their say on local GP practices, dentists and pharmacies as part of the GP Patient Survey 2025. In most indicators, South Yorkshire are level or above national responses. A total of 93% said they had confidence and trust in the healthcare professional at their last appointment, which was the same as the national figure. In addition, 90% felt that their needs were met during their last appointment, and 70% had a good overall experience of contacting their GP practice, which were both in line with the national figure.

In other areas of primary care, 88% had a good overall experience of pharmacy services, which was the same as the national figure and 75% had a good overall experience of NHS dental services, which was higher than the national figure of 71%.

2.8 Publication of independent investigation report into the care of Yusuf Nazir

Yusuf Mahmud Nazir was a five-year-old boy from Rotherham who tragically died whilst receiving NHS care in November 2022. An independent patient safety investigation commissioned by NHS England, involving a number of organisations, into the care of Yusuf Mahmud Nazir has been published.

Dr David Crichton, Chief Medical Officer, on behalf of NHS South Yorkshire, accepted the report's recommendations in full. The report and appendices have been published on the [NHS South Yorkshire website](#). All organisations involved in Yusuf's care are taking steps to implement learning from his sad death. An inquest into the death of Yusuf was opened by the Senior Coroner for South Yorkshire (West) in August.

3. NHS South Yorkshire

3.1 Commissioning Policies Involvement

NHS South Yorkshire has launched a 12-week public involvement exercise to hear from local people about the future of NHS gluten-free food prescribing. In addition, a 12-week public engagement exercise will also take place asking for our communities to share their views on the future of NHS-funded in vitro fertilisation (IVF) services.

The gluten-free food prescribing review focuses on prescriptions of gluten-free breads and mixes for people with diagnosed conditions such as coeliac disease or dermatitis herpetiformis. Prescribing of gluten-free products has been in place for many years, but changes in product availability, cost pressures, and growing demands on NHS resources, have prompted a fresh look at how these services are funded locally.

The engagement on IVF follows a review of provision across the region, which currently offers up to two funded cycles of treatment. The ICB is considering whether this level of provision remains appropriate in the context of growing pressures on NHS services and the need to ensure best value for public funds.

The engagement will run for both until 17 October 2025, with a decision expected to be taken at the ICB Board meeting in November.

In addition to the local involvement taking place, the Department for Health and Social Care (DHSC) has this week opened a consultation on proposed changes to the NHS dental contract. The NHS dental contract quality and payment reforms 2026 represent a significant and essential step on the journey to improve access to and quality of NHS dentistry. The proposed changes aim to improve access for those requiring urgent care, enhance treatment pathways for complex cases, and deliver better preventative care for children.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Sheffield Teaching Hospitals NHS Foundation Trust is leading a £3.8m research project aiming to improve communication between people with aphasia and their communication partners. The Aphasia Partnership Training (APT) project plans to co-design and evaluate a novel communication partner training (CPT) programme. Starting in autumn, the intervention will be trialled in approximately 30 NHS speech and language therapy services in the UK.

4.2 Doncaster

Over £15.7m worth of funding has been secured to improve primary care estates in Doncaster, with two new GP hubs set to be opened in Rossington and Bentley. Following a thorough stage of planning, public consultations and legal processes, the final documentation has been signed off by NHS England. Funding to develop the new hubs will be provided by the NHS and given to City of Doncaster Council (CDC) to build and maintain the sites. As the owner of the buildings, CDC will be landlord to both, with each being home to two GP practices who will each occupy under a long-term lease. The two new GP hubs will boost NHS South Yorkshire's capacity to deliver quality healthcare services in Doncaster, ensuring that primary care services continue to reflect and adapt to patient needs.

4.3 Rotherham

The Rotherham NHS Foundation Trust's paediatric diabetes project has been shortlisted for a Health Service Journal (HSJ) Award in the Early Intervention and Prevention for Children, Young People and Families category. The Trust is combining diabetes technology and nutritional support to assist children and families from underserved communities in Rotherham.

4.4 Barnsley

In August, senior leaders from the Department of Health and Social Care visited Barnsley to learn more about our trailblazing Health on the High Street developments. Tom Riordan CBE, Second Permanent Secretary for the Department of Health and Social Care (DHSC), was in Barnsley to learn more about the Health on the High Street developments. He was given a tour of the Alhambra Centre, where the next phase of the Health on the High Street initiative will bring more accessible, convenient health and wellbeing services to thousands of residents.

5. General Updates

5.1 Preparations for World Menopause Day

NHS South Yorkshire will host #MenoFest25 on Saturday 18 October 2025 in Sheffield. The event was incredibly successful last year in breaking down the stigma surrounding menopause, in everyday life and the workplace, by creating a safe, welcoming space for open conversation, learning, and connection. The event is designed for health and social care professionals, friends, family members, and anyone seeking support or wishing to support others through the menopause.

5.2 Awards

Liz Leggott from the Primary Care Workforce and Training Hub was named the HSJ's Digital Innovator of the Year. Liz won the award for her work in proving that digital innovation could help tackle some of the biggest issues facing primary care, such as a lack of capacity to teach, experienced supervisors and facilities and space. Liz's project was focussed on tackling these issues by seeing if digital tools could make a difference and she worked on expanding capacity and access and bringing training to life to make it more engaging, both of which showed incredibly positive results.

The NHS South Yorkshire Star Awards recent winners were:

- July: Alison Hague and Tom Cragg won the July award for their work on the Cyber Assessment Framework submission. The submission was reviewed by auditors who gave our improved arrangements their highest assurance rating.
- August: Craig Hampshire won the August award for his work supporting colleagues on a complex data sharing situation when the ICB was required to securely transfer a large amount of confidential data within an extremely short timescale.

Gavin Boyle

Chief Executive, NHS South Yorkshire Integrated Care Board

3 September 2025

7. For Information

7.1. Chair Report

For Information

Presented by Michael Richmond



**REPORT TO THE
BOARD OF DIRECTORS - Public**

REF:

BoD: 25/10/02/7.1

SUBJECT:	CHAIR'S REPORT – AUGUST & SEPTEMBER DATA				
DATE:	2 October 2025				
PURPOSE:		<i>Tick as applicable</i>			<i>Tick as applicable</i>
	<i>For decision/approval</i>			<i>Assurance</i>	✓
	<i>For review</i>	✓		<i>Governance</i>	
	<i>For information</i>	✓		<i>Strategy</i>	
PREPARED BY:	Mike Richmond, Chair				
SPONSORED BY:	Mike Richmond, Chair				
PRESENTED BY:	Mike Richmond, Chair				

STRATEGIC CONTEXT

To report events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight several items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

1.1 Brilliant Awards

Since our last meeting, we've had the pleasure of presenting several prestigious awards to colleagues and teams. These accolades celebrate individuals who have been nominated by peers, leaders, or members of the public who have contacted the Trust. With so many outstanding nominations received each month, selecting the winners is always a rewarding yet challenging task.

During August, we were proud to present awards to Sue Burgan in recognition of her exceptional support and her calm, professional approach throughout the challenging rollout of the national NHS uniform for nurses, midwives, and Allied Healthcare Professionals. Lisa Bruerton received an award following two heartfelt nominations from colleagues. Her quick thinking and compassionate support were vital when she assisted a patient who was in the process of delivering a baby in their vehicle in the car park. Lisa remained with the patient, offering reassurance and care until medical help arrived - an extraordinary act that truly exemplifies the values we hold dear.



In September Brilliant Awards were proudly presented to Sarah Russell, a truly exceptional midwife. Sarah consistently goes the extra mile for every patient in her care, demonstrating remarkable dedication and compassion, even while navigating the personal challenge of her son's cancer battle. Her thoughtful, caring nature, calm presence, and positive attitude bring comfort not only to mothers but also to fathers during one of life's most significant moments.



James Bottomley has demonstrated outstanding leadership and professionalism by stepping into a management role during a challenging period when several team members were off work. His commitment to maintaining high service standards and ensuring staff felt supported has been truly exceptional. Showing the qualities of a capable manager and an inspiring leader with a calm, caring approach and ability to make thoughtful decisions have helped maintain morale and operational stability whilst reflecting the Trust's core values and strategic goals by ensuring continuity of safe, high-quality, patient-focused care and supporting and developing our staff.



1.2 Board Visit

Following the conclusion of both the public and private Board meetings, Board members undertook a series of visits across the organisation on Thursday, 7 August 2025. These visits offered an opportunity to explore several key areas, engage directly with staff, and observe daily operations in action. Members gained valuable insights into the outstanding work being delivered, as well as the challenges faced by teams. Constructive feedback was shared, and staff were commended for their dedication and professionalism throughout the Trust.

1.3 Cavell Team Visit & Cavell Star Winners/Award

On Tuesday, 12 August 2025, the Cavell Team visited the Trust to recognise and celebrate the outstanding contributions of our staff. A dedicated session was held to highlight the exceptional work being carried out across the organisation, fostering a spirit of appreciation and pride. During the visit, a Cavell Award was presented to a colleague in recognition of their dedication, compassion, and excellence in patient care. The event served as a meaningful opportunity to reflect on the values that underpin our work and to acknowledge the individuals who embody those values every day.

Best for Performance



2.1 Performance

Our commitment to recovery remains strong, with continued emphasis on improving overall performance and reducing waiting lists. This is a dynamic process - while progress is being made in shortening wait times, new patients are continually added to the lists. We are working closely with our partners to ensure an effective urgent and emergency care response in Barnsley, aiming to minimise waiting times in our emergency department. Achieving this requires coordinated efforts across all partners, including primary care, community services, and social care, each playing a vital role.

2.2 Financial Position and System-Wide Pressures

The entire NHS system continues to face significant financial pressures, and we are no exception. We have delivered our 2024/25 financial plan, but as part of the South Yorkshire system, we remain under considerable pressure to reduce the overall deficit. This challenge is expected to persist into future financial years.

We are working diligently - both internally and in collaboration with our partners at place and across the wider system - to further reduce the deficit. Our focus is on driving greater efficiency while maintaining the quality of care, as we work towards achieving a balanced financial position over the coming years. This is not a quick fix, but we are committed to improving both effectiveness and efficiency, and are actively developing plans to support this ambition.

Best for Patients and the Public



3.1 Council of Governors

An Extraordinary Council of Governors meeting was held on Thursday 12 June 2025. The primary agenda item was the discussion surrounding the appointment of a new Chair.

The virtual format enabled wide participation, allowing governors to join from various locations and ensuring inclusive engagement in the decision-making process.

Overall, the meeting was both productive and engaging, reflecting the Trust's ongoing commitment to transparent, inclusive, and effective governance



4.1 Barnsley Place Committee and Partnership Board

This group continues to convene with partners from across the health and care system, including primary care, the Voluntary and Community sectors, and the Local Authority. Meetings are held in public, with opportunities for members of the public to submit questions. The most recent session focused on the Health and Care Plan 2025 - 2030 and included agreement on priority areas for development and exploration across the partnership. These discussions were underpinned by a clear framework for action and ownership, building on the strengths of our collaborative work.



5.1 Acute Federation

We continue to meet as Acute Providers from South Yorkshire and have a clear delivery plan in place with several areas of focus for us collectively including a clinical strategy. The Acute Federation Strategy Session NHS ICB and Trust Chairs' Event took place in Central London.

5.2 Joint Strategic Partnership Programme

We continue to meet regularly as Acute Providers across South Yorkshire, with a clear and coordinated delivery plan in place. Our collective efforts are focused on several key areas, including the development of a shared clinical strategy.

Mike Richmond
Trust Chair
September 2025

7.2. Chief Executive Report

For Information

Presented by Richard Jenkins



REPORT TO THE BOARD OF DIRECTORS			REF:		BoD: 25/10/02/7.2	
SUBJECT:		CHIEF EXECUTIVE'S REPORT				
DATE:		2 October 2025				
PURPOSE:		<i>Tick as applicable</i>			<i>Tick as applicable</i>	
	<i>For decision/approval</i>			<i>Assurance</i>	✓	
	<i>For review</i>	✓		<i>Governance</i>		
	<i>For information</i>	✓		<i>Strategy</i>		
PREPARED BY:		Emma Parkes, Director of Marketing & Communications				
SPONSORED BY:		Richard Jenkins, Chief Executive				
PRESENTED BY:		Richard Jenkins, Chief Executive				
STRATEGIC CONTEXT						
To report particular events, meetings publications and decisions that the Chief Executive would like to bring to the Board's attention.						
EXECUTIVE SUMMARY						
This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.						
RECOMMENDATIONS						
The Board of Directors is asked to receive and note this report.						



1.1 Barnsley Hospital Operational Update

The 'Be The Best' improvement work on our urgent and emergency care performance has had an early impact, with the Trust achieving the 78% trajectory for August; September performance to date is just below 78%, largely as a result of a single challenged weekend. A comprehensive improvement programme is being worked through and the Trust is having fortnightly meetings with NHSE and ICB colleagues as part of the Tier 2 process. As well as the internal Trust focus, the Tiering work is focusing on demand management in Barnsley, on Mental Health delays and in reviewing our approach to bed cleaning after patients are discharged.

Looking ahead to the winter period, we are implementing a comprehensive seasonal resilience plan to manage anticipated increases in demand. These measures are designed to enhance system resilience, safeguard patient safety, and maintain operational continuity through the winter months.

The Trust is significantly behind the trajectory for 18 week Referral To Treatment (RTT) performance. A recovery trajectory is being developed to recover performance for the end of December 2025. There are a number of factors that have driven the deterioration, including a change in referral patterns (more urgent and cancer referrals), absence of medical staff in some critical specialties and industrial action. Overall activity for elective pathways is within 2% of plan but there has been a disproportionate decline in RTT performance. An independent validation exercise is running from 22nd September for 2 weeks to ensure pathways have been correctly coded.

1.2 Teletracking Implementation

In October, Barnsley Hospital introduced TeleTracking, an electronic patient flow system designed to enhance our operational efficiency and improve patient care. TeleTracking is an advanced healthcare operations platform that helps manage patient flow by supporting faster and more efficient patient placement and discharge processes, optimised bed utilisation, and streamlined communication and coordination among teams and across departments. It provides real-time data and analytics to support decision-making and improve overall hospital performance as we move to the traditionally busy winter period. Other Trusts that use TeleTracking have reported significant improvements in hospital flow.

1.3 Health on the High Street – Barnsley Alhambra

The next phase of Barnsley's successful Health on the High Street programme, aimed at improving access to preventative services, will launch on 27 October

with Ophthalmology outpatient services transferring to the newly refurbished Alhambra Centre.

1.4 NHS Winter Vaccination Programme

The NHS winter vaccination programme starts this October and we encourage all NHS staff to get vaccinated. The flu vaccine helps protect against flu, which can be a serious or life-threatening illness. It's offered on the NHS every year in autumn or early winter to people at higher risk of getting seriously ill from flu.

Barnsley Hospital is delivering a robust flu vaccination campaign to reduce sickness, avoidable admissions and protect vulnerable cohorts.

1.5 Digital Innovation

I am delighted to share that Jamie Miles will be stepping into a new role as the Trust's Acting Chief Innovation, Improvement and AI Officer (CIAO), reflecting our ambition to harness digital innovation and artificial intelligence to improve care, drive productivity, and support our teams in delivering the best possible outcomes for patients.

Over the past year, Jamie has worked to align our clinical and digital capabilities. He will now be leading on the development and implementation of our innovation and AI strategy, working across Barnsley and in Partnership with Rotherham.

This role is about more than technology - it's about people, partnerships and purpose. Jamie will be working closely with colleagues across the Trust, our ICS partners, and national bodies to ensure we stay ahead of the curve while keeping patients and staff at the heart of everything we do.

1.6 Finance

The Trust remains on financial plan after Month 5. Significant work has been done to develop the efficiency programme with progress made. Finance and Performance Committee has been updated on progress in detail. The Trust awaits NHSE's decision on whether South Yorkshire will receive the Q2 and Q3 deficit support funding.

Best for Patients and the Public



2.1 Barnsley Hospital delivers consistently high standards in national inpatient survey

Barnsley Hospital has been recognised for maintaining high standards of care in the 2024 NHS Adult Inpatient survey, published by the Care Quality Commission (CQC). The survey captures experiences of patients who stayed overnight in hospital during November 2024.

Key highlights were:

- **Staff Conduct and Care:** Numerous comments praised the kindness, professionalism, compassion, and dedication of nurses, doctors, and other staff members, including cleaners and caterers. Many patients felt well-cared for and treated with dignity and respect.
- **Effective Medical Treatment/Diagnosis:** Patients reported positive experiences with immediate diagnosis, good medical care, and successful operations, with special mentions for outstanding doctors and effective care in specialised units like intensive care and cardiology.
- **Positive Environment:** Feedback described the hospital atmosphere as good and enjoyable, with the cleanliness of wards also noted positively.
- **Top 5 scoring questions:** Patients reported high satisfaction in key areas including information and support whilst waiting to come into hospital for planned care, discharge planning, support from health and social care services, and communication about virtual ward care.

The results have placed the Trust in the top quarter of hospitals for 'overall patient experience' whilst being cared for as an inpatient.

2.2 Environmental Update

Barnsley Hospital has moved from a central pipeline system to mobile cylinders for delivering nitrous oxide, a potent greenhouse gas, in theatres and the Emergency Department. The move concludes a two-year project aimed at a range of environmental, financial and operational benefits. Nitrous oxide, with a global warming potential 298 times that of CO₂, accounts for 80% of anaesthetic gas emissions in the NHS. The new system offers better control, eliminates leaks, and supports sustainability goals. Usage and carbon savings will be monitored over 12 months.

Best for People



3.1 Obstetrics and Gynaecology Recognition

Our Obstetrics and Gynaecology unit has been highly commended in the Royal College of Obstetricians and Gynaecologists' national Training Evaluation Form (TEF) awards.

Recognised in the professional development category for medium-sized hospitals, the award reflects trainee feedback from 167 units nationwide. Consultant Dr Fawzy praised the team's dedication, highlighting their expertise, supportive culture, and commitment to passing on skills.

RCOG's Training Evaluation Form (TEF) collects feedback from trainees on their training experiences, focusing on areas like support, supervision, professional

development, and training quality. This feedback is crucial for identifying strengths and areas for improvement within training environments.



- 4.1 Gavin Boyle, Chief Executive of the South Yorkshire Integrated Care Board, will be leaving his role in October. An announcement on future interim leadership arrangements is expected in early October.

Dr Richard Jenkins
Chief Executive
September 2025

7.3. 2025/2026 Work Plan

To Note

Presented by Michael Richmond

Board of Directors Public Work Plan: April 2025 - March 2026

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Introduction									
Apologies & Welcome	Mike Richmond Chair	Mike Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Declarations of Interest	Mike Richmond Chair	Mike Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Mike Richmond Chair	Mike Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Mike Richmond Chair	Mike Richmond Chair	Approve	✓ (06.02.25)	✓ (03.04.25)	✓ (05.06.25)	✓ (07.08.25)	✓ (02.10.25)	✓ (04.12.25)
Action log	Mike Richmond Chair	Mike Richmond Chair	Review	✓	✓	✓	✓	✓	✓
Culture									
Patient/Staff Story	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Steve Ned Director of People	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Steve Ned Director of People	Note	Patient	Staff: Helen Rymill/ Dave Booth	Patient	Staff	Patient	Staff
Freedom to Speak Up Report (6/12)	Steve Ned Director of People	Theresa Rastall Freedom to Speak Up Guardian	Assurance		✓ (People May 25, Annual Report 2024/25)			✓ (People Nov 25)	
NHS Staff Survey 2025	Steve Ned Director of People	Steve Ned Director of People	Assurance						
Annual Guardian of Safe Working	Simon Enright Medical Director	Simon Enright Medical Director/ Jess Phillips Guardian of Safe Working	Assurance						✓ (10.00 am: People Jan 26)
Assurance									
Chairs log: Quality and Governance Committee (Q&G)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Gary Francis Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓	✓	✓	✓	✓	✓
Annual Safeguarding Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/	Information		✓ (Q&G May)				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Analysis/debrief capturing the lessons learned from the recent industrial action - carried over from 24/25 is this still required Infection Prevention and Control Annual Report & Annual Programme Patient Experience Annual Report 2024/25 Dementia Annual Report		Gary Francis Chair of Q&G Non-Executive Director							
	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						
	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval		Deferred	✓ (Q&G June 25)			
	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval			✓ (Q&G July 25)			
	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Information		✓ (Q&G May)				
Fire Code Statement	Michael Wright Managing Director	Michael Wright Managing Director	Assurance/ Approval				✓ (Q&G Aug 25)		
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Alison Knowles Chair of F&P/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓ (F&P May 25)				
Cyber Security Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance			✓ (F&P June 25)			
Chairs Log: People Committee	Steve Ned Director of People	Steve Ned Director of People	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Equality Delivery System (EDS) Report	Steve Ned Director of People	Steve Ned Director of People Pauline Garnett/ Roya Pourali	Assurance/ Approval	✓ (People/ Q&G March 25)					
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Stephen Radford Chair of Audit/ Non-Executive Director	Assurance		✓			✓	✓
Chairs Log: Barnsley Facilities Services (BFS) Request from Dawn Barron- BFS – Private Board only from 10/25	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓			
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓					
Performance									
Integrated Performance Report (IPR)	Michael Wright Managing Director	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
Trust Objectives 2025/26 Sign Off	Michael Wright Managing Director	Michael Wright Managing Director	Review /Endorse	✓					
Trust Objectives 2024/25 End of Year Report	Michael Wright Managing Director	Michael Wright Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance		✓ (Committees May 25)				
Trust Objectives 2025/26	Michael Wright Managing Director	Michael Wright Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance			✓ Q1		✓ Q2	✓ Q3
Winter Plans	Michael Wright Managing Director/ Lorraine Burnett Director of Operations	Michael Wright Managing Director/ Lorraine Burnett Director of Operations	Assurance			✓ (F&P July 25)			
Mortality Report (6/12)	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Perinatal Quality Assurance Scorecard (previous reports Maternity and Neonatal Board Measures Minimum Data Set)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Midwifery Workforce Staffing Report: Six Monthly Update	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance		✓ (Q&G May 25)			✓ (Q&G Oct 25)	
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						✓
Nurse Safe Staffing Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance		✓			✓	
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ Approval				✓ (People Sept 25)		
Annual Workforce Disability Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ approval				✓ (People Sept 25)		
Annual Trust Self-Assessment for Education and Training	Simon Enright Medical Director	Simon Enright Medical Director	Assurance/ Approval				✓		
Fit and Proper Person Policy – <i>dates to be confirmed</i>	Steve Ned Director of People	Steve Ned Director of People Angela Wendzicha Director of Corporate Affairs	Approval						
Annual Health and Safety Report	Michael Wright Managing Director	Bob Kirton Managing Director	Assurance					✓ Q&G November 25	
Annual NHSE Emergency Core Preparation Standards	Michael Wright Managing Director	Mike Lees Head of Resilience & Security	Assurance						✓ (F&P Dec 25)
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Jeremy Bannister Deputy Medical Director	Assurance				✓ (People Sept 25)		

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Governance									
Constitution Review	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓ (Amendments)				
Board Assurance Framework / Corporate Risk Register	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval	✓	✓	✓	✓	✓	✓
Board Code of Conduct – <i>date to be confirmed</i>	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval		Deferred				✓
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance				✓		April 2026
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Assurance		Deferred				
Reservation of Board Powers and Scheme of Delegation to Board Committees	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance/ Approval		✓				
Terms of Reference for: • Audit – Audit April 25 • Q&G – Q&G Jan 26 • F&P • People – People Jan 26 • Executive Team	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓ ✓ ✓ ✓	✓ (Audit)				✓ ✓ ✓
Risk Management Policy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓ (Audit April 205)				
Risk Management Strategy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓ (Audit April 205)				
NED Champion role (annual)	Mike Richmond Chair	Mike Richmond Chair	Assurance		Deferred				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Annual Effectiveness Review	Mike Richmond Chair	Mike Richmond Chair Angela Wendzicha Director of Corporate Affairs	Assurance						✓
5-year Communication Strategy last received 10/25	Emma Parkes Director of Communication	Emma Parkes Director of Communication	Assurance				✓		
Benefits Realisation Papers Schedule of Return									
PACS Solution – (Benefits Realisation Paper to check with PMO, - carried over from 24/25 is this still required)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
Electronic Prescribing & Medicines Administration (EPMA) to check with PMO, - carried over from 24/25 is this still required	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
System & Partnership Working									
System Partnership Update including: • Barnsley Place Partnership • Integrated Care Board Chief Executive Report	Mike Richmond Chair Richard Jenkins Chief Executive Michael Wright Managing Director	Mike Richmond Chair Richard Jenkins Chief Executive Michael Wright Managing Director	Note	✓	✓	✓	✓	✓	✓
Joint Strategy Partnership Update - carried over from 24/25 is this still required	Michael Wright Managing Director	Michael Wright Managing Director	Assurance						
Quarterly Place Update - carried over from 24/25 is this still required	Michael Wright Managing Director	Michael Wright Managing Director	Information						
For Information									
Chair Report	Michael Richmond Chair	Michael Richmond Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
NHS Horizon Report: No longer needed 09/2025	Emma Parkes Director of Communications & Marketing	Emma Parkes Director of Communications & Marketing	Assurance	✓	✓	✓			
Work Plan 2025 – 2026	Mike Richmond Chair	Michael Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Mike Richmond Chair	Michael Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Mike Richmond Chair	Michael Richmond Chair	Note	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Mike Richmond Chair	Michael Richmond Chair	Note	Gary Francis	Grant Whiteside	Kevin Clifford	Michael Wright	Mark Strong	Angela Wendzicha

Strategic Objectives:

Best for Patients and the Public	We will provide the best possible care for our patients and service users.
Best for People	We will treat people with compassion, dignity and respect, listen and engage, focus on quality, invest, support and innovate.
Best for Performance	We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.
Best Partner	We will meet our performance targets, and continuously strive to deliver sustainable services.
Best for Place	We will work with partners within South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
Best for Planet	We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.
	We will build on our sustainability work to date and reduce our impact on the environment.

8. Any Other Business

8.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Michael Richmond

8.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Michael Richmond

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of next meeting: Thursday 4
December 2025 at 9.00 am, Lecture
Theatre 1 and 2

Matters arising from previous meeting