Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the Board of Directors held in public on
Tuesday 27 January 2026 at 9:30am
in the Boardroom at Doncaster Royal Infirmary

Present:	Mark Bailey - Interim Chair (Chair) Helen Best - Non-executive Director Karen Jessop - Chief Nurse Emyr Jones - Non-executive Director Zara Jones - Acting Chief Executive Zoe Lintin - Chief People Officer Dr Nick Mallaband - Acting Executive Medical Director Lucy Nickson - Non-executive Director Kath Smart - Non-executive Director Denise Smith - Chief Operating Officer Sam Wilde - Chief Finance Officer
In attendance:	Rebecca Allen - Associate Director of Strategy, Partnerships & Governance Tomas Barani - Obstetrics and Gynaecology Clinical Director (agenda items B1 -3) Angela O'Mara - Deputy Company Secretary (minutes) Lois Mellor - Director of Midwifery (agenda items B1 - 3) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Hannah Beardmore - Staff Side Laura Brookshaw - 360 Assurance Jackie Hammerton - Lead Governor Tracey & Fiona - Members of the Public
Apologies:	Jo Gander - Non-executive Director Richard Parker OBE - Chief Executive Stephen Radford - Non-executive Director

ACTION

P26/01/A1 **Welcome, apologies for absence and declarations of interest**

The Chair welcomed everyone to the Board of Directors meeting, including Helen Best who had recently joined the Board as a non-executive director. The above apologies for absence were noted, and no conflicts of interest were declared.

Holocaust Memorial Day was recognised by the Board of Directors.

P26/01/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 1 - P25/07/D1 - Doncaster & Bassetlaw Healthcare Services – the action was closed and referenced only for completeness.

Action 2 - P25/11/B2 – Board Assurance Framework – risks relating to the audiology service were captured as part of overarching strategic risk 3434 (strategic risk 3 - access to timely diagnostic care). Several actions were assigned to the risk, including the requirement to work to the recognised clinical standards and address long waits. All actions were managed at a divisional level and monitored through the Risk Management Group. **Action to be closed**.

P26/01/A3 **Chair's Report including Partnership Update (Enclosure A3)**

The Board received and noted the Chair's report, which provided an overview of activities since his appointment on 1 January 2026. There will be a focus in future reports on the Trust's strategic ambitions.

The Board:

- ***Noted the Chair's Report***

P26/01/A4 **Chief Executive's Report (Enclosure A4)**

The Chief Executive's report provided an overview of items of interest at a local, system and national level, connected to the work of the Trust and aligned to its own and its partners' strategic priorities.

The Acting Chief Executive recognised the continued and deliberate focus on the delivery of safe patient care during periods of high activity. Board members had visited wards, service, and support areas to see first-hand the pressures faced.

An unannounced Care Quality Commission (CQC) inspection of Doncaster Royal Infirmary's Emergency Department had taken place in December 2025, with a subsequent follow up visit in January 2026, the inspection report was awaited.

The Acting Chief Executive reflected on the positive results in the 2025 national maternity survey, which confirmed that the local delivery of standards was in line with national expectations.

Investment at Bassetlaw Hospital was having a positive impact on patients and colleagues with the opening of the Same Day Emergency Care unit and the provision of improved diagnostic capacity.

Work continued to refine the Trust's medium-term plan (2026/29) ahead of the final submission in early February 2026; patient safety and enabling change at pace were fundamental elements of the plan.

The Trust's commitment to being an anti-racist organisation and promoting diversity had been recognised with the achievement of a bronze status award in the North West Black, Asian and Minority Ethnic (BAME) Assembly Anti-Racist Framework.

The Acting Chief Executive welcomed Helen Best to the Board of Directors and took the opportunity to share her personal thanks, and those of the Board, for the care, commitment and resilience shown by colleagues across the organisation every day.

Non-executive Director, Helen Best, welcomed the wealth of positive news within the report and enquired if there was an opportunity for wider stakeholder engagement in the development of a therapeutic palliative care garden at Doncaster Royal Infirmary, the Acting Chief Executive confirmed this could be explored.

In response to a question from Non-executive Director, Kath Smart, regarding the reporting of the CQC's findings, the Acting Chief Executive confirmed that this would be via the Board's Quality Committee. Action had been taken in respect of initial verbal feedback, however, wider themes would be progressed from the report.

Non-executive Director, Kath Smart, acknowledged the bronze status award and enquired of the Trust's future aspirations. The Chief People Officer confirmed that in due course the requirements of the silver status would be established, with a focus on ongoing improvement. It was confirmed that the Trust was the first NHS organisation within South Yorkshire to secure this recognition.

In response to a question from Non-executive Director, Kath Smart, the Chief People Officer confirmed that the publication date for 2025 Staff Survey results was not yet known, however, it was expected to be in mid-March 2026.

The Acting Executive Medical Director, Nick Mallaband, welcomed the investment in emergency facilities at Bassetlaw Hospital, however, noted a marked difference with those at Doncaster Royal Infirmary's Emergency Department. The Chief Nurse acknowledged this and recognising the limitations of the estate anticipated this may impact upon the CQC's assessment. The Chief Operating Officer confirmed that capital bids to support improvements at Doncaster had been submitted and the outcome was awaited.

The Chair acknowledged the high activity levels and placed on record his appreciation of colleagues efforts.

The Board:

- ***Noted the Chief Executive's Report***

P26/01/A5 **Well-led and DBTH in Action (Enclosure A5)**

The Acting Chief Executive confirmed that two independent reviews had been commissioned by the Board, to support their understanding of governance, leadership and culture across the organisation and the potential impact on patient outcomes. A Well-led review, aligned with the CQC's single assessment framework and an in-depth cultural review (DBTH in Action). `

An overview of the strengths and development areas from each report was provided.
In view of the limited response to the cultural review, it was suggested the findings be considered alongside wider sources of information and the evidence triangulated. The

reports and recommendations were accepted by the Board and would be made publicly available after this meeting.

In terms of next steps, there would be an opportunity for colleague engagement, triangulation of evidence and the development of solutions. The importance of this improvement work was recognised and the Acting Chief Executive looked forward to working with colleagues to progress this.

Non-executive Director, Emyr Jones, enquired of the level of confidence that the report provided meaningful insight. The Acting Chief Executive recognised the range of situational opportunities taken by thevaluecircle to gather feedback, whilst the qualitative feedback was valuable, in view of the limited source, it was recommended this be considered alongside other evidence.

The Chief Nurse encouraged the inclusion of Patient Safety Partners, engagement and seldom heard groups when consulting with stakeholders.

Non-executive Director, Lucy Nickson noted the reference to bullying and harassment in both reports and enquired how this would be considered alongside other evidence. The Chief People Officer confirmed that all concerns were taken seriously. The most recently published Staff Survey indicated that the Trust performed better than the sector average in relation to bullying and harassment and confidence that concerns would be acted on. A variation in experience had been seen from the Freedom to Speak Up (FTSU) data and there was a focus on improving consistency. A data triangulation group considered metrics from the People & Organisational Development directorate, FTSU, and patient safety to understand the trust wide picture.

In response to a question from Non-executive Director, Kath Smart, the Chief People Officer confirmed that the FTSU peer review report had now been received. The FTSU Forum would review the feedback theme and identify strengths and development areas which would subsequently be shared with the People Committee and Board.

The Acting Executive Medical Director reflected on the size of the organisation and the variable ways of working across teams; he suggested there was a need to consider the potential impact of professional registrations and establish boundaries using a bottom-up approach. The information gleaned from the review should be considered alongside existing knowledge and improvement work, including previous workshops with the Nursing and Midwifery and General Medical Councils.

In response to a question from Non-executive Director, Helen Best, in respect of maintaining oversight of quality, safety and culture as improvements progressed, the Acting Chief Executive confirmed that governance arrangements would be critical, testing to gain assurance through the triangulation of evidence. There would be a need to be curious about differences, utilising benchmarking data and a clear action plan, with ownership to track progress, which would be overseen by the People Committee and the Board of Directors.

In response to a question from Non-executive Director, Helen Best, the Chief Nurse recognised the importance of hearing the patient and learner voice when considering culture and confirmed there had been no patient safety concerns raised as part of the review.

Non-executive Director, Kath Smart, reflected on the feedback received in respect of the storage of clinical waste from thevaluecircle and confirmed that the Finance & Performance Committee had received a comprehensive report detailing the remedial actions and oversight arrangement now in place.

In response to Non-executive Director, Emyr Jones' observation of recent media coverage related to the dismissal of a former Board member, Non-executive and Senior Independent Director, Lucy Nickson confirmed that the Well-led and culture reviews were in no way connected to the individual employment case and offered assurance that patient safety and organisational effectiveness remained at the core of decision making. The employment case had been subject to a full and independent investigation, which concluded that the employment relationship had broken down irreparably.

The Board:

- ***Noted the Well-led and DBTH in Action report***
- ***Supported the report's recommendations:***
  - ***Independent reports published following the Board meeting – 27th January 2026***
  - ***Engage colleagues in shaping solutions and monitoring progress – Q4 2025/26***
  - ***Develop the action plan, triangulated with upcoming staff survey results to address the improvement areas – March 2026***
  - ***Communicate openly about actions taken and outcomes achieved – ongoing***
  - ***Continue to foster a culture of equity, inclusion, and psychological safety and seek regular feedback to see how we are doing – ongoing***
  - ***Celebrate and share examples of positive practice and teamwork – ongoing***
  - ***Report back to the Board of Directors held in public – quarterly.***

P26/01/B1 **Year 7 Clinical Negligence Scheme for Trusts' Board Declaration (Enclosure B1)**

The Chair welcomed the Director of Midwifery and Clinical Director of Obstetrics and Gynaecology to the meeting, to present the Trust's final position against the Year 7 Clinical Negligence Scheme for Trusts' standards.

The Director of Midwifery confirmed that all ten maternity safety actions had been met, with no identified risks. The Local Maternity & Neonatal System (LMNS) had conducted deep dive assessments during October and December 2025 and following the LMNS Collaborative Board earlier this month had recommended sign off to the Integrated Care Board.

The Chair recognised the wealth of evidence supporting the assessment. It was noted that the minutes from the LMNS Collaborative Board and this meeting would be required as the final pieces of evidence. The deadline for submission to NHS Resolution was 3 March 2026.

The Acting Chief Executive shared her appreciation of the work undertaken and enquired of the subjectivity of the assessment, the Director of Midwifery confirmed that whilst the Trust determined if the evidence was sufficient, advice was available from the Trust's Maternity Incentive Scheme contact. Non-executive Director, Emyr Jones, clarified the provision of the scheme and the financial implications. In respect of

subjectivity, his opinion, as a non-executive maternity champion, was that the Trust was cautious when declaring compliance.

In response to a question from Non-executive Director, Kath Smart, with regards to the breadth of evidence, the Director of Midwifery confirmed these included minutes from the Maternity & Neonatal Voices Partnership, the co-production of leaflets, inclusion of the patient and family voice and partnership working.

The Board:

- ***confirmed it was satisfied with the evidence provided to achieve the ten maternity (perinatal) safety actions***
- ***delegated authority to the Acting Chief Executive to sign-off the Board Declaration, prior to submission to NHS Resolution on 3 March 2026***

P26/01/B2 **Maternity & Neonatal Safety Report (Enclosure B2)**

The Director of Midwifery drew the Board's attention to the findings and associated learning from the Q2 Perinatal Mortality Report and the accompanying quality metrics.

A deterioration in performance was noted in the rate of postpartum haemorrhage (PPH) and neonatal deaths. A business case for the use of a new drug to reduce the PPH rate had been submitted and whilst the deterioration in neonatal deaths was noted, it was confirmed to be within expected levels. To further validate this, it was confirmed that no level one or two alerts had been received from the Maternity Outcomes Signal System.

The Chief Finance Officer welcomed the use of statistical process control charts in the report and encouraged opportunities for wider use to be explored.

The Board:

- ***Noted and took assurance from the Maternity and Neonatal Safety Report***
- ***Reviewed and approved the Q2 Perinatal Mortality Report***
- ***Reviewed the Trust's Quality Metrics***

P26/01/B3 **Bi-annual Midwifery Workforce Report (Enclosure B3)**

The report provided an overview of the systems and measures in place to ensure safe midwifery staffing. It was confirmed that since writing the report a revised Birthrate Plus® assessment had been received. The Chief Nurse clarified that Birthrate Plus® was refreshed every three years and served as a decision support tool, supported by professional judgement, whilst the Safer Nursing Care Tool was reviewed twice a year.

Due to increased acuity, the Trust's midwife to birth ratio stood at c.1:20, as compared to the national recommendation of 1:28 and 1:1 care in labour continued to be maintained across both sites.

Early careers recruitment, including that linked to the government's Graduate Guarantee Scheme was expected to eliminate vacancies, however, it was noted that the Graduate Scheme funding was limited to one year. The limitations of non-recurrent

funding, to support long-term staffing, was highlighted by Non-executive Director, Kath Smart.

Non-executive Director, Kath Smart, enquired if there was an opportunity to introduce statistical process control charts for the reporting of red flags, however, due to many reporting lines consisting of small numbers, this was not expected to be beneficial.

In respect of delays to the induction of labour, the Director of Midwifery confirmed that risks were managed dynamically, locally and across the system, to ensure delays were safe.

There was now a national requirement to submit a daily maternity services situation report (sitrep). Non-executive Director, Kath Smart suggested it may be helpful to include benchmarking data in future reports.

Non-executive Director, Lucy Nickson enquired of the impact of large cohorts of newly qualified midwives, the Director of Midwifery confirmed there was a robust preceptorship programme in place with strong pastoral care, mindful of the support required as colleagues transitioned from training into the maternity unit. Going forwards, due to the staffing position, the cohorts were not expected to be as large.

The Chief Finance Officer recognised the successful recruitment and in response to his enquiry about colleague retention, the Director of Midwifery confirmed that there had been minimal attrition since 2022, when a significant number of colleagues had left due to retirement, relocation and promotion.

The Chair encouraged the promotion of the service, and a shift in the tone of national media coverage was recognised by the Director of Midwifery.

The Board:

- ***Noted and took significant assurance from the Bi-annual Midwifery Workforce Report, including the additional scrutiny and monitoring that had been applied to ensure all aspects of safe staffing had been triangulated.***

P26/01/C1 **Skill Mix Business Case – Registered Nurse (Enclosure C1)**

The Chief Nurse sought the Board's approval of the business case for phased investment to increase the registered nurse skill mix from 57% to a minimum of 60%, across acute adult inpatient wards.

The paper identified the required investment, benefits, risks and mitigations. The business case had been considered at the Corporate Investment Group and recommended to the Board for approval by the Finance & Performance Committee.

Non-executive Director, Emyr Jones welcomed the business case to move towards an optimal position, with clear benefit realisation.

Following a rigorous assessment, the Chief Finance Officer confirmed that the case had received the unanimous support of the Corporate Investment Group. A neutral/positive impact had been identified as part of the Quality Performance Impact Assessment.

In response to a question from Non-executive Director, Helen Best, the Chief Nurse confirmed a collaborative system approach to recruitment would take place and there was a reasonable level of confidence that the required level of interest would be secured.

The Chief Operating Officer highlighted interdependencies with the Urgent and Emergency Care improvement programme, in supporting patient flow and ward efficiencies and recognised the role of registered nurses in supporting flow and reducing pressures at the front door.

Noting the business case supported the achievement of a 60% skill mix, Non-executive Director, Kath Smart, enquired of the strategy to progress beyond this. The Chief Nurse confirmed that modelling work would be required to inform subsequent investment and recognised that in time the number of qualifying registrants may be a constraining factor.

The Acting Executive Medical Director acknowledged the benefits of increasing the skill mix and enquired how the Trust benchmarked compared to its peers. The Chief Nurse confirmed that in the absence of skill mix reporting, Care Hours Per Patient Day data could be used as a crude measure, however, her knowledge of the South Yorkshire system indicated that the Trust was positioned in the middle of the pack. From a financial perspective there was the potential for a reduction to be seen in negligence claims.

The Acting Chief Executive welcomed the business case which achieved a balanced approach to patient safety, the quality of care and the efficient use of resources.

In response to an observation by Non-executive Director, Helen Best, the Chief Nurse confirmed this was included in the developing medium-term plan.

The Board:

- ***Approved the Skill Mix Business Case for Registered Nurses***

P26/01/D1 **Integrated Quality & Performance Report including Month 9 financial position (Enclosure D1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for October 2025 and remaining access, quality, and workforce standards for November 2025. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The finance and activity report (appendix two) presented the financial risks, delivery of financial sustainability over time, delivery of the 2025/26 plan and the South Yorkshire Integrated Care System position.

The executive directors provided an overview of their respective key performance indicators.

Progress was noted in respect of the Trust's elective waits of more than 52 weeks, and as a result the Trust had been advised they would return to Tier two NHSE monitoring and oversight. The Acting Chief Executive recognised the work of the Chief Operating Officer and her wider team, including the articulation of the plan which had improved NHSE's confidence and assurance of the required improvement journey.

The Chief Nurse confirmed there had been no patient harm arising from MRSA, all cases had been identified as potential contaminants and learning had been identified to improve the practice of collecting blood cultures.

Following recent media coverage, the Acting Executive Medical Director confirmed that the audiology waiting list had reduced by 700, with a reduction in wait times seen from 52 to 22 weeks. Work to improve the management of patients on the waiting list continued and insourcing, and subject matter experts were being utilised to assist with follow up waiting lists. The Acting Chief Executive confirmed she had taken the opportunity to discuss audiology services with Sally Jameson MP at a recent site visit, the MP was an advocate of investment in the Doncaster Royal Infirmary site and alongside the Trust continued to hear constituents' concerns, working with the audiology and patient action groups.

The Chief People Officer reported an improvement to the sickness absence rate, which contrasted with that seen at a system and regional level, although it was noted that absence levels remained above target.

The Chief Finance Officer confirmed that at month nine the year-to-date surplus stood at £1.1m, £0.8m of non-recurrent technical benefits had been made ahead of plan. In month, Elective Recovery Fund income had exceeded the plan, although there was a future risk of non-payment due to system level ceilings.

The cash balance was £20.6m, favourable to plan. Funding in respect of industrial action had now been confirmed, and the year-to-date capital expenditure was £17m, £14.6m below plan.

Non-executive Director, Emyr Jones, noted the improvement in the audiology waiting list and brought the Board's attention to the national shortage of hearing aid batteries, reported in the national media. In respect of Summary Hospital-level Mortality Indicator (SHMI) data, the variance seen in reporting the first episode of care across organisations was noted.

Non-executive Director, Kath Smart reflected on the scrutiny of performance data at January's Finance & Performance Committee and confirmed a further update in respect of audiology would be received. In respect of deficit support funding, it was recognised that this was earnt on a quarterly basis by the system and not individual organisations. As not all organisations remained on track the Chief Finance Officer noted a reduced level of confidence in full year delivery by the Integrated Care Board.

In response to a question from Non-executive Director, Lucy Nickson, regarding the factors contributing to the reduction in the level of absence, the Chief People Officer highlighted a focus on supporting attendance, rather than absence management, with policy refinements and training and guidance support provided to line managers.

In response to a question from the Acting Executive Medical Director regarding over performance in activity, the Chief Operating Officer confirmed that planning had focused on the delivery of core business ahead of elective recovery funding and demand and capacity modelling.

In response to a question from the Chair, the Acting Executive Medical Director confirmed that trends in the causes of death were considered by the Mortality Review Group, which informed specific areas of focus for Structured Judgement Reviews. Work continued in respect of sepsis management and the identification of deteriorating patients through the implementation of Martha's Rule. The impact of coding was also noted, with a desire to further strengthen the depth of coding. Non-executive Director, Emyr Jones, welcomed the Trust's systematic approach to learning from deaths.

The impact of coding was highlighted by Non-executive Director, Kath Smart, from a quality and financial perspective and the importance of feedback to colleagues noted. The Acting Executive Medical Director highlighted the benefits which would be realised through the introduction of an Electronic Patient Record.

The Board:

- ***Noted the Integrated Quality & Performance Report***

P26/01/D2 **Board Assurance Framework including Trust Risk Register (Enclosure D2)**

The refreshed Board Assurance Framework was received following consideration by each of the Board's assurance committees.

The Associate Director of Strategy, Partnerships & Governance brought the Board's attention to the change in risk rating and the target risk date for strategic risk two. The increased risk score of 16 and the extended target risk date of March 2028 was recommended by the People Committee in view of the local and national influences on the NHS workforce, including industrial action, national pay awards and the challenging financial and operational environment. It had been recognised that these external issues could influence the actions that the Trust could take and reduce their positive impact in the immediate term.

Non-executive Director, Kath Smart, acknowledged the progress made to date in risk management and enquired if this could be sustained. The Associate Director of Strategy, Partnerships & Governance highlighted improved, embedded practice at all levels, including ward and divisional governance with the oversight of higher-level risks at the Risk Management Group. In terms of long-standing risk scores, the Acting Executive Medical Director confirmed there was an appropriate level of challenge taking place at Risk Management Group, however, many of these related to the estate, which without significant investment were not able to be reduced. The Board Assurance Framework for strategic risk four relating to the care environment was due to be considered at the Board Development Session on 3 February 2026.

The Board:

- ***Noted the Board Assurance Framework and Trust Risk Register and approved its current content, which enabled the Board to fulfil its duty to monitor its strategic risks.***

P26/01/D3 **Board of Directors Fit & Proper Persons Test & Reporting (Enclosure D3)**

The report confirmed compliance with the requirements of the Fit & Proper Person Test Framework.
The application of the framework had been audited during 2025/26 and a significant assurance opinion provided.

The Board:

- ***Noted and took significant assurance from Board of Directors Fit & Proper Persons Test & Reporting***

P26/01/D4 **Board Workplan (Enclosure D4)**

The Board:

- ***Approved the 2026/27 Board workplan, subject to any subsequent changes arising from Year 8 CNST standards***

P26/01/D5 **Chair's Assurance Log – Finance & Performance Committee (Enclosure D5)**

The Board received the Finance & Performance Committee Chair's assurance log from November and December 2025 and January 2026's meetings, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

Non-executive Director, Kath Smart, suggested it may be helpful to consider the findings of the health and safety culture review alongside those of the DBTH Way in Action when determining actions. **ZJ**

In respect of the increase in sharps injuries referenced in the Health & Safety report, it was confirmed this would be considered by the Quality Committee, the Chief Nurse confirmed she would be happy to pick this matter up outside of the meeting. **KJ**

The Board:

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

P26/01/D6 **Chair's Assurance Log – Quality Committee (Enclosure D6)**

The Board received the Quality Committee Chair's assurance log from December's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

The benefit of contributing to the national audit programmes was recognised by Non-executive Director and Chair of the Quality Committee, Jo Gander.

The Chief Nurse brought the Board's attention to the divisional thematic analysis of patient safety over the last five years and an update in regards to the implementation of Martha's Rule. In respect of the reference to digital stories, the Chief Nurse confirmed this related to patient experience.

The Board:

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

P26/01/D7 **Chair's Assurance Log – People Committee (Enclosure D7)**

The Board received the People Committee Chair's assurance log from December's meeting which summarised the assurance taken.

Non-executive Director and Chair of the People Committee, Lucy Nickson noted the reduction in the 2025 Staff Survey response, which reflected the national position. The Board's attention was drawn to the progress made in respect of the Resident Doctors 10-point plan and the ongoing efforts to progress outstanding actions, some of which were awaiting national guidance.

The Board:

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

P26/01/E1 **Minutes of the meeting held on 4 November 2025 (Enclosure E1)**

The Board:

- ***Approved the minutes of the meeting held on 4 November 2025 as a true record***

P26/01/E2 **Pre-submitted Governor or public Questions regarding the business of the meeting (verbal)**

The following questions were received from the Lead Governor:

Could the board reassure governors that the financial requirements to meet the increase in registered nurses will not be at the cost of other posts across the Trust. The governors note the metric of reduced falls as part of the business case for increased registered nurses. We would wish it to be noted that falls reduction requires a muti disciplinary approach. There is also a risk that reduced falls are achieved through reduced patient independence and reduced mobility all of which can have secondary harmful impacts not being recorded.

The Chief Nurse confirmed that the proposal to increase the number of registered nurses was being taken forward because the evidence showed clear quality, safety, and efficiency benefits. However, each workforce investment was always considered on its individual merits, supported by a robust business case and evaluated against organisational priorities, service needs, and workforce risks.

Resources were constrained nationally, and all investment decisions must therefore be carefully weighed to ensure they are affordable, sustainable, and aligned with the Trust's overall strategic direction. With that in mind, this investment had been designed using a phased and financially responsible approach that avoids displacing or deprioritising other essential posts.
We can therefore reassure governors that whilst we are recommending to the Board the investment in registered nurses due to the clear case for doing so, this is not at the expense of other staff groups. The Trust remains committed to supporting a balanced, multidisciplinary workforce, and will continue to consider all future investment proposals fairly, transparently, and on their merits within the broader NHS financial landscape.

The Trust's Falls Improvement Strategy includes a dedicated deconditioning workstream alongside the fall's reduction programme. We recognise that positive risk taking is essential to safe mobility, improved patient outcomes, and reductions in length of stay and associated complications. Furthermore, while nursing input is a key component, sustained improvement depends on coordinated contribution from therapy services, medical teams, pharmacy, estates, and wider clinical colleagues.

The governors note that the audiology service is recorded as having achieved significant improvement and assurance. How does this align with the questions recently raised in Parliament by Sally Jameson MP.

The Acting Executive Medical Director confirmed that the assurance provided on audiology reflects substantial and evidenced improvement from a very poor historic baseline. Over the last two years, the Trust had delivered significant improvement across parts of the pathway that were subject to the longest waits:

Diagnostics (new referrals)
- Average wait has reduced from over 52 weeks in 2024 (with some patients waiting up to two years and a list in excess of 2,000) to 22 weeks by December 2025.
- The waiting list has reduced to around 700 patients.
- All remaining patients will have a first appointment by the end of March 2026, and from April 2026 new referrals are expected to be seen within 6 weeks, meeting the DM01 national standard (95%).

Hearing aid fittings
- Average waits reduced from over 104 weeks in 2024 to 15 weeks by December 2025.
- From April 2026, fittings will be provided within 8 weeks of diagnosis.

These improvements had been enabled by system replacement, new equipment, refurbished sound-proof rooms, additional senior staff, strengthened training and competencies, and targeted insourcing.

However, the Parliamentary question raised by Sally Jameson MP rightly reflects the fact that we have more work to do to clear our backlog and reduce all of our long waiting times, particularly for patients requiring review appointments.
This cohort reflects historic workforce and capacity constraints and the requirement for staff to be signed off for diagnostics and fittings before undertaking reviews, which has limited flexibility. Insourcing to date has therefore focused on new referrals and fittings where clinical risk was greatest.

In parallel, the MP's question was raised on behalf of members of the Audiology Action Group in Doncaster. Those individuals, alongside members of the deaf community, have been actively involved in the Trust's patient experience work for the last year, including shaping patient communications. They have been supportive of the progress made and the Trust's openness. We appreciate their ongoing input into our improvement work.

The Acting Chief Executive met with Sally Jameson MP on 23 January and discussed the issues. We are aligned that the purpose of raising the issue is to maintain focus, transparency, and momentum and we continue to work with our MPs and other stakeholders to recover the service to ensure our patients and communities receive a high-quality accessible audiology service.

Is the Trust expecting Annual Quality Review (AQR) reports from education providers, other than the University of Sheffield?

The NHS Education Funding Agreement requires all placement providers to provide regular assurance to NHS England confirming compliance with the Agreement and NHS England's Education Quality Framework. The Trust do not expect AQR reports from any other education providers other than the University of Shefield. This is because the NHSE Self-Assessment, most recently submitted by the Trust to NHSE in October 2025, provides a multi-professional and nationally consistent provider self-assessment which all other education partners use for their quality assurance of placement.

The assessment questions focus on the six NHS England Education Quality Framework domains and NHS Education Agreement's key performance indicators. This is complemented by the NHSE Senior Leadership Engagement visit, most recently hosted at the Trust in November 2025. The School of Medicine and Population Health at the University of Sheffield requested an additional annual AQR complemented by a senior leaders visit to provide quality assurance specifically for the students on the MBChB (medical students) curriculum. This is comparable to all other placement providers for medical students.

On page 131 of the Board pack, we have KPIs for ambulance handover times for the Trust as a whole. Is the system for handover in the new Emergency Department at Bassetlaw the same as in the old one? Has there been an improvement in handover times since the new ED opened?

The Chief Operating Officer confirmed that the Trust implemented the Transfer of Care protocol with East Midlands Ambulance Service (EMAS) at Bassetlaw Hospital in November 2025, this is to ensure the majority of ambulance handovers take place within 45 minutes of arrival. Ambulance handover times at Bassetlaw hospital had improved since the new Emergency Department opened in in February 2025, with a reduction in the proportion of handovers taking over 45 minutes and an improvement in the average handover time noted.

The following questions were received from members of the public:

The recent culture review highlighted that some staff have experienced bullying and inappropriate behaviour. Given that the review only involved a small proportion of

the workforce, the true scale of the problem may be higher. What specific measures is the Board taking to address bullying and inappropriate behaviours and embed psychological safety into everyday practice, so staff feel confident to raise concerns without fear of negative consequences? I would appreciate a clear response from the Board on these important issues, as they directly affect both staff wellbeing and patient care.

The Chief People Officer confirmed that it was correct that the culture review engaged a relatively small proportion of our workforce, and it was important to be clear about what that means. This was a qualitative review designed to provide depth of insight, not a statistically representative measure of prevalence. Because of that, we cannot use it to infer the scale of the issue across the organisation in either direction and it would not be appropriate to assume the true scale is higher based on this review alone.

This is why we triangulate the review's findings with other evidence, including the NHS Staff Survey, workforce data and local intelligence, Freedom to Speak Up information, patient feedback and what senior leaders and Board members see directly through engagement and visits.

Any reference to bullying or inappropriate behaviour is taken seriously. The independent reviews highlight that experiences were not uniform across the organisation, with variation between local teams and the wider Trust.

The Trust continues to strengthen its Freedom to Speak Up arrangements, including through peer review, investment in resource, increasing the number of Speaking Up Champions and enhancing training for colleagues and managers.

As well as the Freedom to Speak Up Guardians, there were a range of routes and partners for people to speak to across the organisation about any concerns they have about the workplace including bullying and inappropriate behaviours. These includes trade union colleagues, HR team, Equality, Diversity & Inclusion Lead and Professional Nurse/Midwifery Advocates. In the last year, we have also introduced a new online reporting form where concerns about any inappropriate behaviours can be raised anonymously.

Other workforce data and staff survey results were also used to identify any concerns or trends in specific areas. Our focus is on addressing inconsistency, reinforcing expectations around behaviours and ensuring concerns are identified and acted upon wherever they arise. Our DBTH Way framework and Just Culture approach alongside the embedded Patient Safety Incident Response Framework provide support and expectations and encourage a focus on learning and improvement.

It is our intention to also undertake a deep dive into concerns about bullying and harassment/inappropriate behaviours raised through the Freedom to Speak Up route and the feedback from this review will also feed into this work.

Across agenda items D1 (Integrated Quality & Performance Report) and D2 (Board Assurance Framework and Trust Risk Register), many papers state that committees have 'taken assurance'. What evidence does the Board itself see, beyond committee assurance, that patient safety and other risks are being reduced?

The Acting Chief Executive confirmed that the Board does not rely solely on committees stating that they have "taken assurance". In addition to committee scrutiny, the Board seeks assurance directly, by triangulating multiple sources of evidence and testing whether improvements are visible in practice. In practice, this includes:

Seeing services first-hand - Board members undertake regular walkabouts and visits to clinical and non-clinical areas, observing conditions, staffing, patient flow and safety issues directly and testing whether what is reported reflects day-to-day reality.

Direct engagement with staff and patients - through site visits, listening events, and staff engagement sessions, Board members hear directly from colleagues and, where appropriate, patients about risks, pressures, and whether changes are improving safety. These insights are fed back into Board discussion and challenge. This includes testing whether staff feel able to speak up about concerns, whether those concerns are heard, and whether action is taken, as part of the Board's oversight of organisational culture and psychological safety.

Reviewing data and trends at Board level - the Board reviews underlying performance and safety data itself, including trend data and statistical process control charts in the Integrated Quality & Performance Report, to understand whether risks are improving, stable, or deteriorating over time.

Scrutiny of harm, incidents, and patient experience - the Board reviews serious incident themes, learning from deaths, complaints, claims and patient stories to assess whether harm is reducing and whether learning is being embedded.

Tracking risk movement and control effectiveness - for risks on the Board Assurance Framework and Trust Risk Register, the Board reviews changes in risk scores and the effectiveness of controls. Risks are only reduced or closed when the Board is satisfied that mitigations are working in practice and are sustainable.
Testing the quality impact of improvement actions - the Board reviews Quality Performance Impact Assessments for major changes, signed off by the Chief Nurse and Executive Medical Director, to ensure that actions to improve performance or productivity do not increase patient safety risk.

Independent and external assurance - external reviews, regulatory feedback and independent assessments are used to corroborate or challenge internal assurance. This includes external audit and compliance with statutory and regulatory requirements, where findings are tracked through governance processes until addressed.

Learning from others and proactive risk identification - the Board uses external benchmarking and improvement methodologies, including Getting It Right First Time and Patient Safety Incident Response Framework, to identify unwarranted variation, learn from best practice elsewhere and proactively look for potential risks ahead of actual harm, rather than relying solely on retrospective incident review.

Example of triangulation in practice - where a service reports improvement, the Board will typically test this by triangulating:

- Performance and safety trend data presented at Board

- Patient experience and complaints relating to that service.
- Risk ratings and mitigations on the Board Assurance Framework
- Feedback from Board visits and staff engagement.

Where relevant, this also includes external benchmarks, audit findings or regulatory feedback relating to the service.

If these sources do not align, the Board will not accept assurance and will request further evidence or action.

Ongoing improvement and refinement - the Board recognises that assurance is not static. In areas of sustained pressure or long-standing backlogs, the Board continues to test whether reported improvements are felt by patients and staff and whether risk reduction is durable rather than temporary. Where improvement is incomplete or fragile, this is reflected in risk ratings and ongoing scrutiny rather than premature closure.

Committees provide detailed scrutiny, but the Board's assurance comes from triangulating data, direct observation, staff and patient insight and independent challenge, alongside a willingness to continue testing itself where risks remain.

P26/01/E3 **Any other business (to be agreed with the Chair prior to the meeting)**

At what was Non-executive Director, Emyr Jones, last Board meeting before his term of office ends in February 2026, the Chair invited him to share with the Board an insight into his service with the NHS, which spanned an incredible 53 years. The majority of this time had been served as a consultant, Clinical and Medical Director at the Trust but had also included national and commissioner roles.

The Chair thanked Emyr, personally and on behalf of the Board of Directors, for his significant contribution to the Trust and the NHS and shared the Board's best wishes for the future.

P26/01/E4 **Date and time of next meeting (verbal):**

Date: 24 March 2026
Time: 9:30am
Venue: Boardroom, Bassetlaw Hospital

P26/01/E5 **Withdrawal of Press and Public (Verbal)**

The Board:

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

P26/01/F **Close of meeting (Verbal)**

The meeting closed at 12.22

Mark Bailey
Interim Chair of the Board
24 March 2026