

BOARD OF DIRECTORS – PUBLIC MEETING

**Minutes of the Board of Directors held in public on
Tuesday 24 March 2026 at 9:30am
in the Boardroom at Bassetlaw Hospital**

- Present:** Mark Bailey - Interim Chair (Chair)
Helen Best - Non-executive Director
Jo Gander - Non-executive Director
Karen Jessop - Chief Nurse
Zara Jones - Acting Chief Executive
Zoe Lintin - Chief People Officer
Lucy Nickson - Non-executive Director
Stephen Radford - 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
Paula Hill - Freedom to Speak Up Guardian (agenda item D3)
Joseph John - Medical Director for Operational Stability and Optimisation
Mohammad Khan - Guardian of Safe Working (agenda item D4)
Angela O'Mara - Deputy Company Secretary (minutes)
Lois Mellor - Director of Midwifery (agenda item D1)
Emma Shaheen - Director of Communications & Engagement
- Public in attendance:** Gail - Member of the Public
Alec Phillips - Member of the Public
Tracey - Member of the Public
- Apologies:** Dr Nick Mallaband - Acting Executive Medical Director
Richard Parker OBE - Chief Executive

ACTION

P26/03/A1 Welcome, apologies for absence and declarations of interest

The Chair welcomed everyone to the Board of Directors meeting, the above apologies for absence were noted, and no conflicts of interest were declared.

P26/03/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 2 – Action Plan - DBTH in Action - to be received at the Board meeting of 5 May 2026.

Action 3 – Sharps Injuries - a deep dive report would be received by the Quality Committee in August 2026

P26/03/B1 **Chair’s Report including Partnership Update (Enclosure B1)**

The Board received and noted the Chair’s report, which reflected on the Trust’s strategic ambitions and the development of its medium-term plan, which translates ambitions into practical, structured and stretching plans to deliver measurable improvements.

Whilst it was recognised that there was a national reset required across the NHS, the Chair encouraged colleagues not to lose sight of the positive work underway to deliver services across the communities served.

The Board:

- ***Noted the Chair’s Report***

P26/03/B2 **Chief Executive’s Report (Enclosure B2)**

The Acting Chief Executive brought the Board’s attention to the following highlights of the report.

As the end of the financial year approached, the Trust was in a strong position, and the Acting Chief Executive recognised and shared her appreciation of colleagues’ contributions.

The positive impact of improvements to lung cancer services and diabetic eye screening was noted, improving co-ordination, earlier intervention, patient experience and engagement.

The Trust had recently welcomed the Lord Lieutenant of Nottinghamshire to Bassetlaw Hospital. The adult and paediatric emergency care and assessment facilities had been showcased, and colleagues had been able to share the positive impact on patient flow and experience.

Productivity improvements at the Trust had been recognised at a national level and in Quarter 3 the Trust’s ranking in the NHS Oversight Framework (NOF) league table had increased from 60th to 45th out of 134 trusts. The Trust remained in segment three, due to the financial override associated with its deficit financial plan.

The Trust had been invited to take part in the NHS Spring Reset programme, it would be fully engaged in this work to accelerate delivery in key operational areas.

The Acting Chief Executive thanked executive colleagues for their support in the absence of the Chief Executive and wished Richard a speedy recovery.

Non-executive Director, Stephen Radford, recognised international pressures on the supply chain and enquired of any impact in respect of the availability of bone cement. The Chief Operating Officer confirmed there had been an impact on activity, however, the Trust had worked closely with NHSE, and an alternative product had been sourced, and the matter was now resolved.

Non-executive Director, Kath Smart, welcomed the improvements seen in productivity and highlighted the positive impact on patients and colleagues, alongside the financial benefit.

Non-executive Director, Helen Best, reflected on the Trust's improved position in the Quarter 3 NOF league tables and enquired of the drivers of change. The Chief Operating Officer confirmed marginal improvements had been realised over a range of performance measures.

The Chair thanked the Acting Chief Executive for her leadership.

The Board:

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

P26/03/B3

Medium Term Planning Framework Final Submission (Enclosure B3)

The Acting Chief Executive welcomed the introduction of multi-year planning. A draft medium-term plan had been iteratively developed to deliver a strong position, with clarity on the progress required to deliver its ambitions. Discussions continued with NHSE to finalise the plan.

There would be a need for the Board to satisfy itself of the plan's credibility, whilst recognising the need for delivery at pace and in a sustainable manner. A significant step change would be necessary to deliver service and workforce transformation. Partnership working and the receipt of deficit support funding would be key, as would the delivery of workforce reductions.

Dedicated support would be required to oversee delivery of the plan, which would be subject to regional scrutiny and require a strong oversight and governance framework.

The Chief Finance Officer confirmed that a 2026/27 deficit financial plan of £15.7m (excluding deficit support funding) had been submitted, it was noted that some elements of the support package required national approval.

The final activity submission confirmed a compliant Referral to Treatment position of 92% by the end of three-year planning period.

In response to a question from Non-executive Director, Stephen Radford, regarding alignment of provider and commissioner intentions, the Chief Finance Officer confirmed one exception would be worked through in Quarter 1 2026/27 with South Yorkshire Integrated Care Board in respect of growth and the level of rebasing that may be required to the block contract.

Non-executive Director, Kath Smart, enquired how the impact of service change would be considered, recognising the Trust would not wish to compromise patient safety and the quality of care. The Chief Nurse confirmed a Quality Performance Impact Assessment (QPIA) would be undertaken where a change in service was proposed, should the assessment indicate the proposed change was high risk the matter would be considered by the Board of Directors.

Non-executive Director, Kath Smart, enquired of the role of the Board's assurance committees in overseeing delivery of the medium-term plan. The Acting Chief Executive confirmed committee workplans would be reviewed to establish alignment with the key programmes of work, to ensure the correct flow of information and discussion. Whilst it was recognised that reporting was reflective in nature, the Acting Chief Executive encouraged the need for a forward view, with improvement trajectories and the use of Statistical Process Control charts.

In response to a question from Non-executive Director, Lucy Nickson, regarding trust wide communication plans and the opportunity to understand colleagues' views. The Acting Chief Executive confirmed executive visibility and engagement opportunities had been strengthened. Mechanisms to support colleague input and avoid working in isolation were in place and following today's meeting the Chair and Acting Chief Executive would share the key outputs from the Board. The Chief Finance Officer encouraged clarity on the multi-year approach of the plan.

Non-executive Director, Jo Gander, noted the challenges presented by the Doncaster Royal Infirmary estate and enquired if there would be a future opportunity to be part of the New Hospital Programme (NHP). The Acting Chief Executive confirmed that this was not being pursued as a solution, referencing the extensive delays experienced by those organisations included in the programme. The Trust's business case for the development of the East Ward Block was progressing and would serve to mitigate risks and drive change.

The Chair recognised the need to ensure focused and clear communication, recognising the importance of sharing positive change in a tangible way.

The Board:

- ***Noted the final planning submission and the attached conditions related to financial support and monthly oversight. Delivery of workforce reductions were key to delivery***

P26/03/C1

Integrated Quality & Performance Report including Finance Report (Enclosure B1)

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for December 2025 and remaining access, quality, and workforce standards for January 2026. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The Chief Operating Officer confirmed that improvements had been seen in four hour waits during February and the Trust was currently on track to deliver the 78% standard by 31 March 2026, in line with national expectations.

The standard for patients waiting less than 18 weeks from referral to treatment had not been met, the assurance report confirmed the actions in place which included Q4 Sprint funding to increase outpatient capacity, marginal gains were expected.

In relation to cancer, the Trust had delivered the Faster Diagnosis Standard and 31-day decision to treatment standard. The 62- day wait from referral to treatment standard had not been met and focused work continued on cancer pathways.

The Medical Director for Operational Stability and Optimisation confirmed that the twelve-month rolling Summary Hospital-level Mortality Indicator (SHMI) stood at 113.6. against the threshold of 100, the latest reported monthly data in September 2025 stood at 117.4. The assurance report identified the reduction of avoidable mortality as a core priority, with significant improvement work in train, including clinical coding, sepsis management and through the completion and learning identified from Structured Judgement Reviews (SJRs). There were plans to integrate mortality management in the Medical Directors' Office, with recruitment of a Mortality Co-ordinator and senior data analyst planned.

The Chief Nurse confirmed that no significant variation was reported in respect of patient safety key performance indicators, with the exception of E. coli and MRSA, where thresholds were based upon historical performance. The assurance report documented the actions to address risks, issues and emerging concerns. The Director of Infection, Prevention and Control had direct oversight of this, and the strengthening of antimicrobial stewardship was a key quality priority for the Trust.

The Chief Finance Officer highlighted improvements to financial risks related to recruitment and bank mandate checks. A new model to assess the Trust's underlying deficit had been developed, the current estimated underlying deficit was £42.2m, which had improved in month due to CIP performance.

The latest published data (month six) showed implied productivity was 6.9% behind pre covid levels, this was an improvement from 13.8% in month five and placed the Trust in the second-best quartile nationally. Delivery of recurrent efficiencies was ahead of plan.

At month 10, a year-to-date deficit of £0.6m was reported, £1.4m behind plan due to Q4 deficit support funding not being secured by South Yorkshire Integrated Care Board. No cash support was expected to be required until September 2026.

The Chief People Officer confirmed that sickness absence stood at 5.5% as at January 2026, against a target of 5%, the Trust continued to perform relatively well when compared to other organisations in this area. Statutory and Essential Training compliance was 88.2% against a local target of 90%.

The Acting Chief Executive confirmed that SHMI had been the subject of discussion by the Executive Team and whilst the complexities were recognised, and the situation was not unique to the Trust there was a need to re-evaluate the position, including divisional discussions at the Performance Review Meetings. A plan of action and improvement trajectory would be required to move towards the threshold of 100. An established governance route for the reporting of SHMI was in place, however, this was a key metric for the Board, on which they were required to take assurance.

NM

Non-executive Directors, Jo Gander and Kath Smart, reflected on previous work to strengthen clinical coding, as SHMI continued to increase and an impact was not being seen they supported the reassessment, recognising that a return to the threshold of 100 may not be realistic during 2026/27.

Non-executive Director, Kath Smart, noted a lack of improvement in the number of patients receiving antibiotics within one hour of a positive sepsis screening, despite ongoing sepsis education. In addition to the actions in the assurance report the Chief Nurse confirmed divisions were developing action plans to address Sepsis 6 as part of a quality improvement project.

In response to a question from Non-executive Director, Lucy Nickson, regarding any changes to the IQPR arising from the medium-term plan, the Acting Chief Executive confirmed that the report remained under review and was currently aligned with the contract requirements of commissioners. The volume of detail within the report was acknowledged, with the need for clarity on how the report was utilised to add value.

The Board:

- ***Noted the IQPR***

P26/03/D1

Maternity & Neonatal Safety Report (Enclosure D1)

The Director of Midwifery drew the Board's attention to the findings and associated learning from the Q3 Perinatal Mortality Report and the accompanying quality metrics.

In response to a question from Non-executive Director, Stephen Radford, the Director of Midwifery confirmed that the Trust had declared full compliance against the Year 7 Clinical Negligence Scheme for Trusts' standards. Validation of the submission was awaited.

In response to the deterioration in the neonatal death rate per 1000 births, the Director of Midwifery advised Non-executive Director, Stephen Radford that the rate had been impacted due to early gestational deaths, no trends had been identified.

Non-executive Director, Helen Best, acknowledged the full compliance CNST declaration and commended the Director of Midwifery and her colleagues for their work.

Year 8 CNST standards were expected to focus on six core areas, the detail of which was expected by 31 March 2026. Once received, reporting arrangements via the Quality Committee and Board would be confirmed.

Whilst the delivery of Year 7 CNST standards was recognised and feedback on local maternity services was positively reported, the impact of national maternity safety reviews and media coverage continued to be felt by midwifery and medial colleagues, as recognised by the Royal College of Midwifery.

The Board:

- ***Noted and took assurance from the Maternity and Neonatal Safety Report***
- ***Reviewed and approved the Q3 Perinatal Mortality Report***
- ***Reviewed the Trust's Quality Metrics***

P26/03/D2 Learning from Deaths Report (Enclosure D2)

The Medical Director for Operational Stability and Optimisation shared with the Board the key highlights from the Quarter 2 2025/26 Learning from Deaths report.

The number of in-hospital deaths were consistent with that seen in the previous quarter, however, the number of Structured Judgement Reviews (SJRs) had fallen, due to limited capacity. All hospital deaths had been subject to review by the Medical Examiner's Office.

The Summary Hospital-level Mortality Indicator remained higher than hoped, changes made to the coding of Emergency Department admissions and transfers of care from April 2026 were expected to impact SHMI and align the Trust's performance with that of its peers.

The report confirmed the learning from SJRs, which included the timely completion of mental capacity assessments and the application of Deprivation of Liberty Safeguards. Improvements were required in respect of blood culture sampling, sepsis management and the timely administration of antibiotics.

At the request of the Chief Nurse, the Board paused to acknowledge the significance of this report to family members observing the meeting.

During Q3, 46 SJRs had been completed, showing an improvement in overall numbers to this report, it should be noted there was no national guidance on the numbers required and where a death had been referred to HM Coroner completion of a SJR would not take place, due to the coronial process.

In response to a question from Non-executive Director, Jo Gander, regarding links to the Patient Safety Incident Response Framework, the Chief Nurse confirmed governance around the tracking of actions and thematic analysis from the Prevention of Future Deaths Reports had been strengthened. The Trust Executive Patient Safety Oversight Group monitored the closure of actions through validation of evidence. An increase in the number of Prevention of Future Deaths Reports was a national trend, and not unique to the Trust.

Despite ongoing work to address learning, it was acknowledged there was a need for more rapid improvement. The refresh of the Trust's Patient Safety Incident Response Plan would take into account incident themes.

In regards to the implementation of Martha's Rule, the Chief Nurse confirmed this was being rolled out in accordance with the national programme. The introduction of the Patient Wellness Questionnaire had alerted colleagues to a deterioration in patient wellbeing prior to this being seen in the National Early Warning Score following observations. Escalation processes in Martha's Rule would require further consideration due to the absence of a 24-hour critical care outreach team at the Trust.

The Chief Nurse recognised an increase in demand for the completion of mental capacity assessments and the Deprivation of Liberty Safeguards. Work to educate colleagues was ongoing, with the senior doctor in charge assessing this on admission to the ward, as part of determining a care plan, as appropriate.

In response to a reflection from Non-executive Director, Helen Best regarding statutory and mandatory training for adult safeguarding and learning disabilities. The Chief Nurse confirmed that training compliance was overseen by leaders across the organisation and reported through the governance structure, including at the Board's People Committee. Following the Care Quality Commission's inspection in 2023 two mental capacity assessment co-ordinators supported the process and safeguarding colleagues were proactive in their support of, and presence in, clinical areas.

Non-executive Director, Stephen Radford, enquired if capacity was assessed at the point of access, the Chief Nurse confirmed this may not be completed in the Emergency Department but should be assessed within 12-24 hours of admission on to a ward, as there would be an impact upon the individual's treatment plan. A Mental Capacity Assessment (under the Mental Capacity Act) determined whether a person could make a specific decision at a specific time and, if not, how a best interests decision should be made. The Accessible Information Standard (AIS) required organisations to identify, record and meet a person's information and communication needs arising from a disability, impairment or sensory loss, regardless of whether the person had capacity. The Trust captured patient needs as part of "This is Me" documentation.

Non-executive Director, Lucy Nickson, enquired how she could be assured that learning from deaths was being implemented and the impact evidenced. In the Executive Medical Directors absence, the Chief Nurse noted ongoing improvement work, including plans within the Medical Directors report to recruit. The report had been considered at the Quality Committee and partial assurance taken, it was proposed to consider how the report could be developed to address gaps in assurance.

Non-executive Director, Kath Smart, confirmed that compliance with the Mental Capacity Act had been the subject of an internal audit approximately 18 months ago, which provided limited assurance and enquired if there was a need to reframe and refresh the risk assessment. It was proposed that this be considered by the Quality Committee on behalf of the Board. **KJ**

The increase in the number of completed SJRs in Q3 was noted by Non-executive Director, Kath Smart, in view of the reference in the paper that the majority were completed by staff with no protected time to do so, she enquired if the gain was fortuitous. The Chief Nurse confirmed that medical colleagues supporting the completion of SJRs now have Programmed Activities within their job plan, whilst nursing colleagues complete them within their existing job role.

Non-executive Director, Kath Smart, reflected on a recent visit to the Medical Examiners and Bereavement Team which highlighted the connections made between families and the Medical Examiner.

Reflecting on the Trust's performance in respect of administering antibiotics within one hour of a positive sepsis screening and the sepsis related learning from SJRs, it was

proposed that a deep dive on sepsis management be undertaken and considered on behalf of the Board by the Quality Committee. **NM**

The Board:

- ***Noted the Learning from Deaths Report.***

P26/03/D3 Focused Freedom to Speak Up Report (Enclosure D3)

The Chair welcomed the Freedom to Speak Up (FTSU) Guardian to the meeting to provide an overview of the paper which reported the progress of deferred actions from the Speaking Up Reflection & Planning Tool 2024-2026. A more detailed version had been considered by the People Committee in February 2026, when significant assurance had been taken.

Non-executive Director, Stephen Radford, enquired how the findings of the peer review, triangulated with those from the staff survey and colleagues views of Speaking Up. The FTSU Guardian confirmed that the staff survey indicated colleagues felt safer in raising concerns related to patient safety. Colleagues across the organisation reported differing experiences of Speaking Up and the Chief People Officer acknowledged the need to understand this variation by area and professional groups.

Non-executive Director, Lucy Nickson recognised the volume of information provided and reflected on the need for this to be distilled and triangulated to understand the impact. In terms of the key programmes of work in the year ahead, the FTSU Guardian recognised the need to address inconsistencies in experience across the organisation, progress the learning from the peer review, development of detriment guidance and completion of a deep dive to understand the prevalence of bullying and harassment.

The use of a peer review was welcomed by the Chief Finance Officer.

The Chief Nurse noted a shift over time in the reasons for Speaking Up from the initial focus on patient safety and enquired if there was value in revisiting this. The link to wider cultural improvements, the requirements of the Care Quality Commission and the independence of the FTSU Guardian were referenced by the Guardian and Chief People Officer.

It was proposed that a discussion paper would be prepared for consideration by the People Committee to determine the focus and requirements of future Speaking Up reports to be received by the Board and People Committee. **ZL**

The Board:

- ***Noted the Focused Freedom to Speak Up Report***

P26/03/D4 Guardian of Safe Working Report (Enclosure D4)

The Chair of the Board welcomed the Guardian of Safe Working to the meeting to present exception reporting for the period 1 February 2025 31 January 2026.

A total of 533 exception reports had been made during this period, as compared to 335 in the same period of 2024/25. The majority of exception reports (86%) had been made by resident doctors working in General Medicine, Obstetrics & Gynaecology, General Surgery and Paediatrics in relation to additional hours worked, reflecting the high workload which was often compounded by rota gaps. 6% of reports related to missed educational opportunities.

Changes to NHS Employers exception reporting framework had been fully implemented by the Trust and an increase in the number of reports was anticipated. A standardised report template was awaited.

Exception reports continued to be seen in urology due to a breach of the minimum rest period for the non-resident on call. Work was ongoing to identify actions to reduce the incidence of fines.

In response to a question from Non-executive Director, Stephen Radford, regarding the underlying reason for the increase in exception reports, the Guardian of Safe Working confirmed this was due to rota gaps, and mitigating actions were being worked through. Benchmarking of performance wasn't always possible, as like for like scenarios were not necessarily being compared, although discussions at national meetings provided high level insight.

The Medical Director for Operational Stability and Optimisation confirmed that soft intelligence suggested an increase in the number of exception reports was potentially linked to the industrial action negotiating position.

Non-executive Director, Kath Smart, enquired if there was any benefit in considering areas where persistent placement vacancies were seen, recognising these were determined by the Deanery and outside of the Trust's control. The Chief People Officer **ZL** agreed to discuss this with the Acting Executive Medical Director.

The Board:

- ***Noted and took assurance from the Guardian of Safe Working Report***

P26/03/E1

Paediatric Senior House Officer Business Case (Enclosure E1)

The Board received the Paediatric Senior House Officer business case developed to increase staffing levels that would support the paediatric night on call rota in line with the British Association of Perinatal Medicine (BAPM) standards and Year 7 Clinical Negligence Scheme for Trust (CNST) requirements.

The case had been considered by the Corporate Investment Group prior to receipt by the Board's Finance and Performance Committee, which recommended the case to the Board for approval.

The Board:

- ***Approved the Paediatric Senior House Officer Business Case***

P26/03/F1 Board Assurance Framework including Trust Risk Register (Enclosure F1)

The Board Assurance Framework (BAF) was received following consideration by executive led discussions at each of the Board's assurance committees. As a live document the BAF continued to be iteratively developed, with work to be undertaken to ensure a read across to the medium-term plan.

In response to a question from Non-executive Director, Jo Gander, relating to risk ID 3246 (the risk of regulatory action relating to the poor application of the Mental Capacity Act and Deprivations of Liberty Safeguards), the Chief Nurse confirmed that the risk was reviewed at a divisional level and overseen by the Risk Management Group. Controls were in place and the operational detail would not form part of the BAF.

In respect of strategic risk 5, the Chief Finance Officer provided a verbal update from last week's Finance & Performance Committee, which proposed the current risk rating be reduced to 12 to reflect the on-target delivery of this year's financial plan. This would be included in the next iteration of the BAF.

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.***

P26/03/F2 Chair's Assurance Log – Finance & Performance Committee (Enclosure F2)

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

The Board:

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

P26/03/F3 Chair's Assurance Log – Quality Committee (Enclosure F3)

The Board received the Quality Committee Chair's assurance log from February 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

The Board:

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

P26/03/F4 Chair's Assurance Log – People Committee (Enclosure F4)

The Board received the People Committee Chair's assurance log from February 2026's meeting summarised the assurance taken and decision made.

In response to a question from Non-executive Director, Lucy Nickson, the Medical Director for Operational Stability & Optimisation confirmed the year end position on job planning was expected to be between 90-95% due to levels of completion in general

surgery.

The Board:

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

P26/03/F5 Chair's Assurance Log – Audit & Risk Committee (Enclosure F5)

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

As part of a review of year end processes the committee had considered the going concern assumption and received the cyber security internal report which provided significant assurance and recognised the expertise in the team and work to remain connected with ongoing threats.

The Board:

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

P26/03/F6 Board of Directors Work Plan (Enclosure F6)

The Board:

- ***Noted the Board of Directors Work Plan***

P26/03/G1 Minutes of the meeting held on 27 January 2026 (Enclosure G1)

The Board:

- ***Approved the minutes of the meeting held on 27 January 2026, subject to minor amends to C1 and D1 and to capture the presence of Non-executive Director, Helen Best***

P26/03/G2 Pre-submitted Governor or public Questions regarding the business of the meeting (verbal)

The following questions were received from the Council of Governors, responses were provided during the meeting and added to the database of governor questions and answers.

What consultation process was undertaken regarding the change of title to Chief Medical Officer from Executive Medical Director does it imply that there will be a restructuring of the medical directors office.

The decision to change the title of the Executive Medical Director to Chief Medical Officer was undertaken by the Trust's Board of Directors' Nomination & Remuneration Committee. This is in line with other executive director job titles and medical director roles elsewhere. No wider consultation is required to make changes to Executive Director roles. There has been no restructuring of the Medical Director's team. Once the new post holder is recruited it will be their responsibility to review the

structure and make any changes should they wish, in line with Trust HR processes and procedures.

There is ongoing dependence on agency locums in the orthopaedic department contributing to high locum costs why have efforts not been completed to get these posts filled with regular staff. One of the agency locums has been here for over 4 years.

There are two parts to this: the wider context and the specific position in Trauma & Orthopaedics (T&O).

Wider workforce context - there is a national shortage of appropriately skilled and experienced surgical staff, particularly in some specialties, which has persisted for a number of years. As a result, many organisations, including ours, have had to rely on temporary workforce solutions to maintain safe service delivery.

We have actively reviewed long-standing locum arrangements and, where individuals have been in post for extended periods, we have approached them about moving to substantive contracts. In a number of cases, including those referenced, individuals have chosen not to convert to substantive roles for personal reasons.

Alongside this, over recent years we have taken a range of actions to improve recruitment and retention to key medical posts, and more recently have undertaken detailed work on medical rotas and job planning to ensure roles are structured in a way that is sustainable and attractive.

Specific factors in T&O - the level of locum usage in T&O has increased since the pandemic, driven by a combination of workforce capacity gaps within the rota. These include reduced availability of some senior staff to undertake on-call duties, alongside training-related gaps and less than full-time working within the trainee workforce. Taken together, this has created sustained rota gaps that have required locum cover to maintain safe service provision.

Actions to reduce reliance on locums - we are now moving from managing gaps to addressing the underlying structure:

- Proposed recruitment of two post-CCT fellows (doctors who have completed their specialist training and are qualified to work at consultant level), funded through reductions in locum expenditure
- Changes to the Bassetlaw SAS on-call rota to create a more sustainable model

These changes are planned for implementation in 2026/27. A business case for the fellow posts is in development and is expected to go to the vacancy control panel by late April.

The reliance on long-term locums reflects a combination of national workforce constraints and structural rota gaps, rather than a lack of action. We now have a clear plan to reduce this reliance through rota redesign and targeted recruitment, with actions progressing this year.

The following questions were received from members of the public, responses were provided in the meeting and the following written responses provided post meeting

The Learning from Deaths report highlights repeated failures in fundamental safety, and care, highlighting practices including incomplete fluid balance monitoring, missed recognition of deterioration, and unclear escalation decisions, as identified in Structured Judgement Reviews and Prevention of Future Deaths reports. What specific actions is the Board taking to address these critical safety concerns and how will the Board monitor impact and whether the quality of basic care and culture is genuinely improving at ward level? What further steps will you take if the data shows these behaviours are not changing?

The Board recognises the seriousness of the repeated themes highlighted through the Learning from Deaths (LfD) process, particularly around fluid balance monitoring, recognition of deterioration, and escalation decision-making. These are core safety fundamentals and addressing them remains a priority focus for the organisation.

1. What specific actions is the Board taking to address these safety concerns

Strengthening review, learning and governance

- Q3 report - 93% of cases reviewed were graded as adequate, good or excellent care, with 6.5% identified as poor care. All instances of poor care are escalated to the specialty governance lead and senior divisional team for review, discussion with clinical teams, and targeted learning.
- The monthly Trust wide Mortality Governance group reviews in detail the findings of Structured Judgement Reviews (SJRs) and shares cross divisional learning and any themes identified from the medical examiner's office.
- The Learning from Deaths report is reviewed at each divisional governance meeting, with themes and actions allocated to divisions to ensure accountability for improvement.
- SJRs have been completed for a number of sepsis-related deaths as part of the Recognition of Deterioration Action Plan, ensuring specific learning is identified and acted upon.

Focused improvement on deterioration, sepsis and Acute Kidney Injury (AKI)

- Under Patient Safety Incident Response Framework (PSIRF) recognition of deterioration was agreed as a key local priority, the current PSIRF plan is being evaluated with thematic analysis underway to consolidate learning and inform future improvement plans.
- The Sepsis Action Group is overseeing divisional improvement plans and has already demonstrated progress, including better blood culture sampling in the Emergency Department.
- The AKI Steering Group provides targeted training and supports improved fluid balance monitoring. The AKI bundle went live on Nervecentre on 15 February, giving clinicians

digital prompts and tools to support fluid intake/output monitoring and timely biochemistry checks.

Ward-level assurance and quality monitoring

- The Trust uses Tendable, a digital audit tool, to monitor compliance with fundamental standards at ward level. This includes the review of fluid balance chart completion.
From April, the audit schedule has been strengthened with a specific focus on fluid balance chart completion.
- Sepsis and AKI performance indicators are monitored through the Patient Safety Assurance Group, enabling Board-to-Ward oversight.

2. How will the Board monitor whether fundamental care and culture are genuinely improving?

The Board will receive assurance through:

- Regular triangulation of data including LfD findings, PSIRF insights, Tendable audits, quality metrics, and patient safety incident themes.
- Divisional governance reporting, holding divisions to account for addressing deterioration, sepsis and AKI improvement actions.
- Safety walkarounds and clinical engagement, enabling the Board and executive leaders to assess cultural and behavioural change directly at ward level.
- Monitoring of Tendable audit outcomes, focusing on fluid balance, escalation documentation, and basic care reliability.
- Evidence of sustained improvement trends within sepsis, AKI, and deterioration indicators discussed at the Patient Safety Assurance Group.

3. What further steps will be taken if the data shows these behaviours are not changing?

If monitoring shows that fundamental behaviours are not improving, the Board will consider:

- Targeted executive-led improvement interventions for specific wards or specialties.
- Enhanced clinical supervision and support, including buddying with high-performing areas.
- Escalation through performance and quality management processes, including:
 - strengthened divisional accountability plans
 - mandated action plans with clear timeframes
 - enhanced oversight via the Patient Safety Assurance Group.
- Focused training or competency assessment, particularly for escalation, fluid balance and recognition of deterioration.

- Re-prioritisation of quality improvement resources to support areas where behaviour change is not embedded.

I am submitting a question today on behalf of a concerned group of healthcare workers and patients regarding the intended adoption of the Federated Data Platform (FDP). The issues specifically relate to the involvement of the private company Palantir Technologies Inc. in operating the FDP. Doncaster and Bassetlaw Teaching Hospitals have outlined their intentions to support the adoption of the FDP in their Annual Operational Planning guidance. Whilst we appreciate that the expectation from NHS England is that trusts adopt the FDP, there are sufficient concerns for DBTH to pause it's implementation in order to address these concerns. Considering the grave concerns regarding the partnering of DBTH with technologies associated with Palantir, we have the following questions:

- 1. Was the trust aware of the ethical issues surrounding the complicity of Palantir in genocide?**
- 2. Was the trust aware of the harms associated with the FDPs potential for future inter-agency data sharing and the public's perceived security of NHS data?**
- 3. Is the trust willing to revisit the decision to use the FDP?**
- 4. Would members of the board be willing to meet with us to discuss these concerns further?**

The Trust continues to be clear that the Federated Data Platform is a national programme, led and procured by NHS England, including the involvement of Palantir and is not a local Trust procurement decision. Patient data remains under NHS control with strict role-based access, relevant legal safeguards and full auditability and our responsibility locally is to ensure it is used safely to support improvements in patient care.

The Chief Finance Officer agreed to meet, as executive lead for digital transformation.

P26/03/G3 Any other business (to be agreed with the Chair prior to the meeting)

No items of other business were raised.

P26/03/G4 Date and time of next meeting (verbal):

Date: 5 May 2026
Time: 9:30am
Venue: Boardroom, Doncaster Royal Infirmary

P26/03/G5 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.***

P26/03/H Close of meeting (Verbal)

The meeting closed at 12:35

M.C. Bailey



Mark Bailey
Interim Chair
5 May 2026