Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

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

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

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

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

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

ACTION

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

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

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

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

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

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

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

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

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

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

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

The Board:

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

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

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

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

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

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

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

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

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

The Board:

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

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

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

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

The Board:

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

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

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

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

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

The Chief Nurse confirmed the introduction of a new metric for planned induction of labour and confirmed increased caesarean section capacity. Gram-negative infection

performance had deteriorated, with patient safety learning processes in place. Maternity staffing had fallen below the trigger level; however, mitigation and escalation arrangements were active. Recruitment had concluded, although the appointed colleagues had not yet commenced in post.

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

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

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

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

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

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

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

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

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

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

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

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

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

The Board:

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

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

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

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

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

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

Non-executive Director, Lucy Nickson, said it was difficult to take assurance from the report as it contained little information about the impact of learning. Although the learning themes related to simple but essential care, the evidence did not demonstrate its effect.
Non-executive Director, Stephen Radford, asked whether the Structured Judgement Review (SJR) outcomes that was assessed as good were based solely on clinical review or also included information from families. The Medical Director for Operational Stability and Optimisation confirmed that the conclusion generally arose from a systematic approach. The Chief Nurse added that the SJR considered different perspectives, including consultant, clinical and nursing input, and was based on the documentation available. Where there was no reference to family involvement, an assessment would be made in accordance with the national process.

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

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

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

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

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

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

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

The Board:

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

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

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

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

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

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

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

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

The Board:

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

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

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

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

Changes to clinical practice had been made following complaints, improvements to training, and developments in maternity triage systems.
Colleagues had demonstrated the work more clearly and had explored opportunities to obtain real-time feedback so that the Trust could listen and respond quicker.

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

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

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

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

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

The Board:

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

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

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

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

Non-executive Director, Stephen Radford, referred to an earlier discussion at the Finance & Performance Committee and enquired whether an alternative reserve could be used. The Chief Finance Officer confirmed that other reserves were available but had been allocated to different areas.

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

Non-executive Director, Stephen Radford, asked what lead time was required to secure additional staffing. The Chief Operating Officer confirmed that the estate was readily

available, but staffing and bed openings were not arranged during holiday periods or out of hours. Emergency Department admissions were monitored, and plans were made approximately one week in advance, with site team discussions and executive oversight.

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

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

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

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

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

The Chair referred to the earlier extensive discussions regarding partner capacity and enquired whether submission of the plan should be deferred. The Interim Chief Executive confirmed that the justification needed to be strengthened and the decision reconsidered, including an assessment of the best achievable outcome within the available budget. **SW/DS**

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

The Board:

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

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

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

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

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

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

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

The Chief Operating Officer confirmed that the Doncaster musculoskeletal pathway was not currently mandated, but conversations had taken place with Doncaster Place to progress this. She acknowledged that productivity alone would not deliver the required recovery or long-term sustainability and that available system funding had already been allocated.

The Board:

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

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

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

The Chief People Officer confirmed that the DBTH Assembly had been launched to support colleague engagement, with a focus on behaviours and ongoing activity relating to Speaking Up for patient safety and leadership development. Culture change

was recognised as a long-term process requiring sustained focus. The annual Staff Survey would provide a key measure, supported by pulse checks and ongoing departmental engagement. HR casework and Freedom to Speak Up concerns would be reviewed in September 2026.

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

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

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

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

The Board:

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

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

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

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

The Board:

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

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

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

The Director of Midwifery confirmed that no significant concerns had been identified and that an improved position was expected. She outlined the findings from the

maternity assessments completed for both sites and confirmed that issues had been identified at both Doncaster and Bassetlaw sites. Areas identified were insufficient sizing of the maternity triage area, data analysis capacity, strengthened patient feedback and the lack of recorded telephone calls.

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

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

The Chief Nurse noted that operating maternity services across two separate sites would present a challenge in meeting the requirements. The Medical Director for Operational Stability and Optimisation confirmed that he had discussed the position with the Clinical Director, who was assured that the plans would progress as intended.

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

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

The Board:

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

P26/09/F3 **<u>Mortuary Oversight – Board Assurance Statement</u>**

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

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

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

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

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

The Board:

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

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

The Chief Finance Officer confirmed that minor amendments had been made to the policy to ensure alignment with the exemplar within the Department of Health & Social Care's technical memorandum.

The Board:

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

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

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

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

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

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

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

The Board:

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

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

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

The Board:

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

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

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

The Board:

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

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

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

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

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

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

The Board:

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

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

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

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

The Board:

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

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

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

deep dive which received significant assurance and also highlighted the clinical care frameworks.

The Board:

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

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

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

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

The Board:

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

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

The Board:

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

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

The Board

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

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

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

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

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

The Board

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

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

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

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

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

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

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

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

The Board:

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

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

The pre-submitted questions were addressed during the meeting, and a formal written response was provided post meeting. For completeness the questions and responses are appended to the minutes.

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

The Board:

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

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

There were no items of other business.

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

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

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

The Board:

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

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

The meeting closed at 13:31

M.C. Bailey

Mark Bailey
Interim Chair
3 November 2026

Appendix - questions submitted to the DBTH Board in advance of 1 September 2026 Public Board Meeting and the Trust's subsequent written responses

Theme 1: Learning from Deaths Report Q4 2025/26: Significant Assurance

Request: *As this question relates directly to the level of assurance the Board is being asked to take from the Learning from Deaths Report Q4 2025/26, I would be grateful if it could be considered as part of the Board's discussion of that item, before the Board determines the level of assurance it wishes to take.*

The Learning from Deaths Report Q4 2025/26 (overall pages 113–121) asks the Board to take Significant Assurance that robust mortality governance processes remain in place, citing 100% Medical Examiner scrutiny of in-hospital deaths and escalation through established pathways including PSIRF and structured Judgement Reviews (SJRs).

However, the report itself identifies limitations within those processes. On overall page 120, it states:

"Reviewers need to access several electronic systems to obtain the information needed to complete a review, and in some cases, paper records also have to be accessed."

It notes that this adds considerably to the time required and that the same issue has been recognised and discussed at regional mortality level.

The Board Assurance Framework – BAF 1 (*If learning from incidents, patient experience, clinical outcomes and workforce insight is not effectively triangulated and translated into sustainable quality care, patients could experience avoidable harm, leading to deteriorating outcomes and potential regulatory action for DBTH.)* (overall pages 791–793) provides further relevant context. BAF 1 has a current risk rating of 16 against a target score of 10 and identifies as current gaps in control:

- GC4: insufficient SJRs in line with best-practice guidance to contribute to Learning from Deaths and the overview of mortality rates; and
- GC5: no substantive Learning from Deaths Manager in post.

On overall page 793, the BAF states that SJR completion increased from 7% in Q1 2025/26 to 14% in Q4, against best-practice guidance of 15–20%. However, the detailed Q4 Learning from Deaths table on overall page 120 records 76 SJRs requested (14% of deaths) but only 56 completed within six weeks (10.6% of deaths). The BAF also states that initial recruitment to the Learning from Deaths roles was unsuccessful and that readvertising the roles "will delay implementation and the roles impact." Overall page 791 lists internal audits of Learning from Deaths and mortality data quality assurance as planned rather than completed sources of assurance.

Given the apparent difference between the BAF describing 14% as SJR "completion" and the Learning from Deaths report describing 14% as SJRs requested, could the Trust clarify which measure is being used when assessing performance against the 15-20% best-practice standard?

Response: The Trust recognises the apparent discrepancy between the Q4 Learning from Deaths report and the Board Assurance Framework. The Q4 report records 76 SJRs requested, representing approximately 14% of deaths, with 56 completed within six weeks, representing approximately 10.6% of deaths. These are different measures. An SJR being requested shows that a death has been identified for further review, while an SJR being completed shows that the substantive review has actually taken place.

The Board Assurance Framework therefore will make this distinction clear in future. The 14% figure should not be described simply as an SJR "completion" rate when the detailed report records it as the proportion of deaths for which an SJR was requested. When considering performance against a 15–20% best-practice standard, the Board is clear about what the benchmark relates to and Trust will in future detail reviews requested, commenced or completed. This is important because there is reasonable assurance that the SJR process is operating, but less assurance about the capacity of the process to deliver the intended level of completed review activity. The Trust has already recognised that SJR capacity and recruitment have affected performance. The Board will therefore continue to monitor both the number of reviews undertaken and the timeliness and quality of those reviews.

This is particularly significant in light of the Trust's letter to the HM Assistant Coroner Dr Elizabeth Didcock, dated 7 August 2026, following my mother's inquest. The Trust acknowledged that problems in providing a complete clinical record arose primarily from "the complexity of retrieving records from multiple non-integrated clinical systems, together with differences between printable summary reports and the underlying clinical documentation" and stated that this risk is formally recognised on the Trust's risk register. The letter identifies further actions and safeguards considered necessary to strengthen assurance over the completeness and accuracy of disclosure.

Given that Medical Examiner scrutiny and SJRs depend upon reviewers identifying and accessing complete and reliable clinical information, **what specific controls are actually in place to ensure that Medical Examiners and SJR reviewers know every electronic system and paper source they needed to search, had accessed all relevant records, and identified missing, late or retrospective documentation?**

Has the Trust tested this by auditing completed Medical Examiner scrutinies or SJRs against the underlying source systems, and is there a mechanism for completed reviews to be reconsidered where significant information is subsequently discovered or added?

Response: The Learning from Deaths report itself describes that reviewers may need to access several electronic systems and, in some circumstances, paper records. This can increase the time required to undertake a review. The Trust has also recognised more broadly the risks associated with retrieving a complete clinical record from multiple non-integrated systems. The existence of several systems does not in itself mean that the mortality-review process is unsafe. There are established processes for reviewers to access relevant clinical information.

The Audit and Risk Committee agreed the annual audit plan to be carried out by 360 assurance, the Trust's independent internal audit service in April 2026. There are two separate audits identified in the plan, one for learning from deaths which will be focused on the systems and processes supporting learning through SJRs and a Mortality Data Quality Assurance audit focused on the quality of mortality data.

Medical Examiner scrutiny has an important role in considering the proposed cause of death, the circumstances surrounding the death and concerns raised by bereaved families. However, it is different from an SJR, a patient-safety investigation or a coronial investigation. The subsequent identification of serious concerns through the coronial process does not mean that Medical Examiner scrutiny has no value. The strongest assurance comes from triangulating the outcomes of the Medical Examiner process with other sources of information, including SJRs, Patient Safety Incident Response Framework (PSIRF) investigations, complaints, family concerns, clinical incidents, mortality indicators, clinical audit, coronial findings and Prevention of Future Deaths reports. The Medical Examiner process is independent from the Trust processes, whilst the Trust is aware that the medical examiner regional team do undertake peer review audits, the Trust would not separately audit medical examiner activities, however as described above there are two audits planned by the Trust on mortality processes this year.

Medical Examiner scrutiny

The Learning from Deaths Report states that 100% of all hospital deaths have been scrutinised by a Medical Examiner and uses Medical Examiner scrutiny as part of the evidence supporting Significant Assurance.

In my mother's case, the Medical Examiner was prepared to issue a Medical Certificate of Cause of Death. Our family was not satisfied and pushed for her death to be referred to the Coroner. The subsequent inquest found gross failings in her care, that her death was contributed to by neglect and that she would not have died when she did had her condition been recognised and treated.

That raises a serious question for us about what assurance 100% Medical Examiner scrutiny actually provides. If our family had accepted the proposed cause of death, those failings may never have been identified.

What assurance can the Board have that other deaths which have been scrutinised have not involved serious problems in care which the Medical Examiner process failed to identify?

Response: The Medical Examiner (ME) process is independent of the Trust and is overseen by Lead ME and regional and National medical examiners. We are happy to signpost you to Regional and National Medical examiners if further clarifications are needed.

The Trust cannot provide an absolute assurance that no serious problem in care has ever been missed by the mortality-review process. No retrospective review system can provide that guarantee. The appropriate assurance is instead derived from the number of different mechanisms through which concerns can be identified and brought back into patient-safety governance. These include Medical Examiner scrutiny, Structured Judgement Reviews, Patient Safety Incident Reporting Framework, complaints, Patient Advice Liaison Service contacts, concerns raised by families, incidents, mortality indicators, clinical audit, coronial investigations and Prevention of Future Death reports.

Fluid and electrolyte disorders

Section 6.4 on overall page 123, reports that deaths in the "Fluid and electrolyte disorders" group have been higher than expected throughout the quarter, with 57 deaths compared with 38.8 predicted. Twelve SJRs have been requested and six had been completed at the time of reporting.

The Trust has received two Prevention of Future Deaths reports which raised concerns about fluid-balance monitoring – one issued in 2025 and the PFD following my mother's death, issued in July 2026.

Given these repeated concerns, are the SJRs being carried out for the "Fluid and electrolyte disorders" group looking specifically at fluid-balance monitoring - including whether fluid input and output were properly recorded, reviewed and acted on?
If not, given that this issue has now been raised in two Prevention of Future Deaths reports, will the Trust include fluid-balance monitoring in these reviews?

Response: The Trust recognises the particular significance of this question given the mortality data and the concerns subsequently raised through the Prevention of Future Deaths process. The Q4 Learning from Deaths report identifies deaths in the fluid and electrolyte disorders group as higher than expected, with 57 deaths compared with 38.8 predicted. Twelve SJRs had been requested and six completed at the time of reporting.

In circumstances where there is an identified mortality signal and related concerns about fluid management, it is appropriate that the relevant reviews consider whether fluid management contributed to the patient's deterioration or death. Where clinically relevant, this will include consideration of assessment of hydration status, recording of fluid input and output, completeness and accuracy of fluid-balance charts, whether fluid balance was reviewed appropriately, recognition of abnormal fluid balance,

escalation of concerns, renal function and acute kidney injury, recognition and response to deterioration, and whether the clinical record provides sufficient evidence of the decisions and actions taken.

The purpose will not simply be to establish whether a fluid chart was completed. The more important question is whether the information available to clinicians enabled them to recognise the patient's changing condition and whether appropriate action was taken.

Prevention of Future Deaths reporting

Section 9 on overall page 130 reports a Regulation 28 Prevention of Future Deaths Report received during the quarter and summarises the concerns raised.

Could future Learning from Deaths reports also include the date of the death and the date of the PFD, together with a link or reference to the published PFD and the Trust's response where available? This would enable the Board to understand the chronology of the case, the full concerns raised by the Coroner and the actions the Trust has committed to taking.

Response: The Trust has commissioned a review of Learning from Deaths reporting to ensure it aligns with national guidance and requirements. Any recommendations from the review will be considered and Board reporting will be amended as required to reflect those recommendations and support compliance with national standards.

Learning from Deaths reporting

The Board Annual Work Programme on overall page 828 identifies "Learning from Deaths" as a quarterly report. The published Learning from Deaths reports I have been able to identify for 2025/26 are Q2, presented in March 2026; Q3, presented in July 2026; and Q4, presented in the current September papers. I am aware that a separate Mortality Review paper was presented in May 2026, but this is not identified as a quarterly Learning from Deaths report.

Could the Trust therefore confirm when the Q1 2025/26 Learning from Deaths report was presented to the Board? If no Q1 report was presented, why was it omitted from the quarterly reporting cycle?

Response:

The Q1 learning from deaths information was considered through the Trust's established governance arrangements and reviewed by the relevant sub-Board committees. However, due to an oversight the Q1 report was not subsequently included in the Board reporting cycle. This will be rectified through the inclusion of the Q1 information within the annual learning from Death's report presented to the Board, ensuring the Board has visibility of the mortality trends, reviews, learning and actions across the full reporting year.

The Trust also produced a separate Annual Learning from Deaths Report for 2024/25, bringing together learning from across the four quarters. There does not appear to be an equivalent annual report for 2025/26 in the current papers or Board work programme. Will one be produced and, if not, how will the Board obtain a complete picture of recurring themes and learning from deaths across the year?

Response: The Trust will publish an annual learning from Deaths report for 2025-26 in December 2026.

Taking these issues together, and given the Trust's own definition of Significant Assurance as "good confidence with minor gaps that do not threaten delivery", where controls are "largely effective with isolated weaknesses", what objective evidence supports the proposed rating of Significant Assurance rather than a lower level of assurance?

Response: You will be aware that there was a robust discussion regarding the assurance rating at the Trust Board on 1st September. The Chair determined that the Quality committee consider the discussion around assurance and the outstanding concerns when determining the assurance rating applied to the next LFD reports received.

Theme 2: Patient Experience and complaints

Complaints performance metric (overall page 60)

Overall page 60 reports "Complaints Not Signed Off in Agreed Timeframe", showing zero for July 2026 and one year-to-date.

Please can the Trust explain how an "agreed timeframe" is defined for this metric, including how and when that timeframe is agreed with the complainant, and how complaints are recorded where no timeframe has been explicitly agreed?

I ask because I submitted four formal complaints to the Trust in March 2026, three of which were subsequently combined into a single response. The responses were not received until July, approximately four months later, and a response timeframe was not agreed with me.

How would complaints such as these be represented within this metric, and what assurance does the Board have that reporting only complaints not signed off within an "agreed timeframe" provides a accurate picture of the actual timeliness of complaint responses?

Response: The Trust would define an "agreed timeframe" as the response timescale discussed and agreed with the complainant once the key issues and desired resolution have been clarified. This should form part of the initial complaint management process and be communicated to the complainant. Internal Key Performance Indicators include monitoring of the RAG rated approach with complaints assigned to associated time frames of 20, 40 and 60 days (which the divisions are monitored against) and against an overall six-month timeframe aligned with NHS standards.

The Board metric measures complaint closure compliance against the six-month timeframe in its Annual Report, reflecting the view of the longest reasonable timescale for concluding complaints.

Where multiple complaints are combined into a single investigation, the complaints investigator should inform the complainant that the complaints are being considered collectively and advise them of the timeframe for the overall response. This would be from the date of the initial complaint being acknowledged to a specified deadline, that does not exceed the six-month timeframe (unless exceptional circumstance and in this case the complainant would receive an adjusted timeframe in writing).

The Board therefore receives assurance through monitoring against the NHS six-month time frame.

Complaints performance and quality

Overall page 60 reports performance against "Complaints Not Signed Off In Agreed Timeframe", while the Patient Experience Annual Report states on overall pages 141–142 that complaints are monitored against acknowledgement within three days and closure within six months, and reports that 704 complaints were closed during 2025/26.

These measures appear to tell the Board whether complaints are acknowledged and closed within particular timescales, but closure does not in itself demonstrate that a complaint has been investigated thoroughly, that the response is accurate and addresses the concerns raised, or that the complainant considers the process satisfactory.

In my family's experience, we have submitted multiple complaints to the Trust and only one response has been of the quality we would reasonably expect. We have also not been asked for feedback on our experience of the complaints process or whether the responses adequately addressed our concerns.

How does the Trust measure the quality and effectiveness of its complaints handling, rather than simply whether complaints have been acknowledged or closed, and does it routinely ask complainants whether they were satisfied with the process and whether the response addressed the issues they raised?

If not, what assurance does the Board have that the reported complaints performance reflects the quality of complaints handling from the complainant's perspective?

Response: The Trust measures the quality and effectiveness of complaints handling through a range of indicators rather than solely monitoring whether complaints have been acknowledged or closed. This includes reviewing complaints that are reopened following closure, as these may indicate that the complainant's concerns have not been fully addressed, and monitoring themes, learning and actions arising from complaints investigations.

The Trust has also sought direct feedback from complainants through a complaint's satisfaction survey. While this survey has been paused due to consistently low response rates, work is underway to relaunch (by the end of September 2026) an enhanced survey with additional questions and different methods of engagement to increase participation and obtain more representative feedback on both the complaints process and the quality of complaint responses.

The recommencement of the survey will also include a retrospective exercise to seek feedback from previous complainants, who may have missed the opportunity whilst the survey has been paused enabling the Trust to gain a broader understanding of complainants' experiences and identify opportunities for improvement.

While complaints activity reports provide assurance regarding the management and resolution of complaints, the Board recognises the importance of understanding the complainant's perspective. The reintroduction of a strengthened satisfaction survey, alongside monitoring of reopened complaints and learning from complaints, will provide additional assurance regarding the quality and effectiveness of complaints handling and whether responses have addressed the issues raised by complainants.

Care Opinion feedback

Overall page 140 reports 69 Care Opinion submissions across the whole Trust during 2025/26. Care Opinion is a self-selected method of feedback, yet the report uses these submissions to describe feedback as "predominantly positive", with patients and families "consistently praising" aspects of their care.
If my calculations are correct, when compared with the patient activity reported on overall page 139,these 69 submissions represent approximately 0.007% of activity across the Trust.

Given both the very small number and the self-selected nature of these submissions, how confident is the Trust that they provide a representative picture of patient experience? Could the Board also be

provided with a breakdown of the 69 submissions by hospital site and service, so that it can understand whether the feedback is representative across DBTH?

Response: While the Trust recognises that the number of Care Opinion submissions is relatively low andthat feedback is provided on a self-selected basis, Care Opinion is not used in isolation to assess patientexperience. Instead, it forms one element of a wider triangulated approach to understanding patient feedback and experience across the organisation.

The Trust considers Care Opinion feedback alongside other sources of patient insight, including Friends and Family Test (FFT) data, complaints, concerns and the themes emerging from these processes. Together, these sources provide a broader and more balanced understanding of patient experience than any single feedback mechanism alone.

To strengthen the Trust's approach to capturing patient experience, a pilot of the Care Opinion Team-Based Patient Experience model is currently being undertaken on an elective surgical ward in the trust.The outcomes of this pilot will be evaluated and considered alongside other potential solutions to determine how best to enhance the collection and use of patient feedback across the organisation.

In addition, the Trust has commissioned an external review of its patient experience and patient engagement arrangements. This review will consider:

How the organisation captures, responds to and learns from complaints, PALS contacts, and other sources of patient insight and feedback.

How effectively the organisation engages and involves patients, families and carers in service improvement.

How the NHS England Experience of Care Improvement Self-Assessment (EOCISA) can help shape the strategic direction, delivery and governance of patient experience improvements.

The findings of this review will be considered alongside the intelligence already gathered through existing feedback mechanisms and will help inform future developments in the Trust's patient experience approach.