NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Doncaster Royal Infirmary
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[redacted]
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21 September 2026

Our reference:

Dear Dr Didcock,

Thank you for the Regulation 28 report of 28 July 2026 sent to [redacted], Interim Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, following the inquest into the death of Mrs Eunice Mair Brookes.

Firstly, on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, I wish to express our sincere condolences to Mrs Brookes' family and loved ones. We recognise the distressing circumstances surrounding her death and are committed to ensuring that lessons are learned to improve the care and safety of future patients.

The concerns raised within the Regulation 28 Report are addressed below:

Concern 1: That patients on the wards at Bassetlaw District General Hospital will have inaccurate and inadequate completion of fluid balance charts, particularly when there is persistent vomiting.

The Trust acknowledges the importance of accurate fluid balance monitoring in supporting timely clinical decision making and recognising patient deterioration.

In response to this concern, the following actions have been implemented:

- Revised Trust-wide clinical guidance has been introduced to strengthen expectations regarding when fluid balance charts should be commenced, maintained and reviewed.
- Targeted education has been delivered through the Chief Nurse's Senior Leadership Engagement Sessions across inpatient areas. Mrs Brookes' digital story has been shared as part of this programme to highlight the importance of accurate fluid balance documentation and the impact that omissions can have on patient care and outcomes.
- The principles of professional accountability set out within the Nursing and Midwifery Council (NMC) Code have been reinforced with all Ward Managers. Registered Nurses have been required to confirm they have reviewed both the digital story and associated professional standards.
- Fluid balance monitoring has been strengthened within the Trust's digital quality assurance platform, Tendable. The audit methodology has been reviewed and enhanced, with a specific focus on the accuracy, completeness and clinical review of fluid balance documentation.

- A Trust-wide quarterly audit programme is now in place, with results reviewed through established governance processes, including the clinical Oversight Framework and the CARE (Care Recognition for Excellence) Accreditation Framework.
- Fluid balance monitoring has been identified as a key quality priority within the Trust's 2026/27 CARE Accreditation programme. All inpatient wards will be assessed against defined fluid balance standards as part of the Trust-wide accreditation process scheduled for April 2027. Performance is monitored through monthly data triangulation and evaluation, with oversight provided through the established governance framework. This ensures that areas of concern are identified promptly and that timely actions are implemented to support sustained improvement and patient safety.

These measures are intended to improve compliance, provide ongoing assurance and support earlier recognition of deteriorating patients. Ward A4 has a current Fluid Balance Chart audit result of 95% which demonstrates significant improvements. Audit outcomes will continue to be monitored with divisional oversight and then onwards via quarterly reporting to the Patient Safety Assurance Group. Additionally, the CARE Accreditation outcomes are reported via the Chief Nurse to the Quality Committee.

Concern 2: That nursing assessments will not identify a deteriorating patient, thus preventing necessary escalation for medical assessment.

The Trust recognises the critical role of nursing assessment, physiological observations, clinical judgement and timely escalation in identifying and responding to patient deterioration.

The Trust has established a multidisciplinary Task and Finish Group to improve the quality, ownership and effectiveness of physiological observations. This group is leading a programme of work to transition towards a Registrant-Led Observations model, recognising that assessment of a patient's physiological status is a fundamental nursing responsibility and an essential component of the early identification of deterioration.

Evidence demonstrates that placing the most experienced clinician at the bedside to assess, interpret, and act upon physiological observations supports improved patient outcomes and earlier escalation of care where concerns are identified. The Trust is therefore undertaking a comprehensive programme of workforce engagement, education and cultural change to reduce the routine delegation of this critical assessment and strengthen Registered Nurse ownership of patient observations.

Implementation of the Registrant-Led Observations model will commence in November 2026, with a target that 80% of all inpatient observations are undertaken by Registered Nurses within six months of implementation. Progress will be monitored through the Task and Finish Group, supported by local performance reporting and targeted improvement plans for areas requiring additional support. Delivery against the agreed milestones and performance measures will be subject to regular review through established patient safety and governance arrangements. The effectiveness of the programme will be evaluated through ongoing quality surveillance to provide assurance of sustained improvement in the recognition, escalation and management of deteriorating patients.

Furthermore, the assessment and management of deteriorating patients is a key patient safety priority within the Trust's Patient Safety Incident Response Plan (PSIRP), Version 2 (July 2026). Incidents involving failure to recognise deterioration, delayed escalation of clinical concerns, delayed diagnosis or treatment, severe harm, or unplanned admission to critical care are subject to review through the Trust's patient safety processes.

The Trust has strengthened its approach by ensuring that incidents relating to patient deterioration are reviewed through proportionate learning responses, with oversight provided by the Learning from Patient Safety Events (LFPSE) Panel. Where themes relating to the recognition and escalation of

deterioration are identified, improvement actions are developed, monitored and reviewed through the Trust's governance framework. Where recurring issues are identified, the LFPSE Panel may commission a Patient Safety Incident Investigation to gain a deeper understanding of underlying system factors and opportunities for organisational learning.

In addition to these governance arrangements, the Trust continues to deliver education and training to clinical teams regarding the recognition of deterioration, escalation requirements, and professional accountability.

Concern 3: That the Trust Pain Guideline will not be followed, leading to a delay in diagnosis and necessary management of an acute abdominal condition.

The Trust accepts that effective pain assessment and management are fundamental components of safe patient care and play an important role in the timely recognition of serious underlying pathology, including acute abdominal conditions.

In April 2026, the Chief Medical Officer and Chief Nurse formally agreed that pain assessment and pain management would become a Trust-wide Quality Improvement Priority for a 12-month period. This decision reflected the importance of ensuring that pain is assessed, monitored and acted upon consistently across all clinical areas.

To support this work:

- Compliance with pain assessment and management standards is monitored through the Tendable digital quality audit platform.
- Audit findings are reviewed to identify themes, areas of variation and opportunities for improvement at ward, divisional and Trust level.
- Services are required to develop and implement local improvement plans where gaps in compliance are identified.
- Progress against the Quality Improvement Priority is reported through the Trust Quality Committee, providing organisational oversight and accountability.
- Pain assessment and management standards have been incorporated into the CARE Accreditation Framework, providing an additional mechanism for annual scrutiny and assurance.

In addition to the governance arrangements outlined above, several improvements have been implemented to strengthen clinical practice. Pain Link Nurse meetings are now held quarterly, resulting in a 50% increase in engagement and providing a structured forum for education, shared learning and dissemination of best practice.

A key objective of the Pain Management Task and Finish Group is to promote a cultural shift whereby pain assessment is viewed as a clinical assessment process rather than a single observational task. This approach is intended to strengthen clinical curiosity and support earlier recognition of patients whose pain may indicate deterioration or a developing acute condition requiring further investigation.

A key change to support this cultural shift is a new Adult Inpatient Functional Pain Assessment Tool. This approach moves beyond the recording of a numerical pain score and supports clinical assessment of the impact pain has on a patient's functional ability and activities of daily living. The tool provides clearer guidance regarding reassessment requirements and expected timeframes

following intervention, supporting more timely evaluation of treatment effectiveness and escalation where pain remains uncontrolled.

The Trust is currently working with the digital team to incorporate the Functional Pain Assessment Tool onto Nerve Centre. This will strengthen compliance with assessment standards, improve visibility of pain assessments and reassessments and support clinical decision-making through enhanced digital oversight.

Early indicators of progress are evident, including a 4.5% increase in referrals to the Inpatient Pain Service, suggesting greater recognition of patients requiring specialist assessment and support; latest audit data demonstrates 93% compliance with expected standards. The Trust will continue to monitor compliance, audit findings and patient outcomes through its established governance arrangements to ensure these improvements are sustained and effective in reducing the risk of delayed recognition and management of significant underlying pathology.

Concern 4: That there will be continuing confusion regarding arrangements for surgical review at Bassetlaw District General Hospital at weekends and out of hours.

The Trust acknowledges the importance of clear escalation pathways and unambiguous arrangements for accessing senior surgical review outside normal working hours.

In response, the Chief Medical Officer has worked with the Divisions and developed and approved an Emergency Care Escalation Process (Appendix 1), which formally outlines the process and responsibilities for obtaining surgical review at Bassetlaw District General Hospital.

Key actions undertaken include:

- Launch of the escalation process 10 August 2026.
- Formal approval and implementation of the escalation process.
- Wide circulation of the agreed pathway across relevant clinical services.
- Discussion and review through Divisional Governance meetings on 28 August 2026.
- Review and reinforcement of the process through specialty governance meetings, including the Division of Medicine and Urgent and Emergency Care.
- Discussion at Effective Assurance Group to consider monitoring and audit processes.

This work is intended to ensure that all clinical teams understand the escalation arrangements and that patients receive timely access to appropriate surgical review regardless of the day or time of presentation.

Additional Assurance

Compliance with the actions outlined above will continue to be monitored through the Trust's governance, quality, and patient safety frameworks to ensure that improvements are embedded, sustained and effective. The Trust remains committed to delivering safe, effective and compassionate care, and to learning from incidents to reduce the risk of similar events occurring in the future, and working in partnership with patients and families so that lived experience continues to inform organisational learning, patient safety improvement and the development of safer services.

I hope this response provides assurance that meaningful action has been taken to address the concerns identified and that the Trust remains fully committed to continuous improvement in patient safety and the quality of care provided to our patients.

Finally, I would like to take this opportunity to thank Mrs Eunice Brookes' family for their support and contribution to our improvement programme. Through sharing Eunice's story and in their creation of digital learning resources, they have made a valuable contribution to helping our staff understand the impact of the concerns identified during the inquest. Their generosity in supporting this work will help strengthen learning across Doncaster and Bassetlaw Teaching Hospitals and contribute to improving care for future patients and their families.

Yours sincerely





Interim Chief Executive
Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust