NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – IN PUBLIC

Thursday 25 January 2024 at 10.00am– 1.30pm

Baths Hall, Doncaster Rd, Scunthorpe DN15 7RG

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Dr Janusz Jankowski, Justin Shannahan	Note Information		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Staff Story				
5	Staff Story: Integrated Neighbourhood Teams	Information	RC	Ai
Standing items				
6	Minutes of the meeting held in public on the 23 November 2023	Decision	KL	B
7	Matters Arising and Follow up Action List • Gender Pay Gap (NMcI)	Decision		C Ci
8	Chair's Matters	Information		Verbal
Board Assurance Committees				
9	Report from the Audit Committee	Assurance	DL	D
10	Report from the People & Organisational Development Committee	Assurance	DV	E
11	Report from the Finance, Performance & Informatics Committee	Assurance	PV	F
12	Report from the Public Health Patient Involvement & Partnerships Committee	Assurance	DV	G
13	Report from the Quality Committee	Assurance	DL	H
14	Chief Executive's Report	Information	TL	I
Break				

RDaSH nurturing the power in our communities

No	Item	Request to	Lead	Enc.
15	EPRR update report	Assurance	RC	J
16	Operational Risk Report as at January 2024 including: Risk Management Framework	Assurance Decision	PG	K
17	CQC Preparedness Briefing – Caring	Assurance	SL	L
18	Operating model and new ways of working including: • Board Committee Terms of Reference • Standing Financial Instructions	Decision	TL	M
19	Integrated Quality Performance Report (IQPR) December 2023 inc Finance Report M9	Assurance	TL / IC	N Ni
20	Eliminating Out of Area Placements (OAP) target and Health Based Place of Safety (S136 suites) usage review	Information	RC	Oi & Oii
21	Strategic Objective 5	Information	JMcD	P
22	NHS Professionals update and proposal	Decision	NMcI	Q
Supporting Papers (previously presented at Committee)				
23	Mortality Quarterly Report (Sept & October 2023 data) Guardian of Safe Working Hours (Jun to Sep 2023 data)		KL	R
Closing items				
24	Any Other Urgent Business (to be notified in advance to the Chair)		KL	Verbal
25	Chair's Summary (Actions, Decisions, and new risks)			
26	Public Questions *			
27	Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the meeting.*		KL	

*** Public Questions:**

The meeting will be conducted strictly in line with the above agenda and public questions must relate to the papers being presented on the day.

Questions from the public may be sent in advance and they will be presented to the Board of Directors via the Director of Corporate Assurance.

Responses will be provided after the meeting to the originator and included within the formal record of the meeting.

The next meeting of the Board of Directors in public will take place on
Thursday 28 March 2024 10.00-13.30
CAST Theatre, Civic Quarter, College Rd, Doncaster DN1 3JH

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Chloe Pearson, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.
- The report outlines the changes to the register since the last meeting which relate to Richard Chillery, Dr Janusz Jankowski and Sarah Fulton-Tindall.

Alignment to strategic objectives (indicate with an 'x' which ambitions this paper supports)	
SO1. Nurture partnerships with patients and citizens to support good health.	
SO2. Create equity of access, employment and experience to address differences in outcome.	
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	
Business as usual	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

Not applicable

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board is asked to:

x	**RECEIVE** and note the Register of Interests.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register		
Board Assurance Framework	x	SR6 – Governance
System / Place impact		

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

N/A

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

The Trust and the people who work with and for it, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. The Trust is committed to maximising its resources for the benefit of the whole community. As a Trust and as individuals, there is a duty to ensure that all dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that the Trust uses the finite resources in the best interests of patients. For this reason each Director makes a continual declaration of any interests they have. Declarations are made to the Board Secretary as they arise, recorded on the public register and formally reported to the Board of Directors at the next meeting. To ensure openness and transparency during Trust business, the Register is included in the papers that are considered by the Board of Directors each month.

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, *Chair*	• Owner / Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Consultant with Agencia Ltd. • Chair of the Advisory Board Space2BHeard CIC HULL • Independent Member of Audit Committee for Humberside Police and Fire services • Non-Executive Director at Locala Community Interest Company
Toby Lewis, *Chief Executive*	• Nil
Richard Banks, *Director of Health Informatics*	• Nil
Richard Chillery, Chief Operating Officer	• ~~**Non-Executive Director at Sheffield Childrens NHS Trust which is in the same South Yorkshire ICB. This role ends in December 2023**~~ • **Nil**
Ian Currell, *Director of Finance and Performance*	• Wife is Senior Lecturer in Child Nursing at Huddersfield University • Sister-in-law is Director of Finance for Yorkshire Ambulance Service

Name / Position	Interests Declared
Philip Gowland, *Board Secretary and Director of Corporate Assurance*	• Wife is North Primary Care Network (PCN) Digital and Transformation Lead employed by Primary Care Doncaster (PCD).
Dr Jude Graham, *Director of Therapies*	• Trustee for the Queens Nursing Institute • Executive Coach – registered and accredited with the European Mentoring and Coaching Council • ImpACT International Fellow for the University of East Anglia.
Kathryn Gillatt, *Non-Executive Director*	• Non-Executive Director at the NHS Business Services Authority and Chair of the Audit & Risk Committee. • Sole trader of a Finance and Business Employment Consultancy.
Prof Janusz Jankowski, *Non-Executive Director*	• Non-Executive Director at the Tavistock and Portman NHS Foundation Trust, London • Trustee, Oesophageal Patients Association National Charity, Hockley Heath, Solihull • Clinical Adviser for NHS and National Institute for Care and Health Excellence (NICE) • Adviser and Vice President of Research and Innovation, University of the South Pacific • Consultant Gastroenterologist, Medinet NHS Provider Agency for Ad hoc Remote Out-patient GI work • Consultant to Industry around Healthcare • Magistrate (Family and Adult Courts), His Majesty's Courts and Tribunal Services, Leicestershire • Hon. Clinical Professor, University College London • Chair, Translational Science Board TransCan-3, European Union. • **A Trustee role for a Limited Charity called AGREE (Acknowledge Girls Right to End Exploitation).** • **A consultancy Advisor/ Provost role for the largest private Charity in the UAE, The Saeed Lootah Foundation.**
Dawn Leese, *Non-Executive Director*	• NHS Responder Volunteer • Covid-19 Vaccinator with St John's Ambulance.
Sheila Lloyd, *Executive Director of Nursing & AHPs and Deputy Chief Executive*	• Brother is the Chief Executive of FTW Executive Search.
Jo McDonough, *Director of Strategy*	• Nil
Nicola McIntosh, *Executive Director for People and Organisational Development*	• Nil

Name / Position	Interests Declared
Justin Shannahan, *Non-Executive Director*	• Non-Executive Director and Chair of the Audit Committee at University Hospitals of Derby and Burton NHS Foundation Trust • Vice Chair at University Hospitals of Derby and Burton NHS Foundation Trust
Sarah Fulton Tindall, *Non-Executive Director*	• ~~**Director at CASEwork Services Community Interest Company**~~ • ~~**Trustee and Director at Age UK Sheffield**~~ • Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield. • **Age UK Readers' Panel member.**
Dr Graeme Tosh, *Executive Medical Director*	• Director of Copdoc NI Ltd. • Director of ADHDEASY Ltd. (not trading at present – dormant status) • Partner is the Director of Kennedy Beach Architects Limited.
Dave Vallance, *Non-Executive Director*	• Nil
Pauline Vickers, *Non-Executive Director*	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Associate Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders.

Rotherham Doncaster and South Humber NHS Foundation Trust
Board of Directors – 25 January 2024

Staff Story: South Scunthorpe Integrated Neighbourhood Teams Approach

Presenters:

- **Nolan Bennett,** Head of Integrated Community First Transformation Adults and Health, North Lincolnshire Council
- **Charlotte Jubber,** Community Mental Health Directorate Service Manager North Lincolnshire Care Group, RDaSH
- **Louise Treen,** Transformation Lead for North Lincolnshire Care Group, RDaSH.

Briefing Note

Background: In 2022 Dr Claire Fuller's report presented a new vision for integrating primary care improving access, experience and outcomes for communities centering around essential offer:

- Streamlining access to care and advice providing choice and ensuring care is always available in their community where they need it.
- Providing more proactive, personalized care with support from a multidisciplinary team of professionals to those with more complex needs and long-term conditions.
- Helping people to stay well for longer in a joined-up approach to prevention.

The aim to reduce pressure on the NHS and social care in medium to long term and addressing health inequalities through the Core20PLUS5 approach and action to tackle wider determinants of health.

Strategic Alignment: In North Lincolnshire the Community First Strategy for the Health and Care Partnership is committed to prioritising prevention and early help. To do this across PLACE we will develop Integrated Neighbourhood Teams which will ensure a fully integrated response across health, social care, housing, employment, and voluntary sectors. This approach speaks directly to new RDaSH strategic direction with both Promise 15 to support effective integrated neighbourhood teams in 2024 and Promise 21 to support local primary care networks and voluntary sector representatives to improve co-ordination of care on a hyper local basis.

Approach: A single neighbourhood-based planning tool based on a population management approach is being used by all the organisations to understand need and inform proactive approaches to designing and delivering support that will improve people's health and wellbeing.

An Integrated Neighbourhood Team pilot is progressing in Scunthorpe South. A co-produced risk stratification approach has been agreed. Work has been progressed that has achieved a fully integrated PHM data driven approach to understanding need and targeting interventions. This has been supported by NECS (North of England Commissioning Support), NLC Public Health and the North Lincolnshire Health and Care Partnership B.I.

From this scoping and data deep dive the area of focus for the Scunthorpe South Pilot is the population diagnosed with Severe Mental Illness or a Learning Disability. The aim is to establish person centred interagency MDTs with a purpose of designing targeted, integrated, preventative, person centred and measurable interventions to optimise people's independence by May 2024.

Next Steps: Workshop will look to support design of better integrated person centred care pathways for the Scunthorpe South population with a diagnosis of Severe Mental Illness or a Learning Disability. Safe and enabling Information Governance and Digital solutions are being implemented. And work to facilitate integrated working across each of the five localities. This includes a space where people from across all system partner organisations can regularly work in the same physical space and dynamically review and act on the needs of people who are most in need.

Rotherham Doncaster and South Humber NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING – HELD IN PUBLIC ON THURSDAY 23 NOVEMBER 2023, 10.00-13.30 UNITY CENTRE, ST LEONARDS ROAD, ROTHERHAM, S65 1PD

PRESENT

Kathryn Lavery	Chair
Richard Chillery	Chief Operating Officer
Sarah Fulton Tindall	Non-Executive Director
Kathryn Gillatt	Non-Executive Director
Dr Janusz Jankowski	Non-Executive Director
Dawn Leese	Non-Executive Director
Toby Lewis	Chief Executive
Sheila Lloyd	Deputy Chief Executive / Executive Director of Nursing and AHP
Nicola McIntosh	Director for People and Organisational Development
Izaaz Mohammed	Deputy Director of Finance and Performance (Deputising for DoF)
Justin Shannahan	Non-Executive Director
Dr Graeme Tosh	Medical Director
Pauline Vickers	Non-Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Judith Graham	Director of Therapies
Joanne McDonough	Director of Strategic Development
Lea Fountain	NeXT Director
Jyoti Mehan	NeXT Director
Jade Pullen	Learning and Development Apprenticeship Facilitator
Chris Pym	Head of Quality Compliance
Shaida Khan	Corporate Assurance (Minutes)

10 members of staff, 1 member of the public and 2 Governors joined to observe.

Ref		Action
Bpu 23/11/01 & Bpu 23/11/02	**Welcome and Apologies** Mrs Lavery welcomed attendees to the meeting including Ms Lea Fountain who was attending her first meeting of the Board of Directors in person. Apologies for absence were received and noted from Mr Vallance and Mr Curell.	
Bpu 23/11/03	**Quoracy** Mrs Lavery declared the meeting was quorate.	

Bpu 23/11/04	**Declarations of Interest** Mrs Lavery presented the Declarations of Interest report which outlined the changes to the register since the last meeting. The Declarations of Interest register was agreed subject to the amendments below: • Kathryn Gillatt - Sole trader of a ***Finance*** Business Consultancy. • Dr Jankowski – Appointment to Board of Charity Foundation for Health in the UAE. **The Board received and noted the changes to the Declarations of Interest Report subject to verbal amendments provided.**	
PATIENT / STAFF STORY		
Bpu 23/11/05	**Staff story – Apprenticeships** Mrs Lavery introduced Ms Jade Pullen, Learning & Development Apprenticeship Facilitator and Mr Chris Pym, Head of Quality Compliance, who were welcomed to present the staff story on Apprenticeships. Ms Pullen provided an outline of the apprenticeship programme within RDaSH in terms of apprenticeship numbers, access and eligibility criteria, methods of learning and current level of levy funding available within the Trust including: • The levy fund was currently at £1.2m and continued to grow with over 600 apprenticeships available. • Eligibility criteria required minimum English & Maths at GCSE grade C/4 or Level 2 functional skills and relevant placement / role towards the apprenticeship standard in-work competencies. • There was a wide variety of clinical and non-clinical apprenticeships with learning 20% classroom based and 80% on the job / project. • 35 staff had completed their apprenticeships and further 15 expected to graduate during national apprenticeship week in February 2024. • Currently 17 apprenticeships were due to go live and out of 110 total live apprenticeships 73% were in clinical occupations and 27% in non-clinical roles. The apprenticeship route was open to new starters and existing staff with four levels available to develop skills, knowledge, and expertise for current and future roles. Mr Pym highlighted his own journey via the apprenticeship route to complete his nursing degree after attaining the functional skills maths which added the benefit of combining study and work. He had since been nominated for the Apprentice of the Year award. A detailed question-and-answer session by Members highlighted the following: • Awareness raising on the scope and breadth of the scheme. • Support and flexibility from line managers on the level of supervision, mentorship and tools.	

	• Proactive identification of suitable candidates and sign posting for example, via the talent management programme. • Benchmarking and peer to peer learning with ICB network and neighbouring trusts. • How to increase take up by mature students. • Maximise funding and take up for those with no education or missed schooling with reference to the new strategy (promise 9 on diversifying). • Expansion of number and type of apprenticeships. • Facilitate and create substantive roles needed for the duration of course as the levy pays for the fees only. • Encouragement and facilitation into roles, degree applicants to get redirected to the apprenticeship route with support and guidance from the Institute of Management. Mrs Lavery thanked Mr Pym and Ms Pullen for providing insight into the apprenticeship programme.	
STANDING ITEMS		
Bpu 23/11/06	**Minutes of the previous Board of Directors meeting held on 28 September 2023** The Board approved the minutes of the meeting held on 28 September 2023 as an accurate record subject to minor amendments from Mr Shannahan and Mrs Lloyd which would be forwarded outside of the meeting.	
Bpu 23/11/07	**Matters Arising and Follow up Action Log** There were no matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed subject to noting the below: **CEO Report Bpu 27/07/2023** – it was agreed for email confirmation from Ms Mcintosh regarding completion of the now 3 outstanding DBS cases. **Bpu 28/09/20 –** a verbal update had been provided by Mr Mohammed to Mr Shannahan. Mrs Vickers agreed with Mr Shannahan's proposal for this action to be passed to FPIC and closed on the Board action log. **The Board received and noted the action log and verbal update on progress.**	**NMc**
Bpu 23/11/08	**Chair's Matters** Mrs Lavery provided an update on her leadership work including:	

	Internal meetings • Grounded Research conference with main presentation on the Chimp paradox model (CPM) trial for registered nurses working in the community. • Work was ongoing on socialising and championing the new strategy and structure **External Meetings:** • Mrs Lavery expressed her congratulations to the People Focused Group (PFG) and the funds collected from the PFG Wellness Walk at St Catherine's House. • Mrs Lavery had attended the NHS Providers conference on 14/15 November which had focused on Margerat Hefferner's book 'Wilful Blindness' and the Letby Case. • Excellence in People Awards ceremony scheduled to take place on 30 November 2023. **The Board received and noted the Chair's update.**	
BOARD ASSURANCE COMMITTEES		
Bpu 23/11/09	**Report from the Mental Health Legislation Committee** Ms Fulton Tindall presented the Mental Health Legislation Committee report and highlighted the receipt of the second version of new quarterly legislation client report. This report focused on trends and patients' rights and protections under the Acts, which had highlighted challenge in the following areas: • Staff training on compliance with 'MCA Essential to Role'. • Compliance on consent to Treatment for Psychiatric Medication in Doncaster MH & LD Care Group. • The Recruitment and Training of Trust Associate Managers (TAMs). Members held discussion and noted Dr Tosh's work around medication and consent to pinpoint any issues for improved understanding. The development of the safety aspect of the quality and safety plan would lead to further improvement in MCA compliance and consent. Mrs Lavery would discuss with NEDs to the potential requirement for a cohort to be Trust Associate Managers. **The Board received and noted the report from the Mental Health Legislation Committee.**	
Bpu 23/11/10	**Report from the Audit Committee** Mr Shannahan informed members that the last Audit Committee report had been received at the September Board.	
Bpu 23/11/11	**Report from the Commissioning Committee** Mrs Leese presented the Commissioning Committee report and highlighted the Trust commissioning responsibilities towards Adult Eating	

	Disorders. The Trust was redesigning the whole pathway with South Yorkshire collaborative. Mrs Leese had discussed the commissioning need, for example at Riverdale Grange and Ellern Mede and was comfortable with the oversight and quality of improvements. The waiting list for beds and out of area placements would continue to be monitored until cessation of the Commissioning Committee after its final meeting in February 2024. Ms McDonough confirmed that NHSE had provided non recurrent funding to balance the budget for this commissioning area and an update would be provided in the new year. **The Board received and noted the report from the Commissioning Committee.**	
Bpu 23/11/12	**Report from Quality Committee** Mrs Leese presented the Quality Committee report and highlighted the quality and safety performance indicators were still a work in progress in some areas but the Committee was seeing positive improvements due to interventions. She added where understanding was required, for example, MUST screening not at target and there was a quality and safety issue, this was to be explored to understand why this was the case. With reference to incident reporting and absence without leave (AWOL) data, further work was taking place on differentiation of the figures to understand the data and where focus was required. The quality concerns identified on Brodsworth ward had led to a comprehensive quality improvement plan which had been triangulated by the feedback from the peer review process which had provided confidence around the improvement journey. The Quality Committee were still maintaining oversight on CQC assurance and the CQC Readiness plan was tabled as a separate agenda item. Reference was made to the comprehensive Complaints Annual Report and the Complaints Improvement Plan which demonstrated significant improvements that had taken place and was an example of Trust responsiveness. **The Board received and noted the report from the Quality Committee.**	
Bpu 23/11/13	**Report from Finance, Performance and Informatics Committee** Mrs Vickers presented the Finance, Performance and Informatics Committee report and highlighted the Month 6 Finance report had addressed three areas, financial performance, savings plan and procurement:	

	The deficit stood at £1.53m which was £0.81m better than the planned £2.31m. However, Agency spend was forecast to exceed the imposed cap set by NHSE by £1.8m and was a key area of focus. Further updates had been requested on the admin & clerical and non-qualified nursing agency usage. The Committee had expressed concern at the recurrent position, which had been seen in the delivery of the Cost Improvement Programme (CIP) around considerable agency deviation. Further discussion was requested at the December Committee meeting with a focus on the Quarter 4 remedies required to the address gaps. The meeting would be attended by the Chief Executive. With reference to procurement of Electronic Patient Records (EPR) management system, the minimum viable product (MVP) submissions had been considered and negotiations with the chosen supplier were due to start on completion of legal due diligence by Health Informatics directorate and an update would be presented to the next Board. Ms Gillatt requested her apologies to be added to the FPIC Report to Board **The Board received and noted the report from the Finance Performance and Informatics Committee.**	**RB**
Bpu 23/11/14	**Report from the People and Organisational Development Committee (August 2023)** Ms Fulton Tindall presented the report from the People and Organisational Development Committee meeting and noted the following highlights: • Staff turnover was decreasing. • Successful bid to the Charitable Trust committee to invest in champions and development of the wellbeing offer. • Trust had achieved Menopause Friendly Employer status. • The Committee was keen to understand the programme value for money of the Quality Safety Improvement and Redesign (QSIR) training offer. • Work was ongoing to address MAST compliance and further information had been requested on the human and practical barriers. The Committee Chairs had agreed both PODC and MHLC shared the same issues on MAST compliance and had queried whether this was a Trust wide issue. Mr Lewis referenced the need for separation between operational and strategic aspects, adding that under the new structure, committee focus would be on strategic matters, with the management committees focusing on operational matters.	

	The Board received and noted the report from the People and Organisational Development Committee.	
Bpu 23/11/15	**Chief Executive's Report** Mr Lewis introduced the report and drew attention to four items within his report: • Investment in leadership development; and he outlined the planned commission and process across the Top Leaders' Cadre (TLC) from April 2024. • A focus on improving internal communications; with a first step being the launch of new App through which much more of our effort will be focused. • Consequences from RCRP implementation, with annex 3 setting out the planned data focus - yet noting a lack of baseline. • Ongoing discussions on the back of the national financial re-assessment letter, within which the Trust has needed to forecast a year end position and noting that our current assessment is better than the planned deficit. The Chair offered support for the extended financial position, mindful of system deficits and reiterating the need to provide for the Board's decision on long waiting times in the 24/25 financial plan. Mr Shannahan drew attention to the FBC approval of the EPR and requested clarity on the implementation plans, and specifically benefits realisation. Mr Lewis reminded the Board of discussions to that effect in September's meeting, and again suggested that when contract signature is moved, he would expect the paper from Mr Banks to outline planned benefits and to describe a whole Trust mobilisation plan. Ms Tindall Fulton asked about the place of productivity in the work of the management. A number of members contributed to a rounded discussion, during which Mr Lewis indicated that Quarter 1, 2024/25 would see a structured focus in this area. Mr Chillery highlighted the need to do some work to define our shared meaning in this space, and all agreed that the issues were more complex than simply volume. Dr Graham echoed the report's focus on Older People, through the CMO's report nationally which was annexed to the CEO Report. A future session will be structured to explore the future of Trust services in this field, and how we move during 2024/25 to remove any unjustified age barriers or cutoffs across our services. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	**TL**
Bpu 23/11/16	**CQC Preparedness Briefing – Responsive Domain**	

	Mrs Lloyd presented the CQC preparedness briefing paper and provided an overview of the content of the report which focused on responsiveness of the Trust and how it is viewed, whether through investment, application of the Mental Health and Mental Capacity Acts, apprenticeships or waiting lists. The report contained information that demonstrated how the Trust had dealt with responsiveness and was aligned to the waiting list item on the agenda as one aspect of responsiveness and contribution to accessing services for all. She added responsiveness to risk would take place via the new Risk Management Group in real time, delivering person centred care and ensuring the staff had the tools, knowledge and skills and the techniques to deliver. Members held discussion on whether regulatory reports on personalisation of care aspects was captured in peer reviews. National standardisation and personalisation aspects were compared and addressed through a combination of partnership experts by qualification and experience. There was a tension between communities and inpatients' subjective needs versus what they clinically need and alignment with Trust strategies. Emphasis was noted on the Trust meeting patient need as the primary focus which would in turn meet CQC requirements as a byproduct of the Trust meeting its strategic objectives and promises. Ms Mehan asked whether there was a discussion to be had on the return on investment for the Trust in respect of the underlying cost improvement initiative against the multiple streams of productivity, efficiency, standardisation, personalised care, and preparedness for CQC for better assurance for the Trust in the first instance and then CQC. **The Board received and noted the CQC preparedness update on responsiveness.**	
Bpu 23/11/17	**Waiting List Work** Mr Chillery presented the report on Waiting List work as a sub element of responsiveness. The focus of the report was on mapping internal waits and visibility on this. He emphasised that there was significant work to do, and that the current state was of concern, even though it was longstanding. Detailed discussion highlighted the following points: • Potential harm to patients on a list: are patients waiting one month or 12 months? • Evidence based on deprivation and poverty showed in areas where disparity and gaps already existed in communities. These were further impacted by extended time on waiting lists. This could be a useful	

	future addition to our reporting, but at this stage the priority was capturing accurately all those waiting. • Mr Lewis informed members of his intention to seek external audited advice around the differentiation between RTT pathways and non RTT pathways by 1 April 2024 to establish clear reporting parameters with external bodies. • Mr Chillery wanted to understand the current situation on issues of data quality versus governance and oversight i.e. patients not moved along. It was intended to hold a vision setting exercise putting the basics and building blocks in place before making decision on the methodology to manage waiting lists. Ms Fulton Tindall asked members to note the endemic issue of age defining patients' expectations and queried whether attitudes towards older people needed identifying to raise awareness and recognition in order to address. **The Board received and noted the report on Waiting List work and that further work would be resource and time intensive.**	
Bpu 23/11/18	**Operating Model and new ways of working** Mrs Lavery informed members the Operating Model paper would be discussed in the private session in the interests of time.	
Bpu 23/11/19	**Patient Safety Incident Response Framework (PSIRF) Policy and Plan** Mrs Lloyd presented the Patient Safety Incident Response Framework (PSIRF) Policy and Plan for the purpose of Board approval. The Plan had been to the ICB with positive feedback and PSIRF would commence from 2 January 2024. Mrs Leese asked for an amendment to reflect the new committee titles for audit purposes, and in Board responsibilities and Board committees; differentiation of roles and responsibilities and method of assurance and evaluation of 'how we will know' to be included. **The Board received and agreed the Patient Safety Incident Response Framework (PSIRF) Policy and Plan transition on 2 January 2024 subject to amendments.**	
OPERATING PERFORMANCE		
Bpu 23/11/20	**Integrated Quality Performance Report (IQPR) October 2023** Mr Chillery presented the IQPR report and highlighted the following: • Development work on triangulation had begun with Mr Banks and SROs to enrich data and ensure the next report landed correctly.	

	• The commitment made to increase supply of Talking Therapies in Quarter 4, and a production discussion with commissioners and other, jointly led with Dr Graham. There remained a concern about the current recovery target compliance. Mr Lewis questioned an area of concern for delivery of quality care in the number of inpatients with incomplete MUST assessment (QS36). This had been discussed at CLE and may be due to data not captured correctly and work was being led by the Deputy Chief Nurse. There was an expectation that compliance would be achieved by Christmas, in the event this was not the case that there was a way of ensuring full MUST assessment completion for the Doncaster site. **The Board noted the report.**	**TL**
Bpu 23/11/21	**Finance Report Month 7** Mr Mohammed presented the financial position as at month 7, noting that it provided an updated position to that seen by FPIC earlier in the month with a year-to-date deficit of £0.46m which is £2.18m better than plan due to positive impacts of savings plan and budget holder behaviour and the savings schemes implementation. However, returning the Trust to a longer-term balanced position was dependent upon achievement of the £10m savings target in full. At month 7 the full year value of schemes delivered so far was £5.5m. FPIC would be undertaking a detailed review of savings achieved at the December meeting, both to look to see an improved position and to consider how that reported position reconciled to I&E and cash. Members held discussion which welcome the improvement cautiously, and in particular the cross-group success. There were a variety of suggestions to improve reporting clarity, and Mr Mohammed undertook to follow up these suggestions with FPIC members. Mr Lewis reiterated his request from the prior meeting for a clear reporting separation of unexpected and planned slippage associated with recruitment to allow sign off of care group budgets and trajectories. Mr Mohammed agreed to provide this to FPIC and to the Board going forward, **The Board received and noted the issue raised in the Month 7 Finance report.**	**IC**
Bpu 23/11/22	**Equality Diversity and Inclusion Report** Ms McIntosh presented the Equality Diversity and Inclusion Report. The report covered what was already known, that trust data was drawn from the Workforce Equality Data (WRES) as at March 2023, key areas for improvement under indicators 1, 7 and 9, acknowledging strengths and areas of best performance under indicators 1, 6 and 9 and the additional workstreams.	

	The report also outlined some initial thinking on delivery of Promise 26 to "become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion". Members noted the work done, but questioned whether progress was truly being made. Mrs Lloyd fed back positively from discussions with internationally educated nurses on the openness and willingness of the Trust to address racism, with work planned to future proof positive experiences for the increasing overseas medical workforce. Mr Lewis questioned whether our work was yet systematic and felt that there was a need to provide greater management support and coaching to those involved in shaping our work in this field. Mr Chillery reflected his initial experiences of our people networks, which varied in their maturity and impact. **The Board received and noted for information the Equality Diversity and Inclusion report.**	
Bpu 23/11/23	**Gender Pay Gap Report** Ms McIntosh introduced the paper seeking Board support to take the actions necessary to eliminate our Gender Pay Gap. The paper considered 4 areas: **Reporting**: the Trust had 82% female staff compared to 15% male which was significantly different to the national NHS figure of 77% female. Based on this the Trust had an 11% gender pay gap. **Analysis**: the high proportion of female managers was outweighed by the percentage of males in top quartile for the highest hourly rates. **Calculation**: the salary sacrifice scheme which impacted on final hourly rates was excluded to ensure a level playing field and gave a gender pay gap of 3.5% **Scenario modelling:** use of a modelling tool allowed different scenarios to reach a zero gender pay gap Members held detailed discussion on the current position, and the right route to seek to use to eliminate the gap. There was not an agreement reached and as such the Chair asked for the item to return to January's meeting to include: - Absolute clarity on the current position - A single recommendation for action **The Board noted the Gender Pay Gap Report and agreed to rediscuss the matter at its next meeting**	**NMc**

Bpu 23/11/24	**Operational Risk Report (operational & strategic) at 7 November 2023** Mr Gowland noted that over 2023/4 there were a significant number of risks added to the risk register which stood at 237 live risks compared to 74 in November 2022. Notwithstanding that none were currently judged extreme. As a result of the two significant changes from the new clinical and operational strategy, the Board would be engaged in a refresh of the Board Assurance Framework over the coming months and proposals for change in March 2024. Reference was made back to SR7 relating to EPRR standards in the previous report and the potential significant drop in compliance highlighted by Mr Lewis in September. Mr Chillery confirmed that this had occurred. This was the same for all Trusts as the national standards had had a hard reset and the Trust was at approximately 20%. **The Board received and noted the Operational Risk Report and took assurance that risks are being managed actively and appropriately. In addition, the recommendation to reduce strategic risk 3 from extreme to high was approved.**	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 23/11/25	Mrs Lavery informed the Board of the following additional reports for information which were presented as supporting papers having previously been presented at committee level for scrutiny and challenge: • Mortality Quarterly Report (July & August 2023 Data) • Infection Prevention & Control Annual report 2022/23 • Complaints Annual Report 2022/23 **The Board received and noted the additional reports for information.**	
CLOSING ITEMS		
Bpu 23/11/26	**Any Other Urgent Business** There was no further urgent business raised today.	
Bpu 23/11/27	**Chair's Summary (Actions, Decisions, and new risks)** Mrs Lavery gave a brief overview of discussions from the meeting today	
Bpu 23/11/28	**Public Questions** A question was raised by Mr Vickers regarding international recruitment and whether the impact on the workforce in that country was considered. Ms McIntosh confirmed this was considered and Mrs Lloyd added that this was acknowledged as a risk nationally.	
Bpu 23/11/29	The Chair resolved 'that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be	

	transacted, the public and press would be excluded from the private meeting.	
	Next Meeting Thursday 25 January 2023 at 10 am, Baths Hall, Doncaster Road, Scunthorpe DN15 7RG.	

Rotherham Doncaster and South Humber NHS Foundation Trust

PAPER C – ACTION LOG – BOARD OF DIRECTORS:

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 30/03/13 **Bpu 23/11/23**	**Gender Pay Gap** Manual Scenario exercise related to the Gender Pay Gap findings to be completed and presented at a future Board meeting. Mr Lewis asked for Board agreement for the gender pay gap modelling paper to return to the Board in January 2024 with scenarios showing reduction of gender pay gap to zero for further discussion /scrutiny. This was agreed.	NMc	**January 2024:** please refer to agenda item Ci.	Propose to Close
Bpu 25/05/16c	**Chief Executive's Report** Review of the effectiveness / appropriateness of the quality and safety metrics to be used within the Trust's revised IQPR.	SL	**28 September 2023:** This action will be taken forward through the Quality and Safety Plan. Mrs Leese asked for this to remain open until the Quality and Safety plan was active. This was agreed.	Open
Bpu 28/09/20	**Month 5 Finance Report** Mr Currell to provide a statement to clarify the management and oversight of the stated third-party funds (Patients Monies).	IC	**January 2024**: The Trust has a documented 'patient monies and property' procedure which staff are required to follow and is available on the intranet. This policy will be reviewed and updated in May 2024. The Trust was last audited on this in 2015/16 when the Trust received 'significant assurance'. Finance dept has oversight of all requests to spend which must be authorised by the ward or relevant service	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
			manager. Financial balances are reconciled to the ledger on a monthly basis.	
Bpu 23/11/15a	**Chief Executive's Report** RCRP data management Consequences from RCRP implementation with annex 3 setting out the planned data focus - yet noting a lack of baseline.	TL	Update on RCRP impact using this data to return to Board in **September 2024**	Open
Bpu 23/11/15b	**Chief Executive's Report** Government focus on Productivity in health services particularly NHS Ms Tindall Fulton asked about the place of productivity in the work of the management. A number of members contributed to a rounded discussion, during which Mr Lewis indicated that Quarter 1, 2024/25 would see a structured focus in this area. Mr Chillery highlighted the need to do some work to define our shared meaning in this space, and all agreed that the issues were more complex than simply volume.	TL	**January 2024:** As noted in the minutes of the previous meeting this matter will be considered further and an update provided to the Board at the end of Q1 2024/25.	Open
Bpu 23/11/20	**IQPR Report** MUST Position Mr Lewis referred to the area of concern for delivery of quality care in the number of inpatients that have had a completed MUST assessment (QS36). This had been discussed at CLE; there was some	RC	**January 2024:** Covered in IQPR and being picked up routinely in Board's Quality Committee	Propose to close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	confidence that this may be due to data not captured correctly and a piece of work was being led by the Deputy Chief Nurse with the expectation that compliance would be achieved by Christmas; in the event this was not the case to ensure there was a way for full MUST assessment to be completed for the Doncaster site.			
Bpu 23/11/21	**Finance Report M7** Mr Lewis requested a report with separation of slippage from planned slippage associated with recruitment within the next three weeks to allow sign off of the care group budgets and trajectories.	IC/IM	**January 2024:** Monthly Finance report now includes split between planned and unplanned slippage.	Propose to Close

REF	ACTION	OWNER	PROGRESS	OPEN /CLOSED
27/07/2023 **FPIC Report**	**<u>FPIC - Eliminating out of area placements target</u>.** The CLE had agreed for a 3-month programme looking at all aspects of therapeutic inpatient working discharge led by Mrs Lloyd from September and report back to the Quality Committee and Board before November; and establish when out of area placements would be eliminated in 23/24.	TL	**January 2024:** please refer to agenda item 20 (Paper Oii).	Propose to close
27/07/2023 CEO Report	<u>Staff DBS records</u> May 2023 Board was advised of the 'coming-to light' of inadequate DBS records for a minority of staff. 15% of that backlog has now been cleared.	NMc	**January 2024:** All outstanding DBS cases were cleared by 31 December 2023.	Propose to close

REF	ACTION	OWNER	PROGRESS	OPEN /CLOSED
	The next 8 weeks – work to ensure employee engagement with confirming status by the December 2023 deadline.			
28/09/2023 **CEO Report**	<u>136 Assessment</u> Finalised plan to improve section 136 assessment availability to be presented to January Board meeting to complete both the analytical work, and the engagement with partners required, to construct a convincing plan of comprehensive action.	TL	**January 2024:** please refer to agenda item 20 (Paper Oi).	Propose to Close
28/09/2023 **CEO Report**	<u>Suicide prevention strategy</u> A briefing for the Board on both the current state and the expected impact of plans will be shared in January so that we can test our contribution's sufficiency with partners	GT	A briefing and discussion on this topic will be scheduled for the **March 2024** Board of Directors meeting.	Open
28/09/2023 **CEO Report**	<u>Our Equity and Inclusion plan</u> Enrolled public health physician asked to help us to develop the 'RDaSH five' mental health inequalities standards that we indicated we would focus on, which take us beyond the Core20PLUSfive commitments that we must meet as part of the Long-Term Plan.	JMcD	**January 2024:** A 'long list' of possible inequalities standards was developed and discussed with the Equity and inclusion CLE Group on 9 January 2024. Over the next 8 weeks this will be further considered to reach agreement on the 'RDASH five' and on the plan to take each forward. The Board of Directors will in due course receive the Equity and Inclusion Plan which will include the 'RDASH 5'	Propose to Close

REF	ACTION	OWNER	PROGRESS	OPEN /CLOSED
23/11/2023 CEO Report	<u>Strategic Objectives</u> From January's Board we will commence discussing each strategic objective in turn through the year – commencing with **objective 5.**	All	**January 2024:** agenda item 21 Paper P	Propose to Close
23/11/2023 CEO Report	<u>Audit of Practice</u> Mr Lewis will be coordinating an audit of practice of Oxevision through February which will be shared with the quality committee and board in March 2024	TL	**January 2024:** Audit of practice has commenced and will include 360 Assurance (internal Audit) work on consent. As noted, update report via CEO to Board in **March 2024.**	Open
23/11/2023 CEO Report	<u>Management of NHS Professionals</u> In 2022/23 the Trust had determined that future bank management would best come via NHS Professionals. We will revisit this decision at the January 2024 Board of Directors to confirm that, in a future NHS where flexible working will increase, this outsourced scaled model still makes sense to us.	NMc	**January 2024:** This topic will be the subject of a discussion with reference to paper on today's agenda. Propose to close this action and if needed, new actions will be recorded following the Board's discussion today.	Propose to close
23/11/2023 CEO Report **&** **BPu 23/11/13**	<u>EPR final business case</u> FPIC, having been delegated oversight to approve, has confirmed our EPR final business case. Accordingly, we have commenced negotiation with our preferred supplier, and the outcome of that work will return to the Board during Q4.	RB	**January 2024:** The EPR business case will return to the Board in **March 2024** if commercial negotiations have been concluded.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Gender Pay Gap	**Agenda Item**	Ci
Sponsoring Executive	Nicola McIntosh, Executive Director of People and OD		
Report Author	Lisa Earnshaw, Head of HR systems		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

Further to the discussion at the Board of Directors in November 2023, the paper presents a response to the points raised. GPG has been recalibrated so that Salary Sacrifice is back in the calculation and we seek to confirm the intention of aiming to reduce GPG from 11% towards 5% over the next 2 years, with eventually 0% over a longer time period. Do we still agree and support with the suggested recruitment decisions?

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

SO5. Help delivery social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

Board of Directors – November 2023: requested to put salary sacrifice back in the calculation and revisit the impact of the decisions which is back here in this paper.

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

X	**RECEIVE** and **ACCEPT** what we have suggested as actions to reduce the GPG
X	**CONSIDER** and challenge whether we have missed anything strategic regarding the reality of the aim to reduce the GPG down from 11 %.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register							
Board Assurance Framework	x	SR1 / SR2					
System / Place impact							
Equality Impact Assessment	Is this required?	Y	Y	N		If 'Y' date completed	Feb 2024
Quality Impact Assessment	Is this required?	Y		N	N	If 'Y' date completed	

Appendix (please list)

GPG report

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Gender Pay Gap

Nicola McIntosh
Executive Director of People and Organisational Development
and
Lisa Earnshaw
Head of Human Resources (Workforce Information & Transactional Services)

January 2024

RDaSH nurturing the power in our communities

1 Introduction

Since discussing our approach to reducing RDaSH's Gender Pay Gap in the November Board of Directors meeting, the ultimate goal is to reduce the pay gap between men and women to zero.

There are challenges associated with gender pay gap reporting, since the framework is a rather blunt tool for a complex issue. It does not take account of full-time and part-time working arrangements, or of differences in occupation, grades and salary sacrifices. It does not factor in social differences such as family structures, caring responsibilities, educational attainment, career aspirations and social mobility, or personal choices that employees make in their employment decisions.

As we know within the NHS, the raw data required to complete this report is extracted from ESR and imported into the business intelligence system which calculates the average hourly rate for each employee. There is currently no functionality within ESR to manipulate data to capture different scenarios, therefore the Trust business intelligence team have provided a modelling tool to assist with identifying the actions required to reduce the GPC to zero (section 3).

2 Reporting

All NHS Trusts have a legal requirement to report their Gender Pay Gap data as at 31st March each year. For national reporting purposes this data is always 12 months in arrears and provides a snapshot in time. As indicated previously, in order to effectively monitor progress of any actions undertaken to address the pay gap, this data needs to be refreshed on a regular basis. The data provided in this report is as at 31st December 2023 and includes the changes made to Care Group management structures.

In relation to the elements included in the hourly rate calculation, the Regulation guidance provided by the Government Equalities Office is very clear:

Gross salary (including salary sacrifice) must be used to calculate the hourly rate.

This stance by the Government continues to cause debate amongst NHS Trusts as it is argued that this does not provide a true reflection of gender pay and has a significant impact on the pay gap percentage. This is quite clearly evidenced when we compare the GPC without salary sacrifice provided in the November paper (3.5%) and the GPC with salary sacrifice (11.3%) However, despite legal challenges this EO directive remains unchanged.

3 Calculation/ Scenario Modelling

The Trust GPG as at 31st December 2023 is 11.3%. By utilizing the modelling tool and increasing our overall staff by 95 in the configuration below, this reduces our GPG to 7.1% in the first instance.

This is obviously predicated on the assumption that no-one leaves the Trust or is

promoted, and we do not recruit any new male leaders into Agenda for Change bands 7 and above.

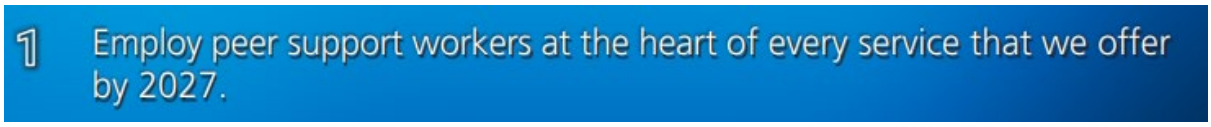
Combined	Staff	Overall Salary	Overall Hours (Weekly)	Average Salary		Average Hours	Average Hourly Rate	GPG
All Staff	3940	£ 121,790,631.80	127,435.30	£ 30,911.33		32.34	£ 18.38	-7.1%
Female Staff	3230	£ 96,800,384.60	102,665.06	£ 29,969.16		31.78	£ 18.13	
Male Staff	700	£ 24,766,417.20	24,395.24	£ 35,380.60		34.85	£ 19.52	

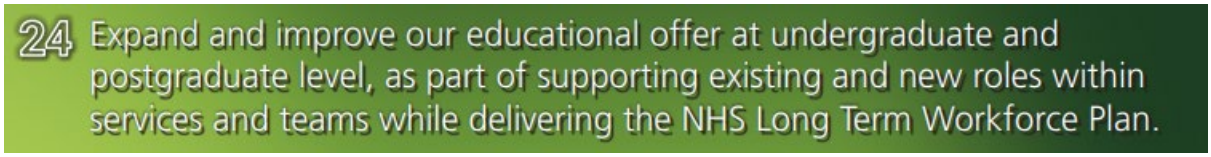
New Jobs

Gender	How Many	Salary (Per Person)	Hours	Total Salary	Total Hours	Hourly Rate	Additional Information
Male	20	£ 29,000	37.50	£ 580,000	750.00	£ 14.87	Band 4 Peer Support Worker
Male	20	£ 22,383	37.50	£ 447,660	750.00	£ 11.48	Band 2 Apprenticeships
Male	10	£ 22,816	37.50	£ 228,160	375.00	£ 11.70	Band 3 TNA's
Male	10	£ 25,147	37.50	£ 251,470	375.00	£ 12.90	Band 4 Nurse Associates
Male	10	£ 22,383	37.50	£ 223,830	375.00	£ 11.48	Band 2 Facilities Staff
Female	5	£ 83,571	37.50	£ 417,855	187.50	£ 42.86	Band 8d Senior Leaders
Female	5	£ 70,417	37.50	£ 352,085	187.50	£ 36.11	Band 8c Senior Leaders
Male	15	£ 28,407	37.50	£ 426,105	562.50	£ 14.57	Band 5 clinicians

It should be noted that there are other factors which may impact on this scenario mapping – achieving Real Living Wage and the national Staff Side submission to undertake the re-banding of clinical Band 2 HCSW's to Band 3. Both of these are complex issues and have multi factor considerations, however it is anticipated that the impact will be minimal as any uplifts will be consistent across both men and women and the hourly rate will be recalibrated. However we will see any impact when we complete the 3 monthly calculations for POD committee.

The scenarios added above supports our strategic objectives and focuses on 3 of our 28 promises.





5 Conclusion

The modelling tool can be utilised as part of a centralised recruitment programme and career pathways, specifically for example for male colleagues, to ensure that gender pay gap principles are embedded within all Trust wide and staff groups. We will choose to make some conscious decisions about the gender of appointed professionals into the roles as detailed in the above example

Further analysis will have to be conducted in order to reduce GPG further down from 7% and when we monitor this every 3 months we will review how this can be further achieved. One example as stated before is to promote more women into roles AFC bands 8 and 9 and VSM grades.

We will ensure that we manage this through POD committee. We may well need to have further discussions about other considerations around positive action if the data in the meetings do not appear to be heading in the right direction.

References:

https://www.gov.uk/government/publications/gender-pay-gap-reporting-guidance-for-employers/preparing-your-data

https://www.nhsemployers.org/system/files/2021-06/Capsticks-GPG-briefing.pdf

Item 8

Chairs Matters

Verbal

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper D
Date of meeting:	7 December 2023		
Attendees:	Justin Shannahan (Chair), Dawn Leese, Pauline Vickers.		
Apologies:	Kathryn Gillatt		
Matters of concern or key risks to escalate to the Board:	• Delays and deferments to the internal audit plan have resulted in an unbalanced plan in terms of quality, the committee noted this as an issue. • The Procurement audit resulted in limited assurance being received, therefore, the committee were not assured there was a fit for purpose procurement function and agreed for this to be escalated to the first meeting of the Finance Digital and Estates meeting. • The committee were partially assured on the BAF due to this not being available until March 2024 and internal audit had raised this as a medium risk. • Head of Internal Audit opinion is likely to give limited or moderate assurance.		
Key points of discussion relevant to the Board:	Delays and deferment of audit reviews: • PSIRF (deferred to quarter 2, 2024/25). • Migration to NHS Professionals (no audit to undertake as Board decision awaited, therefore, the committee could not take assurance due to concerns and weakness in the current bank staff process). • Patient Engagement and Inclusion (deferred to quarter 1 2024/25). • Consent to Treatment (delayed until quarter 1, 2024/25)*.		
Positive highlights of note:	• In-year reassurance on the Code of Governance. • Confirmed that the Value For Money (VFM) review by Deloitte for 2022/23 identified no significant weakness.		
Matters presented for information or noting:	• External Audit Progress Update. • Audit Recommendation Progress Report. • Annual Governance Statement Issues and Events. • Internal Audit Planning process for 2024/25 • Code of Governance. • Standing Financial Instructions.		
Decisions made:	• The Procurement Audit limited assurance to be discussed at the Finance, Digital and Estates Committee. • Additional days added into the internal audit plan for 3 additional pieces of work, IQPR, 5 additional days to increase the audit scope and 2 new audits, Financial Development Plan audit and Taxonomy Audit.		
Actions agreed:	• More committee involvement to sit at level 2 of the internal audit planning process. • Counter Fraud awareness to be reflected in the internal audit work plan. • To look for any errors on the new ledger system. • Identify the resource required for the finance department action plan.		

Justin Shannahan, Non-Executive Director, Chair of the Audit Committee.

Report to the Board of Directors meeting scheduled for 25 January 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper E
Date of meeting:	19 December 2023		
Attendees:	Dave Vallance (Chair), Sarah Fulton Tindall, Nicola McIntosh, Pauline Vickers, Philip Gowland, Sheila Lloyd, Dr Graeme Tosh, Dr Judith Graham, Jyoti Mehan, Christina Harrison, Lisa Earnshaw		
Apologies:	Richard Chillery		
Matters for escalation:	None		
Key points of discussion relevant to the Board:	• **Workforce Plan** – reporting format has changed; Joint Finance and HR meetings in Jan & Feb 2024 will focus on accurate vacancies data / budget allocations to achieve true vacancy rate and skill mix analysis. • **Operational Risk Report** – Risk Management Group (RMG) would focus on longstanding risks and movement on & off the register. • **POD Dashboard** – significant reduction in turnover 10.6% (Nov 2023) compared to 13.5% (Nov 2022) translated to 105 staff who chose to stay with the Trust. Highest percentage of leavers YTD flipped for the first time from registered nursing (29%) to additional clinical support (30%). In response to NHSE on meeting growth targets YTD growth highest in AHPs (10%) with nil growth in Estates, Clinical Support and Medical; positive growth in clinical staff (1.8%). Agency Spend YTD 5.1% at M6 2023/24 (39.2% over target). • **QSIR** - due to national changes a decision was required whether to continue with proposed high licence fees. • **GoSWH** – Admin support and finance / governance for issuing fines raised and addressed through the Junior Doctors Forum (JDF) or Joint Local Negotiating Committee (JLNC). • **Talent Management & Succession Planning** – recent agreement by the CEO for an Executive Talent panel scheduled in January 2024. • **Staff Incidents, RIDDOR, and Non-Clinical Claims Report**; To increase frequency of reporting to Board on claims / clinical claims. Require clearer understanding of the importance of RIDDORS and escalation from the floor to the Board. PO&D to consider costs of fighting cases / bigger picture and get safety profile right as RIDDORS and racism dealt with differently. • **EDI Update** – continuation with anti-racism alliance – a lot of support from ICB around raising profiles of networks. Discussions started on caring responsibilities for colleagues. Although not explicit in the plan, a lot of the background effort in areas of Rainbow Badge training, allyships, civility and respect, was taking place.		
Positive highlights of note:	• **Management of Trust Procedural Documents**; none beyond date. P&OD team have a strong process in place. • **Operational Risk Report** – no extreme risks, risk reviews green across the board. • **Therapies Biannual update** – positive progress on social workers, SBAR reporting format was useful for value add. • **MAST compliance** continued above 90%		
Matters for information/noting:	• **Staff Vacancies** • **NHS Staff Survey Campaign**: significant push early in the new year to increase response rate from 53%. Full staff survey data release in January 2024. Some corporate areas over 70% response but concerns skewed to less clinically focused. • **Clinical Learning Briefing**		

Decisions made:	• **GoSWH report** steer provided on the content; to focus on PODC requirements and GoSWH mandate; discussed that PODC remit did not include decision making / enforcement on this. However, committee noted that the fuller reporting highlighted an absence of priority by the Trust for improvement to facilities and admin support requests for two years plus.
Actions agreed:	• **Terms of Reference & Action Log** - agreed to hold further discussion outside of the meeting to achieve clarity on remit of CLE groups / PODC under the new structure and due diligence to ensure action completion. • **Culture Plan** P&OD to share culture assessment results. PODC to take a fresh look at risks under culture plan with several norms and behaviours risks part of the leadership offer. • **PDR compliance** constant at 83.2% - Need to see an action plan to increase to closer to 100% - reporting to consider cleansing data (It is not possible to achieve 100% given e.g., long term sick/maternity leave, new starters. Concern was raised that we need to ensure focus on ensuring people have a really good performance and development review than 'ticking the box' and driving the wrong behaviours.

Dave Vallance, Non-Executive Director and Chair of the People and Organisational Development Committee.

Report to the Board of Directors meeting scheduled for 25 January 2024.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Performance & Informatics Committee	**Agenda Item:**	Paper F
Date of meeting:	19 December 2023		
Attendees:	Pauline Vickers (Chair), Kathy Gillatt, Sarah Fulton Tindall, Ian Currell, Richard Banks, Phil Gowland, Izaaz Mohammed, Toby Lewis, Will Holroyd, Julie Thornton.		
Apologies:	Richard Chillery and Jo McDonough		
Key points of discussion relevant to the Board:	• The financial position has improved to a surplus of £0.2m in month 8 - £3.1m better than plan. • £4.75m of recurrent savings delivered to date. £10.3m of plans have been identified and forecast to achieve £7.12m in 23/24. • Further insight into the savings schemes at risk or will not deliver savings this year. Arrangements are in place to deliver against the expected target and savings programme. • Agency Spend continues to increase, predicted full year spend on agency is £8.1m, which is £1.8m over the agency cap. Additional controls will be implemented in Q4 to improve the oversight of agency spend and support in reducing the reliance on temporary staffing.		
Positive highlights of note:	• Summary of the Trust's key financial issues including financial year end position, run rate, financial, savings and agency positions, and transformation spend. • Progress update received against the key priorities from the Digital Plan Annual Report - 2021-23. • Robust processes and systems are in place to manage procedural documents (under the remit of FPIC) in line with the Procedural Documents Policy.		
Matters of concern or key risks to escalate to the Board:	None.		
Matters presented for information or noting:	• Expenditure Controls. Self-assessment of the Trust's operational planning controls was received. Plans are underway to comply with NHSE and ICB requirements. • Commercial Development – latest position provided regarding progress with commercial development.		
Decisions made:	• Value for Money: How the Trust Delivers Value. The Committee received the initiated annual report and supported the arrangements in place to secure value for money. • Operational Risk Report – the Committee did not support the reduction in risk score SR3 Financial Stability. The improving financial position was acknowledged and will consider reducing the risk score in future should the improving position be maintained.		
Actions agreed:	• Financial Forecast – to produce a waterfall chart / bridge highlighting the key financial issues including recurrent and non recurrent position. • Savings 23/24 Deep Dive - progress update will be provided at the next Committee regarding three areas of concern who were forecasted to under achieve targets.		

Pauline Vickers, Non-Executive Director and Chair of the Finance, Performance and Informatics Committee

Report to the Board of Directors meeting scheduled for 25 January 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper G
Date of meeting:	17 January 2024		
Attendees:	Justin Shannahan (Chair), Dawn Leese, Dave Vallance, Toby Lewis, Graeme Tosh, Nicola McIntosh, Jo McDonough		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	• Strategic Plan Promises within the Committee's remit noted. Two enabling plans under the remit of this Committee: Equity and Inclusion and Research and Innovation, will be key to the delivery of those promises supported by their respective CLE groups. • Doncaster Fairness and Wellbeing Commission – the Commission has identified five areas to focus action. The Trust will work with the Commission to improve fairness and wellbeing for the residents of Doncaster. • Draft Equity & Inclusion Plan (including Promises 6-13) – this continues to be developed to include measures of success, timelines, metrics and which Promises will be of focus, with a view to bring a final Plan to the Committee in March. • Health Inequalities – Service Profiling. Data will be used through a Core20PLUS lens to start reporting to Board in relation to equity and inclusion.		
Positive highlights of note:	• Promise 6 "Poverty proofing". Work has commenced to identify where our services may be adding to the burden of poverty or creating barriers for those in poverty accessing our services.		
Matters presented for information or noting:	• Delivery of the Research and Innovation Plan – continues to be developed including public relations and wider Trust / partner involvement, identifying the objectives, benefits realisation and key outputs. • Risk Register – Five 'live' risks identified under the remit of the group scored 12 or above. Theming of risks is under review.		
Decisions made:	None.		
Actions agreed:	• Strategic Plan Promises – to map all 28 Promises and align against the Trust Committee governance structure.		

Justin Shannahan, Non-Executive Director and Chair of the Public Health, Patient Involvement and Partnerships Committee

Report to the Board of Directors meeting scheduled for 25 January 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper H
Date of meeting:	17 January 2024		
Attendees:	Dawn Leese (Chair), Prof Janusz Jankowski, Dave Vallance, Sheila Lloyd, Dr Graeme Tosh, Richard Chillery, Richard Banks, Phil Gowland.		
Apologies:	Dr Jude Graham		
Matters of concern or key risks to escalate to the Board:	**Resuscitation Update** – safety concerns raised associated with non-compliance with resuscitation equipment audits (via Tendable) on 13/18 wards and Level 3 training compliance. Robust and timely action required to improve the position. **MUST assessment IQPR data** - The number of inpatients that have a completed MUST assessment on admission remains below a satisfactory level. A deep dive review is ongoing and initial snapshot audit undertaken have identified improvements are required. Follow up report to March QC. **Racist Incidents** – Racists incidents have seen an increase; a deep dive has commenced with a focus on racist incidents - patients to staff. All incidents are reviewed and work ongoing to ensure IR1s clearly detail the abuse received, to identify the necessary learning and ensure the MDT can determine the forward approach in terms of tolerance and behaviours.		
Key points of discussion relevant to the Board:	**Integrated Quality Performance Indicators (December 2023 data)** • Physical health services continue to perform well. • Deterioration reported for children and young people accessing services, immediate deep dive being undertaken to understand and subsequently address the position. Recovery plan pending. • Work ongoing to understand and improve access and recovery to Talking Therapies. Recovery plan pending. • The Committee recognised the importance of leaders having meaningful and timely review / evaluation of the IQPR data (pre-QC) to inform the right conversations and required insights to QC – overall governance and timing of the IQPR reporting to be considered by the executive team. **Top 5 patient safety themes** – • Continued reduction reported in self-harm by ligature incidents. QC noted the actions taken to date and the publication of revised best practice guidance by the CQC. This is currently under review to consider actions required and implications for future learning. • The Patient Safety Incident Response Framework (PSIRF) has gone live, and associated training undertaken. Initial feedback from daily incident reviews are positive. • Work remains ongoing to ensure absent without leave (AWOL) and absconsion incidents are categorised and reported accurately, reviewed, and reported and appropriate actions taken. • Mandatory Patient Safety Checklist currently in development as part of the Quality & Safety Plan (Review at QC March 24)		
Positive highlights of note:	Mortality report received, and QC remain assured by the systems and processes in place associated with learning from deaths. Positive 6 monthly Safeguarding report.		
Matters for information:	Great Oaks SI learning report received which included a summary of the learning that has occurred to date. Further work required to ensure this is embedded and sustained in the organisation. LIVED plan received and organisational review of approach pending noted.		
Decisions made:	None.		
Actions agreed:	Follow up action required regarding resuscitation audits, MUST assessment and sequencing of IQPR (as above)		

Dawn Leese, Non-Executive Director and Chair of the Quality Committee
Report to the Board of Directors meeting scheduled for 25 January 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper I
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

The report inevitably spans both executing on 23/24 commitments as we enter Q4 and getting ready for public sector year 2025/26. Because we have agreed a strategy with promises across the quarters of 2023-2028, we are looking to manage our organisation with less annualization – and helpfully the national planning guidance is also less zig-zagged from prior years than is sometimes the case. Nonetheless, as we develop place-leadership and our collaboratives there are a range of clarion voices to whom we need to respond – and the pressure on local authority budgets dwarfs the challenge the NHS has.

Focusing on a future rating for Caring of outstanding is an important symbol of what matters most in RDaSH. It is a rare achievement, and in our 'sector' rarer still. Our draft BAF will be culturally focused in March – and re-energising a culture that supports people to care is an important step in coming months. How we manage, lead and work is fundamental. The new mechanics of the operating model is largely deployed but will take time to bed-in and to refine – aided by advice from GGI, by our Board's work with TVC, and by feedback from those involved. The two 24/25 "leaps" are our investment in leadership development (currently out to market) and the significant reforming of our appraisal model to better support line managers to manage.

Alignment to 23-28 strategic objectives	
SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2. Create equity of access, employment and experience to address differences in outcome.	x
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Previous consideration

Not applicable

Recommendation

The Board of Directors is asked to:

x	**EXPLORE** the patient, people and population issues described
x	**CONSIDER** any matters of concern *not* covered within the report
x	**NOTE** 24/25 ICB financial planning discussions with 'Chairs and Chief Executives'

Impact

Trust Risk Register		n/a
Board Assurance Framework		Cited
System / Place impact	x	Described

Equality Impact Assessment	required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	required?	Y	x	N		If 'Y' date completed	To be developed on liaison eating disorder service status

Appendix

Annex 1: Update on Governing Body priorities for 2023/24
Annex 2: Guidance summary, incl. national planning guidance
Annex 3: Clinical Leadership Executive note
Annex 4: Note summarising strike impacts from Junior Doctors' strike 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Chief Executive's Report

Introduction

It is perhaps not traditional to begin this report with a downward tone, but it is important to recognise that we have not delivered our ambition to vaccinate 3,000 employees **this winter from flu**. We are nudging 2,500 and jabs remain available. What has been done is larger than before and probably more high profile. We need to reflect as a leadership community on what worked and how we get ready for autumn 2024 – whilst we had higher formally recorded refusals and more jabs than previously – there remain a significant number of colleagues in neither category and, material to today's Board agenda, that includes a large number of bank personnel. Given the central health status of the vaccine, and our reputation for focusing on health and wellbeing, we need to evaluate self-critically, how we succeed in 24/25.

Scaling up is often far harder than initiation, and that is of course central to the work we are trying to do now on **Talking Therapies**. In all three places the Trust has well-established services with comparably good recovery rates (well above what a deprivation adjusted expectation might suggest). There are intra-service differences which do not reflect differences of underlying need – and, like many NEY Talking Therapy services - we do not yet meet the access volume in the Long-Term Plan. Growing our supply by about 30% will take spend above run-rate and will contribute to the MHIS mandated nationally – it will also contribute to pan-party ambitions on employment/mental health, which it seems astute to be ready for.

From work undertake informally and developmentally, Board members are well-sighted on our current digital delivery arrangements, and a plan to take that further in line with our strategy is being refined. The EPR FBC, with concluded contract negotiations, may be expected next time we meet. It will be important that FDE, and the wider Board, can meet collective governance and knowledge standards for being digitally informed, as we might expect raised expectations from policymakers, and increasingly from residents, about how much of our offer is delivered via, and literally by, technology (promise 20). One facet of that transition will be **refining our expectations of line managers within the Trust** to actively impact and improve the 'digital behaviour' of employees and ensure that we achieve much greater consistency in use of products, which will themselves need to become much more intuitive and accessible. This is a new deal between employer and employees, and between line managers and their teams. It is highlighted here because it is such a pervasive and significant transition – and of course recent national publicity for longstanding "IT" failures will make us all wish to explore how best we do that humanely.

1. Our patients

Rightly scrutiny externally of the safety of certain services nationally is increasing. This includes work focused on the safety of S136 and acute ward beds for mental health patients. The Board is aware of the huge amount of work undertaken over the last eighteen months in this space, and is also aware, through both peer review and

CQC updates to the Board, of the work that is still to be done. During January we have begun making regular information returns to NHSE (as all Trusts with RI wards have) on the progress of our improvement work – returns that request specific assistance, on top of the support provided by peers within our collaboratives. The health services safety investigations body (**HSSIB)** have also included RDaSH in their current national review of approaches to managing the best care for people placed out of area and visit us on January 2023/24. As we finalise our arrangements under the quality and safety plan, it will be important that each ward has a clear scorecard in place that is visible centrally and that can demonstrate the current status of that environment of care. The Trust has sought several times to put in place similar programmes and initiatives, and we need to learn and reflect from those efforts before concluding what best will meet our patient, carers and employees' needs in 2024/25. Our emphasis on meeting and exceeding the Caring requirements of the regulatory framework should cause us to consider what soft intelligence needs to form part of such work – beyond simply data.

The development of the quality and safety plan will be in part built from local Care Group intended quality measures for their services. This work, which commenced through our leaders' conference in October, is showing some promise. In particular, it will help us to ensure that the focus on ward safety does not come at the expense of an equal focus on risk in other points of care. When we began to create our directorates last year there was an intended future focus on **reducing handoffs** between individuals and teams, and on ensuring that our practices around pathway management did not reinforce exclusion, for example on grounds of age. The intention to make progress on these issues will be maintained in 2024/25, but the work on data quality and waiting lists highlighted by Richard Chillery in November's Board, needs to be undertaken first.

CLE has overseen a piece of work to review the therapeutic nature of our inpatient care. We will discuss in March how that work is best taken forward. One element of the work is to ensure that admission is truly purposive and indicated. Of course, that decision is wholly clinical, and it will be important to establish that the full range of **alternatives to admission** are readily available in each place served by the Trust. It is encouraging that the South Yorkshire focus of ICB-place efforts in 2024/25 will be on safe admission avoidance, *seven days a week*, and we will want to work with VCSE partners and others, to explore how current arrangements match or exceed best practice.

Out of area placements (OOAP) are considered elsewhere on the Board's agenda. They regularly feature in ICB-led discussions about future models of care. **Real progress has been made over the last few months**, notably in Rotherham, in reducing the length of out of area placements, and in reducing numbers. The Collaborative in South Yorkshire has undertaken to focus time and attention with ICB colleagues on uncommissioned services locally, where someone must be placed outside of a locality because no such type of provision exists in the area. Our efforts will be further assisted by the focus being placed on long-stay patients, who have been in Trust beds for more than six months. Eliminating OOAP in 2024 is both an RDaSH promise (19) and a national commitment.

I have reported previously our, my, and our local coroners' concerns over local eating disorder hospital liaison arrangements. Despite regulation 28 letters, we have not yet cohered a shared set of improvements, either for adults, or for young people. Service gaps remain, and I will be working with ICB colleagues over coming weeks to convene partners to consider how best this can now be addressed. In advance of that, we will assess the current service arrangements using QIA methodologies.

2. Our people

Apprenticeships featured in our prior Board meeting. They also feature in promise 9, with an emphasis on ensuring that we match expected spend levels, and work on the diversity of our offer. In May's Board meeting we will outline how, initially, we plan to do this – and the work required to ensure that all roles at band 3 in the Trust are made apprentice-ready when they fall vacant.

Sickness rates remain above 5% in the Trust, and in certain parts of the Trust far higher than that. This is one area of focus where directorate level data in 2024/25 will assist considerably. The Trust has clear absence policies and a strong support offer for health and wellbeing. Our post incident response team offer a further restorative intervention where colleagues have experienced potential psychological or other harms. In considering **our 'fully staffed'** model for 2024/25 we need to examine what reduction in absence can be achieved, distinguishing short- and long-term absence, and what mitigations we can put in place to best support teams with significant absence, which can then in itself become a source of further ill-health.

A major focus for our January delivery reviews is on progress with identifying and filling residual **vacancies**. This goes beyond the remaining sixteen consultant psychiatry vacancies which drive our agency spend, and certainly includes district nursing and inpatient mental health nursing roles. Live vacancy data, from April, will be centrally maintained and shared monthly, relating back to agreed budgets – and scrutiny of progress with that work has been previously delegated to the FDE meeting in February.

These steps together are critical to work to make the organisation one that is fully staffed. Our learning efforts, attempts to introduce standard practices, and to innovate and experiment, will not be delivered without gains in these areas – it is however encouraging that we now have our overseas medical recruiting accreditation, and senior staff are presently in India, looking to substantively recruit.

Agency spend reductions in 2023/24 have not been achieved, although a number of senior clinicians have moved onto substantive contracts. We need to consider what we can learn from our relative lack of success in this field, and how we both see-through already agreed changes, and adopt new approaches this spring. Potentially moving medical staffing arrangements, after review and consultation, into the mainstream HR functions of the Trust and care groups would ensure that all of HR expertise is focused on all of our professions.

We have a significant focus, as we are in Q4, on **appraisal or PDR**. As indicated in March 2023 there is a need to revisit our appraisal model for 2024/25 and beyond to ensure that it meets the needs of the organisation in the future. This will certainly include a renewed focus on ensuring that everyone in the Trust has defined

measurable *and locally relevant* objectives, and that performance against those objectives is supported, centrally recorded, addressed, and rewarded.

I am pleased to confirm that work commenced in June to eliminate DBS documentation non-compliance in RDaSH has been delivered in full, on time by December.

3. Our populations and partnerships

I am delighted that our first public involvement, public health and partnerships committee has taken place. The equivalence, and conscience, that that meeting will bring, alongside other scrutiny at a Board level, is part of the transformation of our organisation in line with the 2023/28 strategy. Rachel Leslie, acting DPH for Doncaster, outlined the Fairness and Wellbeing Commission report for the city – and Jo McDonough will work to ensure that align our promises plans with these recommendations. Tackling the benefits gap, not simply through employment support, but through actively helping citizens to obtain their entitlements, must form part of **our work to tackle poverty**. Half of all people living in poverty nationally are, or care for, someone with a disability, and the disability claim gap is significant and longstanding.

Our South Yorkshire MHLD&A Collaborative has four priorities: STOMP, place of safety, neurodiversity and eating disorders. In each of the first three we have a singular measure of improvement we are seeking to achieve. There is a risk that achieving data-clarity between parties takes some time, while, perhaps **especially for out of area placements and S136 suites (both on today's agenda) there is a pressing need for rapid change**. Potential collaborative changes around eating disorders are considered in our commercial section – and it remains possible that such moves will not proceed, and it will prove necessary to end contracts and vacate some responsibility.

Reviews of the shape and purpose of the parallel **Humber & N Yorkshire Collaborative** continue. A useful set of proposals from Carnell Farrer informs discussions, as we aim to get the best of both from work at a quasi-regional scale for a handful of sub-specialist services, with the high value need to achieve improvements south of the Humber across North and NE Lincs. Services in North Lincolnshire remain unavoidably dependent on collaborations across institutional or commissioning boundaries: and any approaches must acknowledge that population reality, or they will simply not be future-proof.

ICB South Yorkshire are seeking to develop **a different approach to medium term financial planning** across the four places and with providers. This is a welcome co-production of inevitably difficult choices. It will be important to ground the 3–5-year trajectory in shifting 'left' towards more community powered, neighbourhood interventions where there is credible evidence of reducing high-intensity, expensive, and sometimes absent specialised services. The Trust's strategy is well positioned to assist with this transition.

We continue to **invest in our community partners**, including supporting the People Focused Group to develop a wider 'LERO' network across our geographies – one goal of which is to support our work currently 'branded' as transformation. Moving our relationships with VCSE peers away from being contractual, and towards a

slightly different approach will be important. This is infrastructure building and over time we will want to ensure that the diversity of needs, representation, and capability in our communities is present within that infrastructure.

Concluding comments

In May we discussed the longstanding and **unacceptable waits for neurodiversity diagnoses at the Trust** and in September we agreed we would first tackle adult and CYP ADHD wait times. We committed, if necessary to setting a deficit budget in 24/25 to do this, but fortunately a funding source has been secured for this work and this was reconfirmed by the ICB Director of Finance in recent days. During February, intensive work will take place to finalise our implementation plans, which inevitably will disrupt some existing practice, whilst building on good work done in recent years to make a difference, perhaps especially for families and children.

FPIC's exceptional focus ("deep dive" if we must) on **cost improvement delivery** in December suggested that we had very largely succeeded, and recurrently, with our very ambitious programme of changes in 2024/25 – this then partly explaining being ahead of financial plan going into year end. In finalising consistent budgets at directorate level for 2024/25 we will build on those recurrent gains. We have initiated conversations with Place leadership colleagues to recognise that in and from 25/26 there is a need to move many of our services onto at least a partially volume-related funding model. Aside any other difficulties with such a transition, we will not be able to migrate in this manner unless our data quality markedly improves. With the successful build of an IQPR as a starting gun not a finish line, we have some distance to run to plan for and achieve those gains in what is left of Q4 and through Q1.

Sheila Lloyd steps down from the Board in late March, with our *thanks*, and mine. Due to annual leave, the meeting is her last with us. It is a mark of legacy that she is able to handover to Steve Forsyth, attracted by our recent work, who joins us from Wales via the Midlands, stepping into his first substantive CNO role – and as the NHS' first such male appointee of South Asian heritage. **Jude Graham will act-across** during the leave period and Steve's induction, and her revised substantive role reports direct to me – reflecting the parity that both allied health and psychological professionals merit within the Trust, alongside nursing and medical colleagues.

Annexes provide detail of our progress on the governors' key priorities, report back from CLE, summarise strike impacts, and show the latest guidance documents, which as we get ready for a new year is more extensive than before.

Toby Lewis, Chief Executive
18 January 2024

Annex 1

Board members will recall that, in May and June 2023, we agreed, via our Council of Governors, that we would explicitly focus on some priorities identified by them on behalf of the membership. The commitment was that this would be considered within our Board, as well as being part of routine management business. The three priority areas identified by the Governing Body are:

- Volunteering
- Prevention and health promotion
- Community involvement

We sought, via the Council of Governors in August, to agree measures or metrics of progress, mindful of the broad nature of these priorities, and also that we are seeking to confirm annual progress for 2023/4 – mindful of 2023/28 promises.

The measures below represent the intended data points for use in the balance of this year: in November, January, and March we will complete a reporting cycle against each via this report.

From prior paper to COG	**Current framing**	**Success by March 2024**	**January 2024 status**
Community involvement	GB1 Objective one of the Clinical and Organisational Strategy (C&OS) becomes a real part of how RDASH works and relates to others	High levels of awareness among employees of the strategy's promises (60%+) by survey, including recognition among top leaders' cadre (n150) of the critical role of objective one	We will be looking to undertake employee survey during Feb/March to test strategy awareness. The commitment to promise 5 is reflected in terms of reference for Board committees and in those for CLE groups.
Community involvement	GB2 Every Trust service by 2027 will have peer support workers within it (promise 1 in the C&OS)	15% improvement on current baseline in adult and older adult mental health services	The current baseline is <20. A 24/25 trajectory is being established and bids are included in our investment fund considerations due with the Board in March.
Community involvement	GB3 Promises within C&OS describe commitments to widening access and to expanding apprenticeships	Fully deploy the apprentice levy sum for 2023/24 and create new targeted schemes for vulnerable groups (care leavers, homelessness, and refugees) by	The Board will consider progress in May, with an engagement symposium now diaried for late February. We will miss the timeline to establish new targeted

From prior paper to COG	Current framing	Success by March 2024	January 2024 status
		March	schemes but will maintain the objective into 24/25 and succeed.
Health promotion and prevention	GB 4 The Trust is committed to ensuring health checks are conducted annually for a) local people with a, learning disability who are registered as such with their GP and b, those registered with a serious mental illness)	Meet for both a) and b) and in each of three Places the standard set within the Core20PLUSfive programme by March 2024 AND Expand our work to tackle poverty in local schools through targeted action, likely to include the 'glasses for classes' campaign	Delivery reviews take place this week. 95% target represents a considerable step up from 22/23 outturn of 65% This has been funded and starts work in March!
Health promotion and prevention	GB5 We are mapping community assets in all three communities. Our estate plan will then relocate some services to those assets. This work is also supported by our community MH transformation work and our partnership with Leisure Centres.	Invest in community estate in Rotherham to expand the number of consulting rooms and shared spaces available in the town [other places in 24/25] AND Present finalised asset map to CLE, BOD and COG	Discussions are continuing within Chief Officer's Group in Rotherham over both the Boots site, the market development and opportunities within Riverside Work on the asset map has started (RH) and a draft is due in January.
Health promotion and prevention	GB6 We are working with three local public health departments and others, to assess the calibre of promoted/certified mental wellbeing advice available to both children and young people (CYP) and adults in our three Places.	Six clear access routes to certified information are 'endorsed' by RDASH 3xCYP and 3xadult and their use is tracked and scaled up, in part through our work. AND Grounded Research engaged with each Chamber of Commerce to explore our role with employers in	This work has not progressed and a remedy meeting is being established prior to the COG meeting in February. This work has started, with place leadership and will need to form part of

From prior paper to COG	Current framing	Success by March 2024	January 2024 status
	Our new website goes live in December 2023.	promoting evidence-based wellbeing interventions. AND Funding route for current time-limited support in schools service is established (funding expires 2025).	our R&I plan. Work with politicians regarding the school-support programme is being undertaken, because of the concern that 25/26 funding uncertainty will translate into 24/25 turnover among employees.
Volunteering	GB 7 Our system for recruiting and rapidly enrolling volunteers needs to be effective and pacey. The VSM is making progress with this and internal audit will undertake a review in December/January to ensure that our systems are fit for purpose	The management have confidence that anyone applying to volunteer with us would have a decision and be enrolled within defined, published, and attractive timescales.	There has been good numeric progress. The IA review takes place in Q4.
	GB8 We have committed in the C&OS to expand volunteering from 50 to 350 people (c10% of headcount)	100 active volunteers working within RDASH by March 2024, with a clear path to 250 by March 2025 [ie. we know how we would use a further 150 rewardingly] AND The diversity of our volunteer base is improving against 2023 baseline	This has been met but there is more work to do to secure volume and diversity.

Annex 2

National publications/guidance summary – December/January 2024

Annex 2

National publications/guidance – December 2023/January 2024

Patient choice guidance
(NHS England, published 19/12/2023)

This guidance outlines how commissioners, providers and primary care referrers can meet the statutory, contractual and policy obligations which enable patients' rights to choice as set out in the NHS Constitution for England.
https://www.england.nhs.uk/long-read/patient-choice-guidance/

Update on planning for 2024/2025
(NHS England, published 22/12/2023)
Letter from Amanda Pritchard, Julian Kelly and Emily Lawson with an update on planning for 2024/25. https://www.england.nhs.uk/long-read/update-on-planning-for-2024-25/

Mental Health of Children and Young People in England, 2023 – wave 4 follow up to the 2017 survey
(NHS Digital, published 21/11/2023)

This report presents findings from wave 4 in a series of follow up reports to the 2017 Mental Health of Children and Young People (MHCYP) survey, conducted in 2023. 2,370 children and young people who took part in the MHCYP 2017 survey took part in the wave 4 follow up. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up

Strategic framework for NHS Commercial
(NHS England, published 28/11/2023)

This NHS commercial framework sets out a clear strategic direction across key commercial capabilities in managing key supply markets and suppliers, commercial arrangements with suppliers, as well as looking at unnecessary cost and waste, and missed opportunities to drive additional value and leverage scale.

https://www.england.nhs.uk/long-read/strategic-framework-for-nhs-commercial/

National guidance to support integrated care boards to commission acute mental health inpatient services for adults with a learning disability and autistic adults
(NHS England, updated 19/12/2023)

This guidance supports ICBs to commission acute mental health inpatient services for adults with a learning disability and autistic adults. It is national guidance for ICBs to follow as they commission for their populations and sets out minimum standards and expectations to consider when commissioning high quality inpatient care.

https://www.england.nhs.uk/wp-content/uploads/2023/11/National-guide-about-acute-mental-health-inpatient-services-for-adults-with-a-learning-disability-and-autistic.pdf

The offender personality disorder (OPD) pathway: a joint strategy for 2023 to 2028
(NHS England, published 07/12/2023)

The OPD pathway is a set of psychologically informed services operating across criminal justice and health, underpinned by a set of principles and quality standards. Using evidence-based relational and environmental approaches, it aims to reduce risk associated with serious reoffending and improve mental health within a high-risk, high-harm cohort likely to meet the clinical threshold for a diagnosis of 'personality disorder'. The OPD pathway is a jointly funded partnership between His Majesty's Prison and Probation Service and NHS England.

https://www.england.nhs.uk/wp-content/uploads/2023/12/PRN00321-The-offender-personality-disorder-pathway-a-joint-strategy-for-2023-to-2028.pdf

Meeting the needs of autistic adults in mental health services
(NHS England, published 12/12/2023, updated 13/12/2023)

This guidance is for integrated care boards, health organisations and wider system partners and provides advice on how to improve the quality, accessibility and acceptability of care and support for autistic adults to meet their mental health needs, both in the community and in inpatient settings. It outlines 10 principles for implementation and provides practical examples of how these principles may be applied.

https://www.england.nhs.uk/wp-content/uploads/2023/12/B1800-meeting-the-needs-of-autistic-adults-in-mental-health-services.pdf

NHS vaccination strategy
(NHS England, published 13/12/2023)

The NHS vaccination strategy brings together all vaccination programmes, for the first time, to protect communities and save lives. This strategy is for people and organisations involved in the commissioning, planning and delivery of NHS vaccination services in England. It will shape the future delivery of NHS vaccination and immunisation services.

https://www.england.nhs.uk/long-read/nhs-vaccination-strategy/

NHS equality, diversity and including improvement plan actions
(NHS England, published 14/12/2023)

Letter from Dr Navina Evans CBE about next steps to support you to deliver the NHS equality, diversity and inclusion improvement plan. https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan-actions/

Proactive care: providing care and support for people living at home with moderate or severe frailty
(NHS England, published 20/12/2023)

This guidance is for integrated care boards (ICBs) and provider organisations involved in the design and delivery of proactive care.

https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/

Transitioning to centralised energy purchasing to find efficiencies for the NHS
(NHS England, published 27/12/2023)

A central review identified that there are currently 200 energy contracts in place across trusts in England, under different agreements, with varying value and purchasing strategies. Given this, NHS England has agreed, in partnership with Crown Commercial Service (CCS), to develop an NHS specific energy agreement under the CCS framework – Supply of Energy 2. https://www.england.nhs.uk/long-read/transitioning-to-centralised-energy-purchasing-to-find-efficiencies-for-the-nhs/

Commissioner guidance for adult mental health rehabilitation inpatient services
(NHS England, 09/01/2024)

This guidance supports the planning and commissioning of local mental health rehabilitation inpatient services as part of a whole pathway, to meet the identified need of local populations.

https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/

Improving the physical health of people living with severe mental illness (SMI)
(NHS England, published 10/01/2024)

This guidance supports ICSs and service providers to improve the physical health care of adults living with severe mental illness (SMI), through improved physical health checks and supported follow-up interventions.

https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/

Five key elements for discharge – supporting people with a learning disability and autistic people to leave hospital
(NHS England, published 11/01/2024)

In collaboration with the Local Government Association and Association of Directors of Adult Social Services as Partners in Care and Health, NHS England have published this letter which identifies five key actions that will have the biggest impact on supporting people with a learning disability and autistic people to leave mental health hospital.

https://www.england.nhs.uk/long-read/five-key-elements-for-discharge-supporting-people-with-a-learning-disability-and-autistic-people-to-leave-hospital/

New platform launched for retired consultants to return to NHS
(NHS England, published 16/01/2024)

The NHS has launched its NHS Emeritus pilot scheme to encourage retired doctors to return to the health service to reduce long waits for elective care.

https://www.england.nhs.uk/2024/01/new-platform-launched-for-retired-consultants-to-return-to-nhs/

Freedom to speak up – annual report on whistleblowing disclosures
(NHS England, published 11/01/2024)

Published annual on the number of whistleblowing cases received that considered to be ‘qualifying disclosures’ and how they were taken forward.

https://www.england.nhs.uk/long-read/ftsu-whistleblowing-annual-report-2022-23/

Annex 3

Clinical leadership executive – December 2023 & January 2024

There have been two meetings of this body since the Board last met; the latter of which approved terms of reference for CLE and its ten 'subs' – consistent with the Board's now approved terms of reference and those proposed for its committees. Delivery reviews also support CLE and Board members have had shared the outcome letters from those sessions in November – a second round take place prior to the Board meeting in public. Corporate directorate delivery reviews start from February bi-monthly.

CLE meetings routinely consider – the IQPR and sub-group outbriefs. The key or non-standard agendas items explored are listed below. Any member can list an item on the agenda. Minutes and the action log are available to any Board member on request through Lou Wood.

December	January
Quality and safety draft plan	Complaints handling and processes
Digital delivery plan – post CG feedback	Promises' prioritization and delivery models
Learning half days and L&E plan	Data quality around IQPR
ICB-wide financial controls 23/24	Directorate mobilization

In terms of decisions made, December's meeting approved the executive's arrangements for financial control, which was also noted in FPIC. In January's meeting we approved changes proposed by subs to our mandatory training arrangements.

There are not specific matters to escalate to the Board, but the CLE meeting informs the report to which this is an annex.

Over the next two meetings (Feb/March) we will consider in particular:

- Each of the 8 plans – notably finance, estate, P&T, E&I, and R&I which are not yet visible to members…
- The proposed investment fund schemes from revenue for 2024/25 together with the proposed capital plan – both of which will then come to the Board in March
- Our deployment plan for DIALOG+, which is both critical to mental health transformation locally, and a key part of our promise 16 intent to migrate to focusing far more on patient-defined outcomes of quality
- Making sure we deliver in Q4 on LTP 1, 2 and 13, which form part of our Big Six
- Brokering the time leaders have available to do x, y and z – and making choices about sequencing the "essentials"…

Toby Lewis, Chief Executive – 17 January 2024

Annex 4

BMA Junior Doctor Industrial Action Summary
December 2023 and January 2024

Background

On 5th December 2023 the British Medical Association (BMA) announced that it would resume Junior Doctor industrial action due to a lack of progress in relation to pay negotiations. Subsequently 2 periods of industrial action being announced, 3 days in December 2023, from 0659hrs on Wednesday 20th to 0659hrs on Saturday 23rd. Followed by a further 6 days in January 2024, from 0659hrs on Wednesday 3rd to 0659hrs on Tuesday 9th.

Preparation

To prepare for these 2 periods of industrial action, the Trust conducted an internal self-assurance process alongside the wider ICS and regional system assurance process. Each Care Group within the Trust was asked to create a contingency plan for their area, so which in part existed due to having previously produced winter resilience plans for the Christmas and New Year period. This was integrated to create a Trust wide contingence plan for each period of industrial action. A summary document was created and provided to all Executive Directors within the Trust.

Mitigation

In order to mitigate the effects of the industrial action, the Trust's HR medical recruitment department conducted extensive work to make sure that all On-Call rota's were covered during the periods in question. These were done in advance alongside Consultant Colleagues ready to "step-down" if required. Several other mitigations such as additional bank staff were also used during this period.

Observed strike 'rates'

December 2023				January 2024						
20/12	21/12	22/12	**Total**	03/01	04/01	05/01	06/01	07/01	08/01	**Total**
48.2%	45.6%	38.6%	**44.4%**	42.1%	45.6%	45.6%	N/A	N/A	42.1%	**43.8%**

Patient and staff impact

The overall patient care impact in RDaSH directly attributed to the Industrial Action for both December 2023 and January 2024 has been managed through the mitigations. With a total of 4 appointments cancelled across the organisation during both periods of industrial action. These appointments being from the Children's Care Group, with 2 being cancelled during each period of industrial action and further appointments have been offered. The main impact on RDaSH services from both periods of industrial action has been from wider system pressure from the NHS. Most notably with the Physical Health coming under pressure, due to assisting Doncaster Royal Infirmary and due to members of the public avoiding attending Emergency Departments. The physical health team have 4 winter pressure schemes under way which supported the impact on DRI; the most successful the extension of the IV in community provision and this will be further expanded until March 2024. There was also a focus on flow within the RDaSH community health beds, although *spare* capacity within the virtual wards of approximately 50% remains.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	EPRR Annual Report	**Agenda Item**	Paper J
Sponsoring Executive	Richard Chillery (Accountable Emergency officer), Chief Operating Officer		
Report Author	Katie Speed, EPRR Manager		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

Each year the Trust is required to assess itself against 58 nationally defined Core Standards for Emergency Preparedness, Resilience, and Response. Following a change in how NHSE assesses individual Trust's compliance with the EPRR Core Standards, Rotherham Doncaster, and South Humber NHS Foundation Trust (RDaSH) has been confirmed as non-compliant. This is reflected across the entire system and wider region. The compliance score for RDaSH was 21%, but for a comparator within the region the highest score was 45% and the lowest 10%.

It has been made clear by NHSE that this new, more stringent, approach to compliance will continue moving forwards and has been described as a "hard reset". The Trust, along with all the Trusts in the South Yorkshire and Humber system are now required to undertake a significant programme of work to become compliant and this will likely carry over into 2025.

The key areas of focus for 2024/5 include:

1. Revision of the Trust's EPRR & Business Continuity Plans
2. Evacuation Plan and testing
3. Commander Competencies
4. Exercising/testing & Training

This will be a key focus for the EPRR team but will also require active input from the care Groups and support services.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

The contents of this report have been discussed at EPRR Group for information. This update to Board was requested by NHS England. This is part of the EPRR Core Standard Requirements.

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**RECEIVE** and **NOTE** that the Trust, like all others, has work to do against the new national Core Standards
x	**CONSIDER** and **AGREE** the submission of the Trust EPRR Core Standards rating for 2023/24
x	**DELEGATE** to the COO (as AEO) responsibility for driving that work, overseen through CLE, OMG and EPRR subgroup
x	**AGREE** to receive a further update in September Board, from the AOE, to see progress against Core Standards Action Plan including levels of incident and commander training.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)							
Trust Risk Register	x	O 4/23					
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
Appendix 1 – Core Standards 3 Governance and EPRR Board Report Requirements							

Following two appendices have been sent separately to the agenda pack:

Appendix 2 - NHS England EPRR Core Standards Overview for Boards
Appendix 3 - EPRR Core Standards RDaSH submission 23/24

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Emergency Preparedness Resilience and Response

Annual Report and EPRR Core Standards Statement of Compliance

Richard Chillery, Chief Operating Officer
Katie Speed, EPRR Manager

January 2024

RDaSH nurturing the power in our communities

Introduction
As required by the NHSE EPRR Core Standards, this report is the annual EPRR update and statement of Core Standards Compliance to Public Board. This report is divided into four sections:

Section 1. Details of the updated process and annual compliance rating for the 2023/24 NHSE Core Standards for EPRR which were confirmed in November 2023. Approval is sought from the Board and agreement to submit the annual compliance statement to NHSE.

Section 2. A general update on EPRR work during 2023, including training and exercising. This information is for Boards awareness and oversight.

Section 3. National Minimum Occupational Standards for EPRR and the implications for the Trust, including a proposal for a new digital recording package.

Appendix 1

- Core Standard 3 Governance and EPRR Board Report Requirements

Appendix 2

- NHS England EPRR Core Standards Overview for Boards

Appendix 3

- EPRR Core Standards RDaSH Submission 2023/24

Section 1 – Annual Core Standards Compliance

Background

The NHS England Core Standards for EPRR are the minimum requirements commissioners and providers of NHS funded services must meet. In 2023/24 58 separate core standards are applicable to RDASH. These are divided into 10 sections

1. Governance
2. Duty to assess risk
3. Duty to maintain plans
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10. CBRN/HAZMAT

The assurance process for 2023/24 was changed by NHSE NEY Regional team. This meant the Trust went from a self-assurance submission, to a process which required multiple pieces of documented evidence and a substantially more detailed set of requirements to comply with each standard. The process required a submission by the Trust followed by a 'check and challenge' by NHSE Regional team, a second submission by the Trust and a second 'check and challenge'.

NHSE NEY Regional team have described the CURRENT process as a 'hard reset' and a stringent interpretation of the standard. It is also worth noting that this process was created and implemented without consultation of the ICBs or Trusts.

Trust Position against the 2023/24 EPRR Core Standards

As a result of the new process, the Trust compliance rating is as follows:

Compliance Level	Evaluation and Testing Conclusion
Non-Compliant	The organisation is 21% compliant with the core standards they are expected to achieve.

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
58	12	45	1

To put the rating into context, the assurance rating thresholds are as follows:

- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Attached in Appendix One is the RDaSH EPRR Core Standards Final Submission.

Every Trust across the region was significantly reduced to both their initial self-assessment and their previous year ratings. All Trusts were rated as non-compliant, as indeed were the ICB's and NHSE Regional team themselves. The lowest Trust being 10% and the highest 45%

Next Steps
A detailed action plan is currently being produced to assess the work that must be done over the coming year(s) to bring the Trust into the 'Substantially Compliant' criteria; with the aim of being as close as possible to 99%. There is doubt over whether any Trust can ever be truly 100% compliant due to the changing nature of the standards (changed every three years).

The action plan is being developed by the EPRR Manager with support from a range of teams across the Trust who have responsibility for and input into the different Core Standards. For example, the Security and Health and Safety team lead (Core Standard 17 lockdown) and standard 36 media strategy requires the Communications team. The plan will be monitored bi-monthly at the EPRR Group, and any significant risks will be raised and escalated accordingly through the Chief Operating Officer as Chair of the group and the organisations "Accountable Emergency Officer". The EPRR groups is a subgroup to the Operational Management Group, reporting the Clinical Leadership Executive.

The new Core Standards process, and 'hard reset' is significant amount of work for the EPRR Team and Trust to undertake to gain compliance. However, it is a real opportunity both for the Trust and the wider System organisations to be consistent in their approach and ensure that EPRR is done to a high standard and that our colleagues have had the appropriate training and development to be a competent health commander. This will ultimately mean a more resilient Trust and should an incident occur, a better outcome for patients and communities.

As part of EPRR governance, Core Standard 3 (CS3) Governance and EPRR Board Reports must be improved. CS3 states that there should be an EPRR report should be submitted directly to a Public Board no less than annually and must contain the following: training and exercising, a summary of business continuity, critical or major incidents experienced by the organisation, lessons identified, and learning undertaken from incidents and exercises and the organisations compliance position in relation to the latest EPRR compliance rating. At EPRR Group in December 23, it was agreed that whilst significant EPRR work is in progress, there should be a report no less that twice a year. It is suggested than an update come back to Board on the progress of the action plan in September 2024.

Full details of all requirements of CS3 provided by NHSE NEY Region can be found at Appendix 1 of this report.

Board Request
Board is requested to accept the Trust EPRR Core Standards rating for 2023/24 and agree to submit their agreement to NHSE Regional team.

It is also requested that Board acknowledge and ensure their action against Core Standard 3 and accept EPRR board updates for governance twice a year.

Section 2 – Annual EPRR Update

Key Highlights

1. Industrial Action Planning and Co-ordination

The EPRR Team have coordinated both the Trusts contingency planning and response to various periods of industrial action during 2023 including Nurses, Junior Doctors and Consultants. This involved a significant amount of time and resource planning both internally and with System Partners and the ICB's. Response to strikes has been successful due to comprehensive planning by a variety of teams.

For information, the average strike rate for December 23 was 44.4% and January 24 was 43.8%. This has remained steady throughout the strikes and is slowly decreasing.

2. Yorkshire and Humber Wide Mental Health Trust Collaboration

An informal group of the EPRR leads across all mental health and community trusts has always existed to provide peer support and share information. Following the changes to the EPRR Core Standards, this group has become critical and has become formalised with an agreed Terms of Reference. The group aim is to share best practice amongst peers and to promote the unique differences of mental health and community trusts, especially where guidance and standards are acute focused.

The group is working collaboratively and proactively to share fully compliant processes and documentation in a move to work smarter and share workload for core standards.

3. Interim update of EPRR Policy and Major Incident Plan

Interim updates of both the EPRR policy and the Major Incident plan (now renamed to be the Critical and Major Incident Plan) have been agreed at CPAG. Both documents will need a full review for 2024 and have been included on the wider Core Standards action plan.

4. On-Call Policy Update

Following the Trust review on On-Call Manager structures, the On-Call Managers Policy has been reviewed. Ongoing work to ensure the right people are on the rota and are appropriately trained (also see Section 3 or this report) so that we are resilient for out of office hours and able to respond to any incidents necessary. The updated policy is due for approval at OMG and CLE in February 2024.

5. Evacuation Task and Finish Group

Evacuation and temporary shelter planning is one of the Trusts highest EPRR risks and as such has been included on the corporate risk register. A task and finish group has been established to look at improving the corporate overarching plan and

then individual ward specific plans right across the Trust. Brodsworth, Cusworth and Skelbrooke wards is the pilot plan being developed. Once plans are in place there will be a series of training and exercise to take place. The full programme of works is expected to take around 18 months to complete from the date of this report and will be monitored at EPRR Group and through Board reports.

6. Business Continuity Review Workshops

Trust business continuity plans have been identified by the EPRR Manager as needing improvement. Several workshops with various colleagues right across the Trust have taken place to gather ideas for improvement and how they would like to see the process work going forwards. The overwhelming themes were making the plans fit for purpose, shorter and more user friendly and for authors to receive more training and support.

A full improvement programme will take place over the next 18 months (from the date of this report) to align Trust plans to the international business continuity standard ISO22301.

Training

There are several Core Standards (CS) that refer to colleague training and competence. These include CS10 incident response, CS20 On-Call mechanism, CS21 Trained On-Call Staff, CS22 EPRR training, CS24 responder training, CS25 staff awareness and training. Full details of the NHSE Core Standard requirements can be found here.

It is an NHSE requirement that training figures are reported at least annually to Board. We are looking to secure a specific web-based tool, which captures the specific EPRR training and training levels will be provided in the September update.

7. Principles of Health Commander (PHC) Training

As part of the Core Standard mentioned above, NHSE have developed a mandatory training course for all On-Call staff and incident commanders. There are two levels of PHC training required of all 'Health Commanders' and those on call: Tactical (Silver) and Strategic (Gold). NHSE put on monthly courses for each of these. The whole course must be attended to gain the certificate which is valid for three years and then the course must be reattended.

As of December 2023, the Trust training compliance rates are shown in the table below. The EPRR team are tracking training and making monthly requests of colleagues to attend these courses. These percentage rates do not include those that are already booked onto a course over the next few months. It is anticipated that by June 24, the rates will be much closer to 100%. Several training sessions were stepped down due to the strike action.

Course	Percentage of colleagues who have completed
Tactical PHC	40.38%
Strategic PHC	66.7%

8. On-Call Induction Training

Following the Trust On-Call Managers review, a two day Induction Training course was developed to ensure that all colleagues receive a base level of training on both Trust out of hours calls received and EPRR incident response. The training has been positively received with colleagues stating that they now feel 'more confident' at being on call, especially those new to the Silver rota.

To date the 44.2% of colleagues now on the rota have been trained. This figure of people trained overall is higher in reality, but due to the Care Group restructures there are new colleagues to be added to the rota. The Silver rota has been refreshed and will launch on Friday 18 January, however, those new to this level of rota will need to secure training, shadowing and buddying before formally on the rota.

9. Gold EPRR Session

In August 23, the EPRR Manager ran a session for Strategic (Gold) Health Commanders during an Executive meeting. The training covered changes to the Critical and Major Incident Plan, business continuity, EPRR response structures and the new National Minimum Occupational Standards for EPRR.

Exercises

10. Multi-agency - Exercise Mighty Oak

Exercise Mighty Oak (led by Cabinet Office) was focused on a national power outage scenario. The Trust participated with South Yorkshire Local Resilience Forum (LRF) and a number of multi-agency partners. The exercise identified a number of lessons and a full post exercise debrief report is now available and being addressed by the LRF. Learning from this exercise has been translated to applicable to the Trust and internal work followed.

11. Internal – Exercise Bonsai

Exercise Bonsai was a no notice exercise held at the EPRR Group meeting in April 23 to test the Trust response to a national power outage. A number of lessons were identified and associated actions are being monitored by EPRR Group to ensure compliance.

12. Internal - Bonsai Junior

Exercise bonsai Junior was an exercise ran by EPRR for the People Experience team to test their business continuity plan following Exercise Bonsai. A debrief report and lessons identified were issued to the People Experience team to improve their plan. An open offer was made to all teams across the Trust to conduct a similar exercise, however, no more have taken this up. Through the business continuity improvement works, a more rigorous training and exercise programme will be undertaken with all Care Groups.

Incident Response and Lessons

Power Outage Incident

During 2023 there has only been one incident that involved activating the Trust Critical and Major Incident Plan. This incident was a power outage to the Main Hospital Block at Tickhill Road site which impacted on Trust Switchboard, the Two Wards and the Offices. A full debrief process was carried out and number of lessons and areas for improvement were identified. These lessons are now being tracked by the EPRR Group.

Section 3 - National Minimum Occupational Standards for EPRR

Background

In 2023 a document issued by NHSE sets out the minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve in order to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD) and maintain personal development portfolios (PDPs) in accordance with NHS Core Standards for EPRR.

As part of ongoing CPD, the Skills for Justice National Occupational Standards (NOS) Framework should be evidenced in addition to these minimum standards. Suggestions as to the NOS aligned to roles are provided in the NHSE document. In addition, there may be a need for specific specialist training for roles required.

The NHSE NEY regional team have issued a draft portfolio for commanders along with several suggested courses that assist commanders in complying with the NOS. At the time of writing this document, the Trust is awaiting further information from NHSE NEY regional team with regard to timescales and format for completion of portfolios. Proactively, the EPRR manager has introduced the NOS requirements to both Gold and Silver On-Call via the Induction Training sessions.

Next Steps

The EPRR team will play a crucial part in ensuring all roles covered by the EPRR NOS receive and the appropriate training. This is no small task and to improve

efficiency the aim is to digitise the tracking and monitoring of compliance with a bespoke IT system called CPDMe and CPDTeams.

Final Summary

To summarise this report, the board has been updated on the latest EPRR position and compliance with EPRR Core Standards. It is a very different position to last year and all Trusts have seen their compliance ratings dramatically fall through the new process. This has been described as a 'hard reset' by NHSE and whilst we have a wide range of plans and processes in place for EPRR this reset essentially sets Trusts back to zero.

The opportunity going forwards over the coming years is to really improve EPRR for the whole NEY region, providing consistency and more collaboration between partners and organisations throughout the whole health resilience field. Recent incidents and inquiries such as those from the Manchester Arena attack and Grenfell fire have highlighted the importance of emergency planning and resilience.

With a robust improvement plan, buy in and support from Board, senior managers and colleagues right across the Trust, there are opportunities for the Trust to become even more resilient and efficient.

Appendix 1 – Core Standard 3 Governance and EPRR Board Report Requirements

2023	EPRR Assurance Process
	DOMAIN 1 - Governance

Core Standard	Domain	Standard	Standard Detail	Supporting information/examples of evidence
3	Governance	EPRR Board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.

Compliance Requirements	

CS3	• The need to report to the organisations Board should be set out in policy and confirm what the reporting process/schedule within the organisation is
	• A minimum of two sections of the standard must be achieved for compliance to be marked as full – 1) Reporting to the organisations board and 2) Statement in the annual report/ accounts
	• Both sections have to have been completed to achieve this standard
	• Report to the board must include the elements described under the standard:
	  ◦ Training and exercising
	  ◦ Incidents since the last report
	  ◦ Lessons and learning
	  ◦ Compliance with the assurance process
	• Board reports must be to a public Board. For those organisations without a public board they should have a public statement of readiness activities. The Report cannot just go to a sub committee of the board and must happen at least once in a year
	
	• Advisory for 2023/Compulsory for 2024 – see Good practice recommendation

ICB Specific	Acute & Ambulance Provider specific	Mental Health & Community specific	Good practice
• Best practice would see the report include information on the outputs and discussions of the LHRP	• Nil specific	• Nil specific	• Ensure roles detailed in the EPRR Policy reflect the need for the report (e.g. CEO ensures there is a report) • AEO reports to the board on x frequency

Core standards links	Applicable National Guidance	Applicable Regional Guidance
• Cross linked to Core Standards 1 and 2	• EPRR Framework	• N/A

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Risk Update	**Agenda Item**	Paper K
Sponsoring Executive	Phil Gowland, Director of Corporate Assurance / Board Secretary		
Report Author	Jane Charlesworth, Corporate Assurance Manager		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

Since Summer 2023, there has been a renewed and revitalised approach to the management of risk with the aim of significantly greater awareness to risk across the organisation and with clearer and more distinct consideration of risk in decision making and resource allocation.

This has seen a significant increase in the number of risks on the risk registers along with greater oversight within Care groups (and Directorates) and corporate teams, through their own meetings and via the Delivery Review process. Further scrutiny and oversight will be provided via the Risk Management Group, established from January 2024 as one of the CLE Groups. This significant increase in operational oversight (and the amended terms of reference – as per Paper M) affords the Board Committees the opportunity to focus on related strategic risks within the Board Assurance Framework (BAF), which is currently under review to ensure it fully reflects the new Trust Clinical and Operational Strategy.

As an example of the way by which this greater focus and prominence of risk management will support the decision-making processes, the recently submitted financial investment bids will be assessed and evaluated with reference to the risk registers, and bids clearly demonstrating the mitigation of risk, afforded more positive evaluation.

These new arrangements for risk management are presented in the attached Risk Management Framework (Appendix A). This updated version of the RMF provides clarity on the ways by which responsibilities for risk management stretch from individuals across the organisation; to teams and directorates / care groups / corporate teams, with oversight and challenge via Delivery Reviews and RMG. Reporting arrangements to Committee and Board are also included. As noted above the Board will receive in March 2024, the Board Assurance Framework following review, it will be accompanied by a risk appetite grid in order to clearly articulate the Risk Appetite (see section 3 of the RMF) pertinent to respective risks in the BAF.

From an operational risk perspective, there remain no extreme-rated risks. No further changes are proposed to the scoring of the current strategic risks. Refreshed strategic risks with a Board Assurance Framework will be presented for approval in March 2024. Summary position of the BAF is included at Appendix B.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2. Create equity of access, employment and experience to address differences in outcome.	x
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

- Since the last report to the Board of Directors (November 2023), risk reports have been presented to People and Organisational Development (POD) Committee; Finance, Performance and Informatics Committee (FPIC) (December 2023); and Quality Committee (January 2024). Audit Committee in December 2023 received a report providing assurance on the adherence to the Risk Management Framework.

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board is asked to:

x	**RECEIVE** and **NOTE** the latest position regarding operational risks and the continued absence of any rated as extreme.
x	**RECEIVE** and **NOTE** the latest position regarding strategic risks within the Board Assurance Framework (BAF)
x	**APPROVE** the Risk Management Framework

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register	x	CA 1/23 – Risk management process					
Board Assurance Framework	x	All – and SR3 Financial Stability					
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Appendix A – Risk Management Framework
Appendix B – Board Assurance Framework Summary

NHS
Rotherham Doncaster
and South Humber
NHS Foundation Trust

Risk Management Framework

DOCUMENT CONTROL	
Version:	Draft 0.8
Unique Reference Number:	
Ratified by:	Board of Directors
Date ratified:	
Name of originator/Author:	Corporate Assurance Manager
Name of responsible committee/individual:	Director of Corporate Assurance
Date issued:	
Review and approved by:	
Target Audience	All Staff

Contents

1. Introduction

Successful risk management enhances strategic planning and prioritisation, assists in achieving objectives and strengthens the ability to be agile to respond to the challenges that our Trust faces. If we want to meet our objectives successfully, improve service delivery and achieving value for money, risk management must be an essential and integral part of planning and decision-making. This risk management framework has been developed to improve risk management further and to embed this as a routine part of how we operate.

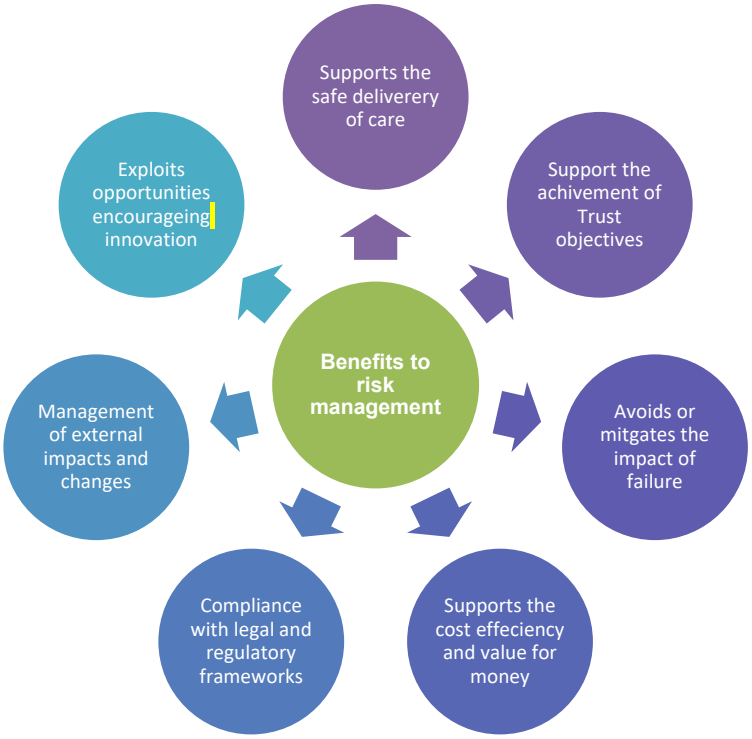
Risk is inherent in everything we do to deliver high-quality services and must be an integral part of informed decision-making, from policy, through implementation to the everyday delivery of services. This isn't about adding new processes; it is about ensuring that effective risk management is integrated in the way we lead, direct, manage and operate.

The effectiveness of risk management depends on the individuals responsible for operating the systems put in place. Our risk culture must embrace openness, support transparency, welcome constructive challenge and promote collaboration, consultation and co-operation. We must invite scrutiny and embrace expertise to inform decision-making.

This framework has been developed to provide an approved framework for all staff that sets out the:

- main principles of effective risk management.
- procedure for both strategic and operational risk to facilitate a consistent, structured and systematic approach to the operational management of risk.

Risk Management is everybody's responsibility and is a fundamental part of the Trust's Governance Structure providing the following benefits:



2. Principles of Risk Management

There are 5 key principles of risk management (as defined in the HM Treasury Orange Book):

1. Governance and Leadership – an essential part of governance and leadership and fundamental to how our Trust is directed, managed and controlled at all levels.
2. Integration – integral to our Trust activities to support decision making for the achievement of our objectives.
3. Collaboration – informed by the available information and expertise.
4. Structure – process is structured to include (also refer to section 5):
    a. Identification and articulation
    b. Assessment and scoring
    c. Treatment
    d. Monitoring, Review and Reporting
5. Continually Improved – through learning and experience

3. Risk Appetite and Statement

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Only by taking risks can the Trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors/regulators, and relevant legislation. This is the risk appetite – defined as "the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time" (HM Treasury Orange Book).

The aim of the Trust's risk appetite statement is to articulate the levels and types of risk the Trust is prepared to accept in delivering of its objectives. This then informs planning and objective setting, focusing on priority areas within our Trust as well as underpinning the threshold used when determining the tolerability of individual risks.

"The Trust recognises that its long term sustainability depends on the delivery of its strategic objectives and, its relationships with its communities, including service users and families, the public and partners. Patient and staff safety is paramount and as such the Trust will not accept risk that materially provide a negative impact on quality and governance. The Trust acknowledges the challenging business environment in which it operates and has a greater appetite to take considered risks in terms of the impact to achieve innovation and excellence."

In agreeing the Board Assurance Framework the Board will consider and agree a risk appetite statement in respect of each strategic risk.

4. Levels and Status of Risk

Within the Trust there are 2 levels of risk:

- Operational Risk
- Strategic Risk

Operational Risk – these are the identified risks that have the potential to impact on the delivery of business, projects or programme objectives. Operational risks are recorded within risk registers. Further detail regarding the systems and processes for managing operational risks is outlined in Section 5 – Operational Risk Process.

In addition to the formal risk registers, when delivering specific projects/programmes, our Trust also utilises the project risk logs which are an essential tool as part of any project management methodology.

Strategic Risks - A Board Assurance Framework is developed in order to identify and record the key strategic risks for the Trust that may impact on the achievement of its Strategic Objectives. Further detail regarding the Board Assurance Framework is outlined in Section 6 – Strategic Risk Process.

In addition to the levels of risk our Trust also defines the status of each risk:

- **Live** - Those risks that are actively being treated and action above and beyond 'Business as Usual' are being taken to reduce the impact and likelihood of the risk occurring.
- **Tolerated** - There are some risks that must remain open as the Trust is unable to implement mitigations that eliminate the risk in its entirety. In these circumstances the Trust may acknowledge that no further action can be taken to mitigate against the risk and decide to tolerate it.
- **Closed** – Fully mitigated and no risk remains.

5. Operational Risk Process

Before we can identify our risks, we need to understand what a risk is. **A risk** is the chance of something happening that will have an impact on business objectives and this can be in terms of:

- A threat - a possible event we want to try to reduce the chances of occurrence or limit the impact to us if it did happen.

or

- An opportunity - a possible event that we might exploit by taking action which could deliver a benefit or positive effect for our Trust.

So how does this differ from an issue? **An issue** is an unplanned event that has already happened. As the issue has already happened it is **not** a risk. However, that does not mean there is no risk associated with the issue.

For example:
Patients waiting excessive time on a waiting list is an issue as this is happening. Not having an adequate process to manage the care of those patients poses the potential risk of harm.

Risk management is the process of identifying and evaluating potential consequences and determining the most effective method of controlling and responding to the risk(s) that we face. It is an ongoing cyclical process, not just a point in time that requires a corporate approach across the whole Trust.

5.1 Identification and articulation

The Trust cannot manage its risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the Trust's risk management process and ultimately the safe delivery of care. Risk should include both threat and -opportunity, and mature risk management should also address both types of uncertainty, seeking to minimise threats and maximise opportunities.

When identifying a risk, consideration should be given as to what could pose a potential threat to the achievement of objectives or otherwise impact on the success of the Trust. Risks can be identified from many sources of information. Some of these are reactive (e.g. incidents), proactive (e.g. risk assessments), internal (e.g. staff consultations) or external (e.g. inspections).

Helpful Resource Appendix 3 – Prompts for identifying risk – to assist in identifying risks

Reactive

- Current incidents complaints and claims
- External decisions which could impact the organisation
- External recommendations, CQC HSE MHRA etc
- Audits; quality, internal or external
- National Initiatives

Proactive

- Delivery plans, Corporate planning & objective setting
- Looking at lessons learned and previous issues
- Benefits of proposed projects and improvement actions
- Horizon scanning Risk assessments
- Staff, staff and stakeholder consultations
- Benchmarking

If you identify a potential or actual risk, discuss this with your line manager so that the most appropriate course of action can be taken.

Helpful Resource Appendix 5 - Risk form - for use when risk identified to aid discussion and articulate the risk

Once we have identified a risk, we then need to articulate what the risk is. Our Trust has adopted the 'If' and 'then' statement model and it is used to describe:

- the risk
- the cause
- the effect

Once we have considered these three elements, we can articulate what the risk is:

If (the risk)… due to (the cause), **then** this could/would lead to… (the effect).

Example - If we fail to ensure the safety and security of staff and patients due to business continuity plans not being kept reviewed and in date then staff will be unfamiliar with the process this could lead to injury, death, prosecution, and reputational damage.

5.2 Assessment and Scoring

What is in place already to stop this risk occurring?

The first stage of assessment is exploring what key controls are in place already, what is in place that reduces either time impact or the likelihood of the risk occurring.

The key controls are the processes, plans, measures that are in place to assist in the impact of the risks or likelihood of the risk occurring, such as:

- Operational plans.
- Statutory frameworks, for instance standing orders, standing financial instructions and associated scheme of delegation.
- Actions in response to audits, assessments and reviews.
- Workforce training and education.
- Clinical governance processes.
- Incident reporting and risk management processes.
- Complaints and other patient and public feedback procedures.
- Performance management systems.
- Strategies/Policies/Procedures/Guidance.
- Robust systems/programmes in place.
- Objectives set and agreed at appropriate level.
- Frameworks in place to provide delivery.
- SLA/Contracts/Agreements in place.

It is important that do not just list these controls but provide narrative for example

How much risk?

Each risk once identified needs to be assessed. This is done by using a risk evaluation tool called the risk scoring methodology. This tool measures the impact of the risk occurring and the likelihood that the risk will occur.

Impact x Likelihood = Risk score

A risk assessment seeks to answer four simple questions:

- What can go wrong?
- How bad?
- How often?
- Is there need for action?

The **impact** is the consequence or 'how bad' it would be if the risk occurred. When assessing this you should not use the worst case scenario, think what the most probable outcome would be.

The **likelihood** is a measure of how likely the risk will occur. When looking at this you should take into account the current environment. Consider the adequacy and effectiveness of the controls already in place and likeliness of the risk being materialised.

	Likelihood Score				
Impact Score	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Helpful Resource - Appendix 4 – Risk scoring methodology – to aid scoring both the impact and likelihood.

5.3 Treatment

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk.

What can we do about this risk?

After assessing the risk score, a decision is made on the required risk treatment using the following criteria:

Treat	In many cases action can be taken to change the way activities are carried out in order to reduce the risk identified
Tolerate	Low and minor risks can be accepted as requiring no further action.
Transfer	This involves another party bearing or sharing some part of the risk e.g. though the use of contracts, insurance arrangements and organisational structures such as Service Level Agreements.

Terminate — It may be decided a particular risk should be avoided altogether. This may involve ceasing the activity giving risk to the risk.

The Trust will regard any risk with a score of 8 or below to be acceptable as a tolerated risk, only when the likelihood is 2 or less. If the likelihood is 3 or higher and the Risk Owner deems that the risk should be tolerated (no further reasonable mitigation can be applied) then authorisation and agreement should be sought from the Risk Management Group (please see table below).

Risk score	Definition	Decision
1 - 3 (Low)	An acceptable level of risk which remains subject to review	Tolerate
4 – 6 (Moderate)	An acceptable level of risk (if the likelihood is 2 or less) which is subject to possible action and remains subject to review	Tolerate or Treat All risks assessed with likelihood score of 3 or above must be treated, any exceptions to this must be authorised by Risk Management Group.
8 – 12 (High)	Requires action and review	Tolerate, Treat or Transfer All risks assessed with likelihood score of 3 or above must be treated, any exceptions to this must be authorised by Risk Management Group.
15 – 25 (Extreme)	Unacceptable level of risk. Requires urgent/immediate review and action. Risk is escalated to the Risk Management Group meeting for moderation.	Treat or Transfer or Terminate

Any risks classed as tolerated will be assessed by the Risk and Assurance Officer, and where the above detailed criteria are not met, an explanation will be requested as to why the risk should be tolerated. The risk will then be presented to the Risk Management Group for authorisation and agreement.

For any risks that have been mitigated including those where the risk rating has been reduced to low, it is acceptable that the risk(s) remain open for a set period of time for monitoring purpose to ensure that the actions taken have in fact mitigated the risk. The time set should be proportionate to the risk and the implemented actions being monitored.

How to treat a risk?

For those risks that are to be treated we now need to evaluate what additional controls can be put in place to reduce the level of risk whether this is the impact and/or the likelihood. We do not automatically try to eliminate the risk but instead managing it down the appropriate level. The time, effort and cost to eliminate may not be appropriate and

therefore proportionate actions need to be undertaken to create controls dependant on the risk and the risk appetite.

The aim of identifying actions is to identify further controls that can be put in place which reduces either time impact or the likelihood of the risk occurring. Examples include:

- Risk around the failure of a process - actions could be:
    - the process/policy to be reviewed
    - training for the revised process to be developed and delivered
    - monitor implementation of the process
    - evaluate whether the revised process is working
- Risk around difficulties in recruitment – actions could be:
    - Role / service redesign
    - Utilisation of a range of networks to continue to recruit
    - Collaboration with other providers
- Risk around achieving activity targets – actions could be:
    - Review of accuracy of data being extracted from the data warehouse
    - Meetings and electronic sharing of reports with team managers to raise concerns and issues
    - Identify finances to offset the loss of income
    - Team managers to ensure that all clinical staff are recording information accurately
    - Monitor progress on Reportal
    - Use of increased staffing on a temporary basis to address backlog

The risk should then be reassessed and a post mitigation risk score identified as to what level of risk will remain once the action plan has been completed and additional controls have been put in place. The target level of the risk should be the agreed acceptable level for the Trust that is achievable and proportionate of the risk being faced.

Recording the risk?

All risks are recorded on a risk register which is the formal record of the risks that the Trust has identified. There are 23 risk registers within the Trust:

- Children's Mental Health - Childrens Care Group
- Children's Physical Health - Childrens Care Group
- Doncaster Acute - Doncaster Adult MH and Learning Disabilities Care Group
- Doncaster Community - Doncaster Adult MH and Learning Disabilities Care Group
- Learning Disabilities and Forensic - Doncaster Adult MH and Learning Disabilities Care Group
- North Lincolnshire Acute - North Lincolnshire Adult MH and Talking Therapies Care Group
- North Lincolnshire Community - North Lincolnshire Adult MH and Talking Therapies Care Group
- Talking Therapies - North Lincolnshire Adult MH and Talking Therapies Care Group
- Rehabilitation - Physical Health and Neurodiversity Care Group
- Community and Long-Term Conditions - Physical Health and Neurodiversity Care Group
- Neurodiversity - Physical Health and Neurodiversity Care Group
- Rotherham Acute - Rotherham Adult Mental Health Care Group
- Rotherham Community - Rotherham Adult Mental Health Care Group

- Corporate Assurance
- Health Informatics
- Finance
- Estates
- Medical and Pharmacy
- Nursing and Quality
- Operations
- People and Organisational Development
- Strategy and Communications
- Therapies

Nominated risk owners are identified for all risks and further information is detailed in Appendix 1 – Roles and Responsibilities.

5.4 Monitoring, review and escalation

Monitoring and Review

Part of managing operational risk is to continually review and update, to capture the changes and progress of mitigation. Each risk is allocated a Risk Owner who is responsible for ensuring changes to the risk are captured, that actions are implemented and the risk is updated accordingly. Reviews of each risk are to be undertaken as follows

- 'Live' risks — on a monthly basis
- Low and moderated rated 'Tolerated' risks — at least annually
- High rated 'Tolerated' risks — at least quarterly

All risks must be robustly and routinely monitored and updated and the following should be considered:

- Live Risks
    - Risk Description – does it still reflect the current situation and potential/actual impact of the risk occurring?
    - Actions:
        - what is the progress being made?
        - have the actions created new controls? If so, does this now affect the risk scoring, can it be reduced?
        - Are more actions required?
- Tolerated risks
    - is the risk still to be tolerated?
    - are the controls up to date and still in place/ are there any additional controls to be added?

The monitoring of the action plan and level of risk must be kept under review. Where the implementation of the action plan is not producing the anticipated results, the risk should be re-assessed and a revised action plan agreed as necessary.

Once all actions have been completed and the risk has been mitigated as far as possible then the risk is moved to Tolerated.

Project risk logs - Where the project or a risk on the project risk log begins to have a significant impact on the Trust then a risk should be added or the risk escalated to the

appropriate risk register for formal monitoring through the Trust's structure (see Appendix 2 Monitoring Arrangements).

Escalation

Where the implementation of the action plan is not producing the anticipated results and further support and guidance is required then these should be reported to the Risk Management Group via the Corporate Assurance Team.

All risks assessed and scored as 15 or above must be reported to the Corporate Assurance Manager so that the risk can be moderated by the Risk Management Group for agreement as an extreme risk.

Any risk with a likelihood of possible (3) or above that is deemed should be tolerated is to be reported to the Corporate Assurance Manager so that authorisation from the Risk Management Group can be obtained.

Any risks identified with an impact of catastrophic (5) is to be reported to the Corporate Assurance Manager so that the Risk Management Group can review and moderate.

6. Strategic Risk Process

In accordance with the Annual Reporting Manual issued by NHS Improvement, all foundation trusts are required to present in their Annual Report an annual governance statement signed by the Chief Executive and underpinned by a supporting Board Assurance Framework (BAF). This aims to provide the Board of Directors with assurance that systems are safe and subject to appropriate scrutiny and that the Board of Directors are able to demonstrate that they are informed of key strategic risks. The BAF contains all the strategic risks that have the ability to undermine the Trust's Strategic Objectives.

The BAF is built up of the strategic risks and includes:

- Current and Target Risk scores
- Lead Committee and Lead Director
- Key Controls intended to manage the risk
- Sources of Assurance to evidence that control measures in place are working effectively to manage risk.
- Gaps in either control or assurance and actions to address the gaps
- Risk Appetite

6.1 Sources of Assurance

The key difference in monitoring strategic risk from operational risks is the use of assurance. Source of assurance refers to the evidence that describes how well the controls are operating. We have adopted the 'three lines of defence' model which categorises the assurance according to how independent it is likely to be:

- First line – operated by managers across the business
- Second line – corporate oversight functions and challenge
- Third line – independent external assurance

Examples for each line of defence are as follows:

First Line of Defence – operational management:

- Budgets
- Risk assessments
- Work programmes of groups / committees
- Planning exercises when, who, relevance
- Training needs assessments

Second Line of Defence – Corporate oversight:

- Performance/Quality monitoring in place and at what level, how and when
- Action monitoring reports
- Complaints and Compliments / Incident monitoring
- National returns
- Training compliance monitoring
- Routine reporting of key targets together with any necessary contingency plans.

Third Line of Defence - Independence assurances:

- External audit
- External inspection bodies, such as the Care Quality Commission and Royal Colleges
- Systems of accreditation
- Mandatory reporting systems
- Internal Audit
- Health and Safety Executive

6.2 Monitoring, review and escalation

Monitoring and Review

Part of managing strategic risk is to continually review and update, to capture the changes and progress of mitigation. Each risk is allocated a Director of the Board as the Risk Owner, who is responsible for ensuring changes to the risk are captured, that actions are implemented and the risk is updated accordingly. Reviews of each risk are to be undertaken with support from the Corporate Assurance Manager as follows:

- 'Live' risks on at least a bi-monthly basis
- 'Tolerated' risks on at least a six monthly basis

All risks must be robustly and routinely monitored and updated and the following should be considered:

- Risk Description – does it still reflect the current situation and potential/actual impact of the risk occurring?
- Gaps in control/assurance – are all gaps covered?
- Actions:
    - what is the progress being made?
    - have the actions created new controls? If so, does this now affect the risk scoring, can it be reduced?
    - Are more actions required?

- Tolerated risks
    - is the risk still to be tolerated?

- are the controls up to date and still in place/ are there any additional controls to be added?

In addition, a periodic review of the strategic risks will be undertaken taking into consideration the operational risk profile to assess whether the appropriate strategic risks have been identified.

Escalation
Escalation for strategic risks will be to the Board of Directors as follows:

- Agree any change of risk description
- Agree and increase or decrease in risk score
- Provide support where the implementation of the action plan is not producing the anticipated results and further support and guidance is required.

7. Training

In addition to the mandatory training delivered and co-ordinated by learning and development, a programme of risk training is provided for all employees. All staff have access to the '000 Risk Management and Governance' training on ESR.

To ensure full consideration of our Trust's risk management approach further training around risk, risk management and identifying risk will be available and encouraged for all staff to undertake through a series of short training videos.

To support risk owners within directorates with responsibilities for registers 1:1 training with the Corporate Assurance Team is available for all identified risk owners which is supplemented with the Easy Step Guide provided after the training. Further training around identifying and articulating risk, assessing, treating and reviewing risk will be available and encouraged for risk owners to undertake through a series of short training videos.

In addition, the Trust will commission external training for cohorts of staff as and when identified.

8. Equality Impact Assessment Screening

The completed Equality Impact Assessment for this Policy has been published on this policy's webpage on the Trust Policy Library/Archive website.

7.1 Privacy, Dignity and Respect

Requirement - The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, 'not just clinically but in terms of dignity and respect'.

Consequently, the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will

be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity, and respect, (when appropriate this should also include how same sex accommodation is provided).

Trust Response – No issues have been identified in relation to this policy.

7.2 Mental Capacity Act

Requirements - Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individual's capacity to participate in the decision-making process. Consequently, no intervention should be carried out without either the individual's informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all employees working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason, all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the rights of individual are protected, and they are supported to make their own decisions where possible and that any decisions made on their behalf when they lack capacity are made in their best interests and least restrictive of their rights and freedoms.

Trust Response - All individuals involved in the implementation of this policy should do so in accordance with the Principles of the Mental Capacity Act 2005.

9. Links to Associated Documents

The Risk Management Framework is supported by the Trusts suite of policies as listed on the RDaSH website. There is a strong link to a range of policies including:

- Clinical Risk Assessment and Management
- Incident Reporting Policy
- Serious Incident Management Policy
- The Handling of Formal Complaints Policy
- Suite of Health & Safety policies
- Claims Management policy
- Standing Financial Instructions
- Information risk policy

10. References

The Orange Book - Management of risk – Principles and Concepts
https://assets.publishing.service.gov.uk/media/6453acadc33b460012f5e6b8/HMT_Orange_Book_May_2023.pdf

Appendix 1- Roles and Responsibilities

All Staff - are responsible for having a sense of ownership and commitment to:

- identifying and reporting risk.
- responding to and minimising risk.
- participating in training sessions.
- carrying out any agreed control measures and duties as instructed.

Line Managers – are responsible for the identification of risks and for implementing and monitoring any identified risk management control or assurance measures, within their designated area and scope of responsibility. Managers should also ensure that all staff are aware of risks within their workplace and provide adequate information, instruction and training to enable them to work safely.

Managers should seek advice on risk management issues, as required, and liaising with relevant specialist advisors where necessary.

Nominated Risk Owners - are responsible for the management of identified risks within the scope of their responsibility, ensuring that open risks are reviewed monthly, controlled risks are reviewed at least annually (high controlled risks at least quarterly) and maintained in a timely manner.

Project Managers – are responsible for the identification of all risks to a specific project, ensuring that they are recorded, regularly reviewed (at least monthly) and maintained in a timely manner.

Risk Register Owners - are responsible for:

- identifying, receiving, managing, monitoring, and reviewing relevant risks within the scope of their Directorate or Corporate team.
- undertaking regular 'horizon scanning' to identify risks by looking forward as part of the development of the Trust Risk Registers,
- ensuring effective escalation of any extreme risk to the relevant Executive lead.

Board of Directors is responsible for:

- taking the lead on the assessment and management of risk and take a strategic view of risks in our Trust.
- ensuring that roles and responsibilities for risk management are clear to support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation.
- determining and continuously assessing the nature and extent of the principal risks that our Trust is willing to take to achieve its objectives – its "risk appetite" – and ensure that planning and decision-making appropriately reflect this assessment.
- assuring itself of the effectiveness of the organisation's risk management framework.
- assessing compliance with the Corporate Governance Code and those explanations
- of any departures are recorded within the governance statement of the annual report and accounts.

Chief Executive as accounting officer is responsible for:

- ensuring that expected values and behaviours are communicated and embedded at all levels to support the appropriate risk culture.
- demonstrating leadership and articulate their continual commitment to and the value of risk management.
- ensuring that risk is considered as an integral part of appraising option choices, evaluating alternatives and making informed decisions.

Audit Committee is responsible for supporting the Board of Director in leading the assessment and management of risk through:

- Understanding our Trust's business strategy, operating environment and the associated risks, taking into account all key elements of the organisation.
- critically challenging and reviewing the risk management framework, to evaluate how well the arrangements are actively working in our Trust.
- critically challenging and reviewing the adequacy and effectiveness of control processes in responding to risks within our Trust's governance, operations, compliance and information systems.

Risk Management Group is responsible for

- ensuring that our Trust is actively identifying and documenting risks in all directorates of the organisation
- overseeing work to mitigate risks, supporting leaders to do so, where necessary by bringing together expertise across the group
- taking responsibility for resolving *cross-trust* risks that are thematic or escalating such concerns for resolution through the Clinical Leadership Executive (CLE) and/or within delivery reviews
- ensuring that the risk management framework is being implemented effectively and to advise CLE or the Audit Committee where this is not the case
- ensuring that risks to delivery of the strategy are reflected within the risk register or, where relevant, the Board Assurance Framework

Senior Information Risk Owner (SIRO) - The Director of Health Informatics fulfils the role and function of the SIRO and is accountable to the Chief Executive for the management of information risk.

Director of Corporate Assurance/Board Secretary is responsible for ensuring that all risk and assurance processes are devised, implemented and embedded throughout the Trust and for reporting of any significant issues arising from the implementation of the Framework including non-compliance or lack of effectiveness arising from the monitoring processes.

Corporate Assurance Manager - is responsible for the development, maintenance and monitoring of risk management processes particularly in relation to:

- Board Assurance Framework.
- extreme operational risks.
- electronic risk management system (Risk module within Safeguard).
- support to the risk owners with regards to the management of risk.

Appendix 2 – Monitoring Arrangements

Both operational and strategic risk is subject to continual review and monitoring by the relevant meeting structure and this is facilitated by the Corporate Assurance Team in producing reports as outlined below.

Strategic Risk Oversight

Board of Directors will receive reports on:

- All strategic risks within Board Assurance Framework for approval - as and when required.
- Any changes to the risk description and /or risk scoring for approval - as and when required.
- Oversight on progress of mitigation of all the strategic risks within Board Assurance Framework – 3 times a year.
- Extreme rated operational risks – as when identified.

Board Committees will receive reports on:

- Oversight on progress of mitigation of the strategic risks within Board Assurance Framework as assigned to the applicable Committee(s) – 3 times a year.
- Any changes to the risk description and /or risk scoring to provide comment and recommend approval - as and when required.

Systems of Internal Control Oversight

Audit Committee will receive reports on:

- An overview of risk management which outlines the process for managing and monitoring risk and provides assurance on achievement to date - each meeting.

Operational Risk Oversight

Clinical Leadership Executive will receive reports on:

- Outbrief from the Risk Management Group summarising decision and any areas of escalation.
- Extreme rated risks – as and when identified

Risk Management Group will receive reports on:

- Longstanding risks – on a rolling programme basis
- Thematic reviews – on a rolling programme basis
- Cross Trust risks – on an as and when basis
- Escalating risks – on an as and when basis
- Compliance data – on a rolling programme basis

Delivery Review meetings will receive reports on based on the applicable risk register:

- Current state of risks – each meeting
- Top 3 risks – each meeting

Care Group Business meetings will**:**

- have oversight of the Care Group risks – at each meeting.

Risk Owners will:

- monitor and review all live risks on a monthly basis.
- monitor and review all tolerated risks at least quarterly (high risks) /annually (moderate and low risks).
- escalate any risks deemed to be extreme to the Risk Management Group for moderation and approval.
- escalate any risks that require further support and guidance to the Risk Management Group.

Appendix 3 – Prompts for identifying risk

Strategy – Risks arising from identifying and pursuing a strategy, which is poorly defined, is based on flawed or inaccurate data or fails to support the delivery of commitments, plans or objectives due to a changing macro-environment (e.g. political, economic, social, technological, environment and legislative change).

Governance – Risks arising from unclear plans, priorities, authorities and accountabilities, and/or ineffective or disproportionate oversight of decision-making and/or performance.

Operations– Risks arising from inadequate, poorly designed or ineffective/ inefficient internal processes that could result in fraud, error, impaired customer service (quality and/or quantity of service), non-compliance and/or poor value for money.

Clinical – Risks arising from inadequate, poorly designed or ineffective/ inefficient internal clinical processes that could result in non-compliance and/or harm and suffering to employees, contractors, service users or the public.

Legal – Risks arising from a defective transaction, potential claim or some other legal event occurring that may result in a liability or other loss, or a failure to take appropriate measures to meet legal or regulatory requirements or to protect assets (for example, intellectual property).

Property – Risks arising from property deficiencies or poorly designed or ineffective/ inefficient safety management resulting in non-compliance and/or harm and suffering to employees, contractors, service users or the public.

Financial – Risks arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting.

Commercial – Risks arising from weaknesses in the management of commercial partnerships, supply chains and contractual requirements, resulting in poor performance, inefficiency, poor value for money, fraud, and/or failure to meet business requirements/objectives.

People – Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, the unavailability of sufficient capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance.

Technology – Risks arising from technology not delivering the expected services due to inadequate or deficient system/ process development and performance or inadequate resilience.

Information – Risks arising from a failure to produce robust, suitable and appropriate data/ information and to exploit data/information to its full potential.

Security – Risks arising from a failure to prevent unauthorised and/or inappropriate access to the estate and information, including cyber security and non-compliance with General Data Protection Regulation requirements.

Reputational – Risks arising from adverse events, including ethical violations, a lack of sustainability, systemic or repeated failures or poor quality or a lack of innovation, leading to damages to reputation and or destruction of trust and relations.

Environmental – Risks arising from changing macro-environment (for example political, economic, social, technological, environment and legislative change).

Project/Programme – Risks that change programmes and projects are not aligned with strategic priorities and do not successfully and safely deliver requirements and intended benefits to time, cost and quality.

Appendix 4 – Risk Scoring Methodology

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Impact score	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis
Service / business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Impact score	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Information Governance/ Confidentiality / Information security	Minor breach of confidentiality. Less than 5 people affected or risk assessed as low e.g. media interest unlikely, small number of encrypted files.	Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious actual breach of confidentiality affecting up to 100 people, media interest and damage to reputation possible. Reportable as an SI if encrypted	Serious actual breach of confidentiality involving particularly sensitive records (e.g. sexual health or child protection) affecting up to 1000 people. Media interest and damage to reputation Reportable as an SI	Serious actual breach of confidentiality involving over 1000 individuals. Damage to reputation, national media coverage, potential for litigation or prosecution of Trust under Data Protection Act. Reportable as an SI and Information Commissioner
Objectives / Project	Barely noticeable reduction in scope/ schedule Insignificant cost increase /schedule slippage	Minor reduction in scope / quality/ schedule <5 per cent over project budget. Schedule slippage	Reduction in scope or quality, project objectives or schedule 5-10 per cent over project budget. Schedule slippage	Non-compliance with national project 10-25 per cent over project budget Schedule slippage Key objective not met	Incident leading to significant inability to meet project objectives, reputation of the organisation seriously damaged >25 per cent over project budget. Schedule slippage Key objectives not met
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability	**0- 5%** Extremely unlikely or virtually impossible	**6 – 20%** Low but not impossible	**21 – 50%** Fairly Likely to occur	**51 – 80%** More likely to occur than not	**81 – 100%** Almost certainly will occur

Impact Score	Likelihood Score				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5.Catastrophic	**5**	**10**	**15**	**20**	**25**
4. Major	**4**	**8**	**12**	**16**	**20**
3. Moderate	**3**	**6**	**9**	**12**	**15**
2. Minor	**2**	**4**	**6**	**8**	**10**
1.Negligible	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

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

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the impact score(s) (I) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: I (impact) x L (likelihood) = RS (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 5 – Risk Form

Date Identified	Click here to enter a date.	**Source**	Choose an item.
Rationale/Background			
Risk Description			
Accountable Director	Choose an item.	**Risk lead**	
Care Group/ Directorate/Project Log	Choose an item.	**Mitigation managed**	Choose an item.
Monitoring Committee			
Controls (in place)			
Current Impact Score	Choose an item.	**Current Likelihood Score**	Choose an item.
Actions to be taken	**1.**	**Target Date for completion**	Click here to enter a date.
	2.		Click here to enter a date.
	3.		Click here to enter a date.
	4.		Click here to enter a date.
Risk Treatment	Choose an item.		
Target Impact Score	Choose an item.	**Target Likelihood Score**	Choose an item.
Update (optional)			

BOARD ASSURANCE FRAMEWORK SUMMARY

Dec-23

Ref	Executive Owner	Strategic Risk	Oversight Committee	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Current	Target Score	Appetite Gap
1	Director of People & Organisational Development	If the Trust fails to recruit and retain skilled staff for groups where there are shortages then this will impact on the delivery of safe services for our patients.	People and Organisational Development Committee	16	16	12	12	12	12	12	12	12	12	12	12	12	12	12	8	4
2	Director of People & Organisational Development	If the Trust does not have quality leadership to embed compassionate care and a high performing culture then the right care will not be delivered.	People and Organisational Development Committee	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	8	4
3	Director of Finance	If the Trust does not achieve the planned budgeted deficit in year and does not return to a budgeted break-even position over the longer term, then it will impact on the long-term sustainability of the Trust and its ability to deliver services.	Finance Performance and Informatics Committee	12	12	12	12	12	12	12	12	16	16	16	16	12	12	12	6	6
4	Director of Strategy	If we do not work in partnership at System and Place then the Trust will fail to meet its duty to collaborate and or deliver integrated care for the benefit of our communities.	Board of Directors			9	9	9	9	9	9	9	9	9	9	9	9	9	6	3
5	Director of Nursing & Allied Health Professions	If the Trust does not develop, approve and deliver the Clinical Strategy, then this may impact on patient safety, patient experience, clinical effectiveness and regulatory compliance.	Quality Committee	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	8	4
6	Director of Corporate Assurance / Board Secretary	If we do not have a robust governance process in place then this may lead to the Trust being ineffective, inefficient and compromise the well-led status of the organisation.	Board of Directors	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	8	4
7	Chief Operating Officer	If a significant destabilising event occurs then the delivery of services, financial performance and wellbeing of staff may be impacted	Quality Committee	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	0
																			Total Gap Appetite	**25**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Preparedness Briefing Caring Domain	**Agenda Item**	Paper L
Sponsoring Executive	Sheila Lloyd Executive Director of Nursing and AHP/ Deputy Chief Executive		
Report Author	Kate McCandlish Deputy Director of Nursing Maureen Green Director of Quality, Safety and Improvement		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

This paper is the third in a series of four, creating space to discuss CQC compliance. The paper outlines the Caring domain to include recommended improvements to work towards achieving an outstanding rating. The Board should consider the following:

- A discussion about the Caring domain to include patient, carer, experience and involvement and the alignment to the good governance identified in the organisation's new operating model.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2. Create equity of access, employment and experience to address differences in outcome.	x
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
SO5. Help delivery social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

CQC Preparedness - July 2023 - Followed by a series of CQC preparedness briefings: Safe Domain September 2023 and Responsive Domain November 23

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**RECEIVE** the latest CQC preparedness paper in a series to Board
x	**CONSIDER** as a Board the questions / discussion points above; and explore and focus on the eight areas for improvement identified in this SBAR that support our strategy, plans and 28 promises to the communities we serve.
x	**AGREE** as a Board the approach taken to date

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register	x	
Board Assurance Framework	x	SR5 Standards of Care
System / Place impact	x	Working with partners, equity and Inclusion, access, experience, outcomes, person centred care.

Equality Impact Assessment	Is this required?	Y	x			If 'Y' date completed	To be completed by end Jan 2024
Quality Impact Assessment	Is this required?	Y	x			If 'Y' date completed	To be completed by end Jan 2024

Appendix (please list)

None.

CQC Readiness: Are we CARING?

Situation

This paper presents the third in a series of self-assessments/ reviews, based on the key lines of enquiry (KLOE) from the regulator, the Care Quality Commission (CQC).

The Trust was rated as Good for CARING in 2019.

Starting initially with SAFE and then Responsive, this third briefing paper identifies the regulator definition of **CARING** and assesses RDaSH status and provides some examples of what this means for RDaSH.

This paper presents the current position and uses a comparator Trust to provide a list of suggestions for the board.

"What does the CQC mean by caring?"

By "caring", the CQC mean that the service involves and treats people with compassion, kindness, dignity and respect.

"What is the ambition?"

RDaSH has expressly stated its ambition to be rated as outstanding for caring going forward.

Background

Regulatory Framework and what constitutes CARING?

Do staff involve and treat people with compassion, kindness, dignity and respect? Is the culture of the organisation a caring one?

Characteristics of services that the CQC would rate as outstanding within CARING are that People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

For CARING, regulation 9,10,12,15,16, 17 and 18 are all applied – but caring and its evidence does not sit solely under any one of these regulations, but rather that the CQC collates evidence under all of these.
Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 12: Safe care and treatment
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 18: Staffing

If we look deeper, the focus are 2 regulations:

CQC would look for evidence under the **regulation 9** that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that RDaSH must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

The intention of **regulation 10** is to make sure that people using the service are always treated with respect and dignity while they are receiving care and treatment. To meet this regulation, RDaSH must make sure that they provide care and treatment in a way that ensures people's dignity and always treats them with respect. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local community. RDaSH must have due regard to the protected characteristics as defined in the Equality Act 2010.

The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. RDaSH must continually evaluate and seek to improve their governance and auditing practice.
As part of our governance, we must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement.

Assessment

1. Benchmarking with a Comparator Trust, sharing and learning from colleagues.

https://www.cqc.org.uk/provider/RWK/inspection-summary#mhpsychintensive
East London NHS Foundation Trust (ELFT)

Several comments in the CQC Report for ELFT are learning for RDaSH, for example:

- The staff were all very aware of the diverse needs of the patients and were able to meet each person's individual needs.
- Patients were involved in many creative ways in their care. We saw evidence of this in care planning and meetings which were in place to ensure that the patient voice was heard. An example of this were patient led audits which had led to improvements in food and how ward rounds were conducted.
- Patients and family members told us that they received good quality and compassionate care on the wards we visited, and this was reflected in observations we carried out on the wards. The care reflected the vision and values of the trust.
- Staff treated young people and their families as partners in their care. They understood the importance of being kind and respectful. There was genuine empathy and understanding of individual needs and wishes, which was reflected in the work undertaken with young people and their families.

2. CQC suggested, risk examples vs RDaSH examples that show we are GOOD for CARING.

CQC CARING domain	RDaSH, QC, POD, CQC meetings, Mental Health Act (MHA) meetings
Kindness, compassion and dignity - We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.	• Staff Survey- 2022 data, 2023 data • Complaints, compliments • Care plans – personalization could be improved but is overall good. • MHA unannounced visits • Peer Review • Audits – part of clinical audit cycle • Friends and Family Test
Treating people as individuals - We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.	• Consent – throughout care plans- current internal audit taking place (360) • MHA reviews • Peer reviews • Protected characteristics information
Independence, choice and control - We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.	• Audit – personalisation and documentation • MHA audits – unannounced visits and results • Care plans • Consent
Responding to people's immediate needs - We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.	• Patient surveys • Staff surveys • Complaints • Unannounced MHA visits • Peer reviews • Staffing establishment data and roster compliance
Workforce wellbeing and enablement - We care about and promote the wellbeing of our staff and we support and enable them to always deliver person centred care.	• Health and well-being feedback • Recruitment and retention feedback • Induction policy • Staff Survey • Supervision data, PDR • Restorative Supervision- could be fully expanded. • Freedom to Speak Up information. • Career framework • Pastoral Care offer for international colleagues

Assessment: We are caring. Our current position = GOOD.

In summary, the ways we monitor caring show that our staff are proud to work for RDaSH, often go above and beyond and provide kind, patient centred care. Examples of evidence to support his include:

- CQC Mental Health Act feedback – the voice of the patient
- CQC feedback at formal and informal meetings, at least quarterly.
- Feedback on themes from the peer review programme.
- Patient feedback via PALS, Your Opinion Counts, Friends and Family Test, surveys, individual and team feedback.
- Talking to patients and staff: informal walk rounds, peer reviews with board members and the 15 -step challenge.
- Intelligence from visible leaders such as team leads, ward leaders, matrons, safeguarding leads, infection control colleagues, suggest our teams are proud to work for RDaSH and recommend the Trust to others.

Recommendations

For RDaSH to be Outstanding within the CARING domain, the recommendation is to explore and focus on the eight areas for improvement that support our strategy, plans and 28 promises to the communities we serve:

1. Staff are well versed and confident to share across the system their local work with carers and families and how they tailor patient care to individuals. As we know there is already great examples of outstanding caring, the improvement will be consistency across services and system.

2. Improve ways the Trust receives feedback from patients and carers to meet their needs. For example, people with Learning Disabilities, plain English and easy read pictorial information, easy access to carer support and full coverage of advocacy services consistently across services. RDaSH promises and operating framework enable this improvement.

3. Provide more meaningful Involvement of patients/citizens in strategic plans, promises and working groups delivering deeper co production to improve and learn. Explore interactive digital platforms with patients, partners and carers.

4. Consistent evidence that services are planned and organised with people and communities in a way that improves their experience across their care journeys. The recent work undertaken by clinical leaders, on the safe and therapeutic bed base, (that includes access when needed and discharge back to the community when ready), provides the foundations for a stronger system patient journey of care.

5. Reduce out of area placements (care closer to home despite significant pressure) linked to the work above.

6. Provide more consistently available evidence that people are supported to make choices that balance risks of harm with positive choices about their lives and

promoting the best possible health outcomes. This should be reflected in MDT notes, care planning and the way teams are able to talk about how they care.

7. Observations and discussions with staff show kindness, care, positive regard, therapeutic activity and close team working. To maintain this, it could be discussed and reported as positive events or always events.

8. Benchmark with other to share, learn and improve.

Kate McCandlish, Deputy Director of Nursing
Maureen Green, Director of Quality, Safety and Improvement

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operating Model and new ways of working	**Agenda Item**	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Phil Gowland, Director of Corporate Assurance / Board Secretary		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

The paper is the latest, and final, version of terms of reference to support the Operating Model agreed by the Board in September: in November we agreed Board TOR/scheme of delegation. Attached is the full suite of Board committees, and the updated SFIs to achieve consistency in 24/25 with agreed delegatory arrangements.

In preparation, Board members have received a reconciliation to existing terms of reference and had the opportunity to provide comments over the past 10-17 days – those received have been considered by the author, chair and Chief Executive. ***Any further comments are requested in advance of the meeting of the Board.*** Necessarily the terms of reference need to be consistent across the meetings, and we have sought to avoid bespoking.

New terms of reference also reflect the changes made to ensure consistency of focus at Committee on four key areas (delivery of associated plans; statutory responsibilities; partnering; and specific areas of delivery concern) but also the change to the focus of Audit Committee (broader governance and audit scope) and the Mental Health Act Committee (focus solely on legal compliance with the current MH Act (and readiness for any new regime), with MCA managed via QC).

The Trust continues to be supported in implementing the new Operating Model by Good Governance Improvement (GGI). GGI is formulating an evaluative process that will report back to the Board in March 2024, and then again later in the year. All Board members have been involved with GGI in the development of the evaluation process, which will reflect not only peer comparators but the ambitions and concerns of members of the Board.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2. Create equity of access, employment and experience to address differences in outcome.	x
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual	x

Previous consideration

Board of Directors meeting – September 2023 and November 2023

Recommendation

The Board of Directors is asked to:

X	**RECEIVE** and **NOTE** the continued progress with the implementation of the Operating Model and the proposed evaluation process.

X	**APPROVE** the updated and revised Terms of Reference for the Board of Directors' Committees.							
X	**APPROVE** the Standing Financial Instructions (SFI)							
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register	x	CA 4/23						
Board Assurance Framework	x	SR6 Governance						
System / Place impact								
Equality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Appendix (please list)								
Appendix A – Board of Directors Committees Terms of Reference: • Finance, Digital and Estates Committee (FDE) • Quality Committee (QC) • People and Organisational Development Committee (POD) • Audit Committee (AC) • Mental Health Act Committee (MHA) • Public Health, Patient Involvement and Partnerships Committee (PHPIP) • Charitable Funds Committee (CFC) Appendix B – Plans and Promises Appendix C – Standing Financial Instructions (SFI)								

Operating Model and new ways of working
January 2024

This paper is about our agreed Operating Model. It outlines implementation steps taken since the last update in November 2023 and describes further steps to complete Board implementation by March 2024. It also describes the evaluative model that it is proposed will be applied.

The chair may choose to take this item in the private meeting to preserve time for other matters in public, however the paper themselves are rightly visible to local people.

1. Terms of Reference

As previously noted in the paper to Board in November a review of all Board Committee Terms of reference has been undertaken to support the strategy and operating model. In particular, revised approaches to committees of the Board reflects the newly established management committees and confirms that Board committees do not have accountability for a domain of work, but responsibility for assurance on progress with specific aspects of that work – notably its impact and delivery of the strategy. In practice this means a unitary committee focused on four roles:

- statutory compliance,
- plan delivery,
- partnership duties and
- matters delegated by the Board.

The last bullet is addressed in scope of work and may be augmented over a given year by the Board itself. What would be rare would be the addition of additional elements at the direction solely of the committee, absent confirmation that such additions are not being dealt with elsewhere in the structure.

The circulated terms of reference from December have been considered by individuals, and in some cases explored within committees themselves. However, consistent with the Board's recently renewed terms of reference/scheme of delegation it is for the Board to set its committees terms – rather than for committees themselves. This is to ensure no duplication, among other purposes.

Where comments have been received from Board members on the new draft terms of reference, they have been accommodated within what is attached. The schedule of promises and plans is also appended for ease.

A handful of comments made have not been accommodated in specific TOR but are addressed as follows:

- Physical health and wellbeing of our patients will be integral part of the Quality and Safety Plan, is part of our Equally Well work, and is fundamental to objective 3 of the strategy: it is not therefore a distinct item nor responsibility of a given committee.

- Facilities services are a core part of care delivery, and any issues with cleaning or catering, will form part of the work of CLE and the Board. In so far as they bear on the four responsibilities of the Quality Committee, they would arise there, in the same way they may in POD or finance or PIPHP.

- Estate is covered by the FDE committee and is not separately delineated in the quality committee.

- There is a well-established and straightforward distinction in our committee work between the individual feedback and experiences of patients, covered through QC, and the involvement of our community, carers and the public, which will covered within PIPHP – with promise 5 itself being held through the Board and CLE.

The revised terms of reference for the following Committees are therefore appended to this paper and presented for approval by the Board of Directors:

- Finance, Digital and Estates Committee (FDE)
- Quality Committee (QC)
- People and Organisational Development Committee (POD)
- Audit Committee (AC)
- Mental Health Act Committee (MHA)
- Public Health, Patient Involvement and Partnerships Committee (PHPIP)
- Charitable Funds Committee (CFC)

The Board approved PHPIP TOR at its last meeting. What is appended here requires re-approval given the introduction of a scope of work section, and to acknowledge consistency with other committees.

2. Standing Financial Instructions

The Standing Financial Instructions (SFI) provide clarity over a range of roles and responsibilities in respect of the financial governance of the Trust.

The Board will recall in November 2023, it received and approved the updated Reservations of Powers / Scheme of Delegation, to which the SFIs sit as a complementary document and as such have also now been reviewed and updated to reflect any changes in titles / positions or governance architecture; and to ensure, where appropriate, consistency with the recently approved Reservations of Powers/Scheme of Delegation.

If any members requires detailed review of the SFIs they are encouraged to contact Ian Currell prior to the Board's meeting.

3. Evaluation

After public procurement Good Governance Improvement (GGI) were appointed to assist with our transition process. They have been working alongside the Trust since

late Q2 2023/24. A key aspect of their work will be on an evaluation of the changes that have been made to the operating model and governance structures.

The primary objective in designing an evaluative framework for the board is to ensure that it supports the delivery of the objectives set out in the new strategy, whilst at the same time remaining compliant with the expectations of regulators, particularly in relation to the CQC well-led domain.

To achieve this, the proposed evaluative framework will be used to assess progress in the short (spring 2024) and medium (late 2024) terms. This will enable the board to assess initial implementation and make necessary adjustments as the new operating model is embedded across the trust. The proposed framework comprises three elements:

1. Compliance

To ensure that the change process is CQC compliant, GGI will assess progress against a series of criteria including:

- Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?
- Are there clear responsibilities, roles and systems of accountability to support good governance and management?
- Are there clear and effective processes for managing risks, issues and performance?
- Is appropriate and accurate information being effectively processed, challenged and acted upon?
- Are there robust systems and processes for learning, continuous improvement and innovation?

2. Ambitions

To ensure the change process is delivering the objectives set out in the new strategy, a series of hour long discussions between GGI and both executive and non-executive board members was scheduled and is now nearing completion. These discussions have explored a number of themes including:

- A general overview of the current environment
- Ambitions for the new strategy over the course of the next twelve months, including outcomes and impact for both service users and the organisation framed around the premise of what good looks like.
- An assessment of likely barriers to change, including potential challenges emerging from both within the trust and the environment it operates in.
- Alignment with the broader system, including the ICBs, along with the three councils, manifold VCSE and many other organisations that RDaSH works with.
- The capacity of the trust to deliver the ambitions, the areas of potential weakness and the culture shift required to deliver.
- An assessment of risks.

3. Efficiency and Effectiveness

Based on their own ‘Making Meetings Matter’ methodology, GGI propose to undertake an evaluation of the new arrangements through an assessment of the written materials produced as part of the new operating model, as well as a series of meeting observations to assess how these are working.

This is a developmental process designed to identify areas for improvement and provide insight that can enable positive habits to be embedded alongside more effective processes.

GGI plan to conduct this evaluation in March 2024 in order that it can be fed into the overall assurance assessment in the spring and to contribute to the Chief Executive’s Annual Governance Statement (AGS) that features in the Trust’s Annual Report.

Reflections to date from Board members:

As noted, the discussions with Board members are nearing completion and the meetings to date have produced a great deal of valuable insight into the challenges and opportunities created by the strategy implementation. Several common themes are emerging, which should help the board maintain effective oversight over the coming months. They are shared below for openness and transparency.

a. ***Recognition***: there is a widespread recognition that change in both mechanics and dynamics was necessary – not that everything in the past was bad, indeed prior good practice must be carried forward – but strategic and financial challenges ahead mean change is necessary.

b. ***Landed well***: people are talking about and thinking about the strategy, it has broad currency across the trust, which must be maintained and developed.

c. **A focus on change**: exploiting the benefits of the strategy and the new operating model will not happen automatically, the supporting change programme will be a critical element of sustained success.

d. ***Distributed ownership***: inevitably. the chief executive has been a primary driver of this change and is closely associated with it. Ultimate success depends on a wide ownership, and it will be important that individuals play their part in stepping in to lead key elements of delivery.

e. ***Integration:*** ‘The job is delivering the strategy and delivering the strategy is the job’ – there is a sense that these are two separate entities still, further work will need to focus on integration.

f. ***Distinctiveness:*** there is a definite pride in the strategy, it is not only bold but tangible and garners identity within the trust.

Rotherham Doncaster and South Humber NHS Foundation Trust

FINANCE, DIGITAL AND ESTATES COMMITTEE

TERMS OF REFERENCE

The Committee is established by the Board to provide oversight of the organisation's financial integrity and appropriate use of resources, including its capital management and estate; and to oversee the future understanding and implementation of emerging digital developments.

Purpose:

- To assess delivery of the Finance Plan; Estates Plan; and Digital Plan that support the Trust's Clinical and Operational Strategy.

- To accept delegated responsibility from the Board of Directors for specific areas of delivery concern, with routine focus on items contained within the IQPR and associated finance report.

- To assure the Board of Directors on the Trust's compliance with related statutory responsibilities and requirements.

- To ensure that the Trust is operating as an effective partner including within both related Integrated Care Boards.

Ways of Working:

The Committee is a unitary body of up to seven members, asked by the Board to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

The parameters of the Finance Plan; Estate Plan; and Digital Plan and the financial performance data will be the principal focus of the Committee's work.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work

1. Ensure that the Trust is demonstrating compliance with the following identified statutory requirements:
    - Digital – Public Records Act 1958; Data Protection Act 2018; General Data Protection Regulation 2016 (GDPR); Freedom of Information Act 2000 (FOIA)
    - Estate - Health and Safety at Work Act 1974

2. Ensure that relevant regulatory reports that require Board approval are received, reviewed and submitted in a timely manner:
    - Data Security and Protection Toolkit

3. Actively consider and monitor the sufficiency and impact of management work to partner effectively at place and system in the delivery of other's plans, and success of our own.

4. Receive the IQPR and by exception, for measures from within the finance domain, where there is greater than 1 standard deviation from plan, assess the creation and delivery of improvement actions.

5. Monitor the delivery of the Finance Plan. This will include understanding the impact of delivery on the ability to build capacity, deliver other plans and promises and the impact on and from the financial performance of partners at place and across the wider system.

6. Monitor the delivery of the Estates Plan. This will include understanding and considering the utilization of the retained and leased estate and the efficiency of delivery of services from said premises, with consideration for partnership working where appropriate.

7. Monitor the delivery of the Digital Plan. This will include examining the timeliness and effectiveness of digital developments and the impact on the time to care and efficiency of service delivery, with consideration for the comparative success in relation to peers.

8. Seek and consider how the Trust demonstrates that it as an effective approach to procuring services, that delivers value for money and benefits to patients, whilst acting as a good partner and supplier.

9. Review the processes / frameworks in place that enable an appropriate self-assessment of value for money and consider any other independent assessment of same.

10. Review significant Business Cases. For those valued between £500k and £1.25m provide approval; for those in excess of £1.25m make recommendation to the Board of Directors).

11. Ensure that there are appropriate mechanisms in place in relation to improving data quality.

12. Annually review the Trust's Standing Financial Instructions / Schemes of Delegation on behalf of the Board of Directors, as appropriate, ensuring they are relevant and up to date and making any appropriate recommendations to the Board of Directors.

13. Seek, monitor, review and consider assurance on the risk, control and governance processes identified in the Board Assurance Framework that are delegated to the Committee by the Board of Directors, providing reports to the Board of Directors and Audit Committee as requested.

14. Contribute to the development of the Annual Internal Audit Plan; receive and consider the related final reports; and seek, receive and confirm that management response to audit recommendations are completed in line with the agreed action plans.

Membership:
Pauline Vickers, Non-Executive Director – Chair of the Committee
Sarah Fulton Tindall, Non-Executive Director
Justin Shannahan, Non-Executive Director
Ian Currell, Executive Director of Finance
Nicola McIntosh, Executive Director of People and OD
Richard Chillery, Executive Chief Operating Officer
Richard Banks, Director of Health Informatics

Two nominated members of the Council of Governors will attend as full members to ensure that our patients' voices are fully considered in the work of the Committee.

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee such that they can introduce and address key recommendations within papers.

Quorum:
The meeting will be quorate with 4 members inc at least two Non-Executive Directors.

Frequency:
The Committee will meet on a bi-monthly basis on the second Wednesday of a month in line with the corporate calendar.

Standing agenda items:
1. Welcomes, introduction, apologies, declarations of interest and quoracy.
2. Minutes of previous meeting and matters arising.
3. Current state performance against the finance domain of the IQPR.
4. Anticipated delivery of the forthcoming quarter's work to achieve the Finance Plan, Estates Plan and Digital Plan.
5. Significant areas of concern or non-compliance at Trust level.
6. Areas of good and best practice to explore with reference to wider application.
7. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and CLE.

IN: The Committee may receive a precis of information from the Clinical Leadership Executive and its supporting groups, in this case notably the Finance; Estate and Sustainability; and Digital groups, and consider the relevant sections of the IQPR

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting.

OUT: Where necessary the Committee will refer escalated matters to the Chief Executive; to the Audit Committee; or to the Chair of the Trust.

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (IC) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its workplan and efforts to improve Trust compliance consistently.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

Rotherham Doncaster and South Humber NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

The Committee is established by the Board to assess the underlying safety and quality of clinical care offered throughout the organisation. The management of the Trust, through care groups and cross organisational committees is responsible for delivery of care at or better than a level viewed as good by the Trust's regulator.

Purpose:

- To assess delivery of the Quality and Safety Plan that supports the Trust's Clinical and Operational Strategy.
- To accept delegated responsibility from the Board of Directors for specific areas of delivery concern, with a routine focus on items contained within the IQPR.
- To assure the Board of Directors on the Trust's compliance with related statutory responsibilities and requirements.
- To ensure that the Trust is operating as an effective partner including within both related Integrated Care Boards

Mental Health Act compliance is assessed via a distinct committee. Other legislative compliance, including the Mental Capacity Act, is within the QC remit.

Ways of working:

The Committee is a unitary body of up to nine members, asked by the Board to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

The parameters of the Quality and Safety Plan and safety/performance data presented within the IQPR will be the principal focus of the Committee's work.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work:

1. Ensure that the Trust is demonstrating compliance with the following identified statutory requirements:
    - Quality Report; The NHS (Quality Accounts) Regulations 2010
    - H&S Act 1974 / Health and Social Care Act 2008: Code of Practice (IPC) / COSHH Regulations 2002;
    - Accountable Officer for Controlled Drugs (The Controlled Drugs (Supervision of

Management and Use) Regulations 2013)
- EPRR, (The Civil Contingencies Act (2004))
- Regulation 28 (The Coroners and Justice Act 2009)
- Mental Capacity Act
- Eliminating Mixed Sex Accommodation

2. Ensure that relevant regulatory reports that require Board approval are received, reviewed and submitted in a timely manner:
    - Resuscitation
    - Complaints and Parliamentary and Health Service Ombudsman
    - Medicines Management
    - Safe Staffing
    - Safeguarding
    - Mortality
    - Infection, Prevention and Control

3. Actively consider and monitor the sufficiency and impact of management work to partner effectively at place and system in the delivery of other's plans, and success of our own.

4. Receive the IQPR and by exception, for measures from within the quality and performance domains, where there is greater than 1 standard deviation from plan, assess the creation and delivery of improvement actions.

5. Monitor the delivery of the Quality and Safety Plan. This will include:

    - Understanding and considering the sufficiency of arrangements to execute the safety plan in all areas of the Trust, and certainly by directorate
    - Examining the timeliness and effectiveness of improvement work described within the quality plan and the comparative success of the Trust in relation to peers

6. Ensure that robust processes are in place for widespread and embedded learning from adverse events and incidents and from the experiences of those that use the Trust's services.

7. Assess compliance with clinical standards and guidelines, including, but not limited to, NICE guidance.

8. Ensure the process for the management of medical devices is working well.

9. Promote the importance and requirement for quality and safety impact assessments (QSIA) and ensure that they are being completed in a timely and thorough manner.

10. Seek, monitor, review and consider assurance on the risk, control and governance processes identified in the Board Assurance Framework that are delegated to the Committee by the Board of Directors, providing reports to the Board of Directors and Audit Committee as requested. The Committee may choose to refer matters to the Audit Committee for follow up.

11. Contribute to the development of the Annual Internal Audit Plan and Clinical Audit Plan; receive and consider the related final reports; and seek, receive and confirm that management responses to audit recommendations are completed in line with the agreed action plans.

Membership:

Dawn Leese, Non-Executive Director – Chair of the Committee
Prof Janusz Jankowski, Non-Executive Director
Dave Vallance, Non-Executive Director
TBA, Non-Executive Director
Sheila Lloyd, Chief Nursing Officer
Dr Graeme Tosh, Executive Medical Director
Richard Chillery, Executive Chief Operating Officer
Richard Banks, Director of Health Informatics
Dr Jude Graham, Director of Therapies

Two nominated members of the Council of Governors will attend as full members to ensure that our patients' voices are fully considered in the work of the Committee.

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee such that they can introduce and address key recommendations within papers.

Quorum:
The meeting will be quorate with 4 members including at least two non-executive directors.

Frequency:
The Committee will meet on a bi-monthly basis on the second Wednesday of a month in line with the corporate calendar.

Standing agenda items:

1. Welcomes, introduction, apologies, declarations of interest and quoracy.
2. Minutes of previous meeting and matters arising.
3. Current state performance against the quality and performance domains of the IQPR.
4. Anticipated delivery of the forthcoming quarter's work to achieve the Quality and Safety Plan.
5. Significant areas of concern or non-compliance at Trust level.
6. Areas of good and best practice to explore with reference to wider application.
7. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and CLE.

IN: The Committee may receive a precis of information from the Clinical Leadership Executive and its supporting groups, in this case notably the Quality and Safety Group, and consider the relevant sections of the IQPR

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting.

OUT: Where necessary the Committee will refer escalated matters to the Chief Executive; to the Audit Committee; or to the Chair of the Trust.

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (SL) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its workplan and efforts to improve Trust compliance consistently.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

Rotherham Doncaster and South Humber NHS Foundation Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

The Committee is established by the Board to oversee that the Trust has adequate and engaged people with the necessary skills and competencies to meet the future needs of patients and service users and to deliver against the strategic objectives within the Trust's Clinical and Operational Strategy.

Purpose:

- To assess delivery of the People Plan and the Learning and Education Plan that supports the Trust's Clinical and Operational Strategy.

- To accept delegated responsibility from the Board of Directors for specific areas of delivery concern, with a routine focus on items contained within the IQPR.

- To assure the Board of Directors on the Trust's compliance with related statutory responsibilities and requirements.

- To ensure that the Trust is operating as an effective partner including within both related Integrated Care Boards.

Ways of working:

The Committee is a unitary body of up to eight members, asked by the Board to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

The parameters of the People Plan; and Learning and Education Plan; and people data presented within the IQPR, will be the principal focus of the Committee's work.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work:

1. Ensure that the Trust is demonstrating compliance with the following identified statutory requirements:
    - Public Sector Equality Duty (Equality Act 2010)
    - Gender pay gap (Equality Act 2010)

2. Ensure that relevant regulatory reports that require Board approval are received, reviewed and submitted in a timely manner:
    - Work Race Equality Standard (WRES) NHS England mandated
    - Work Disability Equality Standard (WDES) NHS England mandated
    - Freedom to Speak Up
    - Guardian of Safe Working Hours
    - Medical Revalidation
    - RIDDOR

3. Actively consider and monitor the sufficiency and impact of management work to partner effectively at place and system in the delivery of other's plans, and success of our own.

4. Receive the IQPR and by exception, for measures from within the people domain, where there is greater than 1 standard deviation from plan, assess the creation and delivery of improvement actions.

5. Monitor the delivery of the People Plan. This will include the success in employing the right people, that fully represent the communities we serve, with the right skills in the right place to deliver care, supported through an increased volunteer base; and through those people to deliver care to the values and standards set out in the plans.

6. Monitor the delivery of the Learning and Education Plan. This will include understanding and considering the extent to which all areas (directorates, teams and individuals) benefit from the support and opportunities presented in and delivered through the plan.

7. Seek, monitor, review and consider assurance on the risk, control and governance processes identified in the Board Assurance Framework that are delegated to the Committee by the Board of Directors, providing reports to the Board of Directors and Audit Committee as requested.

8. Contribute to the development of the Annual Internal Audit Plan; Receive and consider the related final reports; and seek, receive and confirm that management responses to audit recommendations are completed in line with the agreed action plans.

Membership:
Dave Vallance, Non-Executive Director – Chair of the Committee
Pauline Vickers, Non-Executive Director
Sarah Fulton Tindall, Non-Executive Director
Lea Fountain, NExT Director
Nicola McIntosh, Executive Director of People and OD
Richard Chillery, Executive Chief Operating Officer
Sheila Lloyd, Chief Nurse / Deputy CEO
Dr Jude Graham, Director of Therapies

Two nominated members of the Council of Governors will attend as full members to ensure that our patients' voices are fully considered in the work of the Committee.

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee such that they can introduce and address key recommendations within papers.

Quorum:
The meeting will be quorate with 4 members, including at least 2 Non-Executive Directors.

Frequency:

The Committee will meet on a bi-monthly basis on the second Wednesday of a month in line with the corporate calendar.

Standing agenda items:

1. Welcomes, introduction, apologies, declarations of interest and quoracy.
2. Minutes of previous meeting and matters arising.
3. Current state performance against the people domain of the IQPR.
4. Anticipated delivery of the forthcoming quarter's work to achieve the People Plan and Learning and Education Plan.
5. Significant areas of concern or non-compliance at Trust level.
6. Areas of good and best practice to explore with reference to wider application.
7. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and CLE.

IN: The Committee may receive a precis of information from the Clinical Leadership Executive and its supporting groups, in this case notably the People and Teams Group and Learning and Education Group and consider the relevant people sections of the IQPR

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting.

OUT: Where necessary the Committee will refer escalated matters to the Chief Executive; to the Audit Committee; or to the Chair of the Trust.

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (NMcI) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its Terms of Reference.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

Rotherham Doncaster and South Humber NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

Purpose:

The Committee is established to provide the Board of Directors with a means of independent and objective review of financial, clinical, corporate, education and research governance; and risk management across the whole of the Trust's activities. The test across these domains is to consider the system of management control, its design and effectiveness.

To assure the Board of Directors on the Trust's compliance with related statutory responsibilities and requirements, including the NHS England Code of Governance for NHS Provider Trusts

To accept delegated responsibility from the Board of Directors for specific areas of concern and to work alongside other committees to assess control strengths, weaknesses and themes.

Ways of Working:

The Committee is a Non-Executive body of three members, asked by the Board of Directors to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

Three members of the Executive Group will attend each Audit Committee but may be excluded at the Chair's discretion.

All non-executive directors will be issued with Audit Committee papers for information.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work

1. Ensure that the Trust is demonstrating compliance with the following identified statutory requirements:
    - Laying before Parliament of the Annual report and Accounts (Health and Social Care Act 2012)
    - Production of the Quality Account (Health and Social Care Act 2012)

2. Ensure that relevant regulatory reports that require Board approval are received, reviewed and submitted in a timely manner:
    - Annual Report and Accounts (To NHSE and to Parliament)
    - Quality Account

Governance, Risk Management and Internal Control

3. The Committee shall provide the Board of Directors with a means of independent and objective review of clinical, financial and corporate governance and assurance processes and risk management across key Trust activities (clinical and non-clinical) in support of the Annual Governance Statement and Board Assurance Framework. In particular, the Committee will review the adequacy of:

    a. The risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement or other appropriate independent assurances.
    b. The underlying assurance processes (the BAF) that indicates the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
    c. The policies and procedures for all work related to fraud, bribery and corruption in accordance with NHS Counter Fraud Authority Standards for Providers and review and confirm the level of resources assigned for countering fraud.
    d. Arrangements for ensuring that educational and research governance practices are consistent with policies, and these are reflective of externally advised requirements
    e. The use of clinical audit advice, and other mechanisms as it shall determine, to evaluate the quality of clinical provision

4. Review and monitor responsiveness to the findings and recommendations of Internal, Clinical and External Audit – and ensure that the management of the Trust has cogent processes and timely responses to identified issues.

5. Ensure that Trust-wide arrangements for raising concerns (sometimes known as whistleblowing) are adequate and functional

External Audit

6. The Committee shall review the work and findings of the External Auditor and consider the implications and the Trust's management responses. This will be achieved by:
    a. Making recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the External Auditor and (if the Council of Governors rejects the Committee's recommendations) preparing an appropriate statement for the Board of Directors to include in the Annual Report.
    b. Ensuring that the Trust has arrangements in place which ensure that the External Auditor remains independent in its relationship and dealings with the Trust.
    c. Discussing and agreeing with the External Auditor, before the audit commences, the nature and scope of the audit as set out in their Annual Plan and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy and with the Trust's internal auditors.
    d. Discussing with the External Auditors their local evaluation of audit risks, assessment of the Trust, and associated impact on the audit fee.
    e. Considering whether it is appropriate and beneficial to the Trust for the External Auditor to undertake investigative and advisory work for the Trust. A protocol has been agreed with the Council of Governors (as they appoint the External Auditors) in respect of which the Committee has delegated authority to

commission additional services from the External Auditors. Any such work commissioned by the Committee must be reported to the Council of Governors and it should also be reported in the Trust's Annual Report together with an explanation as to how auditor objectivity and independence was safeguarded.

f. Reviewing all External Audit reports, including the report to those charged with governance, and value for money before submission to the Board and any work carried out outside of the annual audit plan, together with the sufficiency of management responses.
g. Ongoing monitoring and annual review of the effectiveness and performance of External Audit.

7. The Committee should meet with the External Auditor at least once a year, without management being present to discuss the External Auditor's remit and any issues arising from the audit.

Clinical Audit

8. The Committee will receive and approve an annual plan of clinical audit that incorporates national requirements as well as locally determined work, prepared with due consideration for the Internal Audit Plan; and monitor the progress made throughout the year with the delivery of this plan including the prompt responses to any areas of improvement identified. Oversight of implications and actions will be primarily through the Quality Committee, but it is for the Audit Committee to ensure that arrangements to audit practice are sufficient to provide a basis of confidence in wider views about service safety.

Internal Audit

9. The Committee shall ensure there is an internal audit function which meets mandatory Public Sector Internal Audit Standards, has an effective internal audit plan, and adequate resource is available to complete the plan. The internal audit function provides appropriate independent assurance to the Audit Committee, Chief Executive and Board which will be achieved by:

    a. Consideration of the standard and quality of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

    b. Review, contribute to the development and approval of the Annual Internal Audit Plan, detailing the programme of work ensuring that this is consistent with the audit needs of the organisation, meets the requirements of annual governance statements, head of internal audit opinion and the Board Assurance Framework.

    c. Considering the major findings of internal audit work and management response, by ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

    d. An annual review of the effectiveness of Internal Audit.

Counter Fraud, Bribery and Corruption

10. The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of

counter fraud, bribery and corruption work.

11. The Committee will seek assurance regarding the organisation's compliance with the Government Functional Standard 013: Counter Fraud by means including reports from the Counter Fraud Specialist, and the Trust's annual Counter Fraud Functional Standard Return (CFFSR).

12. The Committee should review arrangements by which Trust staff are required to make declarations of interest, gifts and hospitality and receive and review the register maintained of such declarations on an annual basis.

Financial Systems and Reporting

13. The Committee shall review the Annual Report and Financial Statements and receive the External Auditor's annual governance report prepared in accordance with ISAs 260, 265 and 450, focusing particularly on:
    a. The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
    b. Changes in, and compliance with, accounting policies and practices and estimation techniques.
    c. Unadjusted misstatements in the financial statements.
    d. Significant judgmental areas.
    e. Significant adjustments resulting from the audit.
    f. Letters of representation.

14. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

15. The Committee will receive a report on behalf of the Board of Directors of:
    a. Losses and compensation payments.
    b. Standing Financial Instructions Tender Waivers.
    c. The use of the Trust's seal.

Research Governance

16. The Committee will ensure that there are appropriate arrangements in place, and where available external assurances are received, in respect to the governance arrangements for the research activities of the Trust. This shall include both the governance of studies' approval and conduct, and the licensing of those involved whether as corporate partners or individual honorary contractors.

Education Governance

17. The Committee will ensure that there are appropriate arrangements in place, and where available external assurances are received (for example via Health Education England (HEE), Deanery Visits) in respect to the governance arrangements for the education activities of the Trust. This is required in order to satisfy the Audit Committee both of the oversight of learning practice for students, and of quality of education provided.

Membership:
Kathy Gillatt, Non-Executive Director – Chair of the Committee
Pauline Vickers, Non-Executive Director (and chair of FDE)
Dawn Leese, Non-Executive Director (and chair of QC)

Attendees:
Ian Currell, Executive Director of Finance
Sheila Lloyd, Chief Nurse
Philip Gowland, Director of Corporate Assurance / Board Secretary

In addition, ordinarily we would expect an Internal Audit representative and an External Audit representative to attend the meeting. The Counter Fraud representative will attend for their designated item.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement and should also attend when the Committee considers the annual accounts, which stand in their name. The Chairman of the Trust shall be invited to attend annually.

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee such that they can introduce and address key recommendations within papers.

Quorum:
The meeting will be quorate with 2 non-executive members, where an executive member also attends, or three non-executive directors outwith this.

Frequency:
The Committee will meet on a bi-monthly basis in line with the corporate calendar.

The Committee should meet privately (without any Trust management representation) with the Auditors at least annually in order to discuss their respective remits.

Standing agenda items:
1. Private discussions with the auditors
2. Welcomes, introduction, apologies, declarations of interest and quoracy.
3. Minutes of previous meeting and matters arising.
4. External Audit Update
5. Counter Fraud Update
6. Internal Audit Update
7. Clinical Audit Update
8. (in line with an agreed workplan) to receive other reports pertinent to the scope of work of the Committee in respect of Research Governance and Education Governance
9. Other Assurance functions – information on behalf of the Board in respect of the SFIs; and declarations of interest
10. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and

information from the Board of Directors, other Board Committees and CLE.

IN: The Committee will receive from management reports from third parties / external, independent sources where relevant to the governance arrangements within the Trust.

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting

OUT: The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

OUT: Where necessary the Committee will refer escalated matters to the Chief Executive; or to the Chair of the Trust.

OUT: The Committee Chair will report to the Council of Governors annually on the External Auditors work (due to the Council of Governors being responsible for the appointment of the External Auditor); and (if the Audit Committee considers it necessary) on matters needing action or improvement, and the corrective steps to be taken.

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (PG) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its workplan and efforts to improve Trust compliance consistently.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

Rotherham Doncaster and South Humber NHS Foundation Trust

MENTAL HEALTH ACT COMMITTEE

TERMS OF REFERENCE

This Committee has a specific and defined remit to provide a current view of, and address issues arising from, the work of the Trust to meet the letter, and spirit, of the legislation.

Purpose:

- To assure the Board of Directors on the Trust's compliance with related statutory responsibilities and requirements, specifically the existing Mental Health Act.
- To support the work of the Trust's management and independent assessors in moving to consistent application for each patient of those responsibilities.
- To act on behalf of the Board of Directors in assessing the Trust's development of its response to foreseeable changes to the Act, notwithstanding parliamentary deferral of the revised Act.
- To accept delegated responsibility from the Board of Directors for any specific areas of concern, including the support regime provided to Trust Associate Hospital Manager's (TAMs).

For the avoidance of doubt, other patient-facing legislative considerations relevant to the provision of care, including the mental capacity act, are under the remit of Board's Quality Committee.

The Committee ***will*** maintain oversight of actions taken as a result of MHA visits from the Care Quality Commission.

Ways of working:

The Committee is a unitary body of six members, asked by the Board to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

A single assessment of compliance will be maintained at all times and significant deviations from the legislation will be notified to the Committee's chair between meetings.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work:

1. The Committee will seek, receive, consider and report to the Board of Directors that effective arrangements are in place for compliance with the Mental Health Act throughout the Trust.

This will necessarily include consideration :

- that the Trust actively listens to, and learns from, the experiences of patients, families and carers in the application of legislation.

- that procedures to manage and monitor Reducing Restrictive Interventions are in place and operating properly.

- that the Trust is contributing to national data sets on the application of the legislation with respect to Equality and Diversity and that we are reviewing our own performance as compared to national trends in this area.

- that learning has been identified and shared across the organisation and actions have been taken where appropriate.

In addition, the Committee will take assurance that the role of TAMs and Senior TAMs are compliant with the requisite training, engage with the appraisal/review process and perform at least the minimum number of hearings expected.

2. Receive reviews of any assessment reports and recommendations from the CQC and any other statutory external bodies in relation to the Mental Health Act and seek assurance that any identified themes, trends or required actions are being addressed in an appropriate and timely manner and that appropriate learning is being undertaken in relation to them.

3. Seek, monitor, review and consider assurance on the risk, control and governance processes identified in the Board Assurance Framework that are delegated to the Committee by the Board of Directors, providing reports to the Board of Directors and Audit Committee as requested.

4. Contribute to the development of the Annual Internal Audit Plan; receive and consider the related final reports; and seek, receive and confirm that management responses to audit recommendations are completed in line with the agreed action plans.

5. Receive the IQPR and by exception, for measures greater than 1 standard deviation from plan, seek assurance in respect of improvement actions. This would be expected in this case to relate primarily to the quality and safety domain on the IQPR and the plan of the same name.

Membership:

Sarah Fulton Tindall, Non-Executive Director – Chair of the Committee
Justin Shannahan, Non-Executive Director
Dr Janusz Jankowski, Non-Executive Director
Toby Lewis, Chief Executive
Dr Graeme Tosh, Executive Medical Director
Dr Jude Graham, Director of Therapies

In attendance:
Given the nature of the Committee's purpose, neither governors nor other public representatives will routinely attend. A nominated TAM may attend for specific items.

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee.

Quorum:

The meeting will be quorate with 4 members including at least two non-executive directors.

Frequency:

The Committee will meet on a bi-monthly basis on the second Wednesday of the month in line with the corporate calendar.

Standing agenda items:

1. Welcomes, introduction, apologies, declarations of interest and quoracy.
2. Minutes of previous meeting and matters arising.
3. Current state compliance assessment.
4. Reports exploring actions to address any persistent areas of non-compliance.
5. Reports exploring best practice work undertake within the Trust in its application of the Act.
6. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and CLE.

IN: The Committee may receive a precis of information from the Mental Health Legislation Operational Group (which is a subgroup of CLE's Quality and Safety Group) and in addition draw information from:

- Care Group: Mental Health Legislation Monitoring Groups.
- Care Group: Section 136 Monitoring Groups.
- Trust Associate Hospital Managers (TAM) Forum.
- MHA Approvals Panel.
- Any other relevant Task and Finish Sub-Groups.

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting.

OUT: Where necessary the Committee will refer matters to the Chief Executive; to the Audit Committee; or to the Chair of the Trust.

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (GT) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its workplan and efforts to improve Trust compliance consistently.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

Rotherham Doncaster and South Humber NHS Foundation Trust

PUBLIC HEALTH, PATIENT INVOLVEMENT & PARTNERSHIPS COMMITTEE

TERMS OF REFERENCE

Purpose:

- To assure the Board of Directors on the Trust's compliance with identified related statutory responsibilities and requirements.
- To ensure that the Trust is operating as a partner within the two ICBs, consistent with achieving our own aims and supporting theirs
- To support the delivery of both the Equity & Inclusion and Research & Innovation plans that support the Trust's Clinical and Operational Strategy
- To accept delegated responsibility from the Board of Directors for specific areas of emphasis or concern.

In discharging these responsibilities, the committee shall seek to ensure that the Trust's Board remains focused on improvement delivery in support of objectives 1, 2 and 5. It will work closely with the quality committee (which supports patient experience measures of quality), with other committees in respect of partnership working, and with the COG to ensure that the voices of patient and community representatives are heard. Employee diversity and inclusion will be the responsibility of the People and OD committee.

Scope of work:

1. There are limited statutory elements to the work of this committee, but it should provide advice to the Board on the broad discharge of the partnering duties of the organisation. It should also pay heed to NHS direction regarding inequalities, and the role of the Board in monitoring patient-facing inequalities.

2. The committee will take responsibility for assurance of work to include and involve patients, carers and communities in the work of the Trust – as necessary receiving reports and presentations from the team around the Chief Nurse. This responsibility for promise 5 is shared across the executive as it needs to imbue all of our work.

3. The Trust has a developed research function, but is seeking through the new R&I plan to significantly broaden and deepen research work into new departments, and to ensure all professions, including managers, play a role in research output. The committee should ensure that the management of the Trust, through its Care Groups, is executing on this expectation.

4. Two elements of inequality are assured, or otherwise, through this committee:

    - Service equity in provision
    - The work of the Trust to reduce inequalities

    Inevitably the first domain may cross over with other committees, and chairs will pay attention to that duplicative risk.

5. The committee will focus time on two aspects of partnerships:

    i) The partners and partnering behaviours within the Trust required to deliver the promises for which it has responsibility

    ii) Identified commercial partnerships held by the Trust. These currently include:

        - Our Aspire contractual joint venture
        - Our work on eating disorders
        - Our Flourish CiC
        - Our relationship with our participation partner, PFG

Membership:

- Justin Shannahan, NED – Chair of the Committee
- Dawn Leese, Non-Executive Director
- Dave Vallance, Non-Executive Director
- Toby Lewis, Chief Executive
- Graeme Tosh, Medical Director
- Nicola McIntosh, Director of People and OD
- Jo McDonough, Director of Strategy
- A representative of the Council of Governors to be agreed between chair/lead governor.

In attendance:

- The committee may benefit from the involvement of one or more of the area's directors of public health attending for specific items.

- In agreement with the Chair, other subject matter experts will be invited to be present for specified agenda items, however, in the main items should be sponsored and overseen by the directors named above.

Quorum:

The meeting will be quorate with 4 members including at least two non-executive directors

Frequency:

The Committee will meet on a bi-monthly basis on Wednesday of "week 3".

The agenda of the committee will reflect its workplan and performance against the four items identified in its purposes. A sample agenda is indicated below.

Standing agenda items: (15 mins):

1. Apologies, quoracy, declarations of Interests
2. Minutes of Previous Meeting and matters arising
3. IQPR – by exception measures greater than 1 standard deviation from plan

Part A items: (85 mins)

Selected from

4. Delivery of the Research & Innovation plan (including promise 28)
5. Delivery of the Equity and Inclusion Plan (including promises 6-13)
6. Consideration of partnering arrangements (a) in support of 4/5 above and (b) Trust-wide in support of our strategy and partnering duty
7. Assurance on any identified commercial collaborations of material value to the Trust, including progress with the two named collaboratives and the specialized services collaboration
8. Assurance on any identified statutory responsibilities

Part B matters (20mins)

9. Board Assurance Framework
10. Risk Register – related 'high' risks (scoring 12 and above)
11. Internal Audit – Plan; completed reports; overdue recommendations
12. Matters for Reporting to the Board
13. Committee effectiveness discussion

Currently no statutory obligations have been identified within this committee's remit.

- Consideration should be given, alongside, the Audit Committee to how oversight of research governance will be confirmed. At the time of drafting it is assumed that this will be routinely discharged through the audit function, but should concerns arise it would for this committee to take responsibility for improvement oversight.

- In order to fulfil its responsibilities the committee will wish to provide assurance to the Board that local JSNA and Annual Public Health Reports from DPHs have been given some scrutiny.

Reporting arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and CLE and its sub-groups. A standard report will be provided for each of the two plans. The IQPR will be received in order to consider both research delivery and equity metrics.

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors at the next available meeting.

OUT: Where necessary the Committee will refer exceptional matters of concern to any of the Chief Executive; the Audit Committee; or to the Chair of the Trust at its discretion.

Support arrangements:

Venue: The venue for meetings will normally be one of the Boardrooms at Woodfield House and / or, where deemed necessary by the Chair, by MS Teams.
Agenda: Set by a meeting involving Chair and Lead Director (Jo McDonough) with due consideration for these Terms of Reference and an Annual Workplan.
Papers: Received from authors 6 business days prior to meeting.

Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Governance, rules and behaviours:

- Collective responsibility / decision making, arbitrated by the Chair
- Compliance with Standing Orders
- Members to speak through the Chair, who will facilitate an approach which is inclusive and respectful
- All members are expected to attend – absenteeism is an exception other than during authorised leave (agreed substitutes may be used for this purpose)
- Meetings will start and end on time, and will be organised to not exceed 120 minutes
- Papers to conform to Trust guidance on Board and Committee papers
- All telephones must be switched off unless expressly agreed by the Chair.

Monitoring:

The committee will review its performance annually against its Terms of Reference and consider its effectiveness in liaison with the full Board.

Date approved: 23 November 2023

Approved by: Board of Directors

Rotherham Doncaster and South Humber NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

The Committee is established by the Board, (in its role as the Corporate Trustee (CT) of the RDASH Charitable Funds) to provide oversight of the charity's financial integrity and appropriate use of resources, including investments and to oversee the future development of the funds – through fundraising and income generation, investment and expenditure.

During 2024/25 the Trust intends to consolidate and reframe the charity's work, profile, and approach. The Board (as CT) delegates to the committee oversight of that transition, using the corporate trustee meetings to affirm material decision making. The management will create a small but regular meeting to ensure that the day-to-day running of the charity is progressed out with the committee.

The committee therefore will focus as below:

Purpose:

- To assure the Board of Directors (as CT) on the Trust's compliance with related statutory responsibilities and requirements.
- To ensure that Charitable Fund resources are appropriately utilised to augment the services and facilities available to the Trust's patients, carers, communities and employees, without substitution of core NHS obligations for charitable sources of funds.
- To ensure that the Trust is legally compliant in its use of donor's gifts.
- To accept delegated responsibility from the Board of Directors (as CT) for specific areas of delivery concern, including the transition of the charity's work outlined above.

Ways of Working:

The Committee is a unitary body of up to eight members, asked by the Board (in its role as Corporate Trustee) to act on its behalf. All members of the Committee should have parity in questioning and addressing delivery by the Trust of its obligations.

The Trust's management will facilitate engagement with other Trusts to maintain a shared appreciation of best-practice work in this field, such that the Committee can understand how RDaSH compares to other organisations.

Scope of work

1. Ensure that the Trust is demonstrating compliance with the following identified statutory requirements:
   - Charites Act 2022

2. Ensure that relevant regulatory reports that require Board approval are received, reviewed and submitted in a timely manner:
    - Annual Charity Return / Annual Report and Accounts (to the Charities Commission)

3. Linked to 2. above, to agree the nature and scope of the Charitable Funds audit or independent review as set out in the annual audit plan by External Audit.

4. To encourage people to use the fund and be responsible for promoting the Charity in order to promote growth in donations, legacies and gifts.

5. To ensure that the activities of the charity are appropriate to the charity's aim and comply with the Charity Commission's guidance on Public Benefit.

6. To receive and give direction in the development of policies, procedures and administrative arrangements relating to the Trust's Charitable Funds including the Reserves and Liquidity Policy.

7. To periodically review the investments held by the Trust's Charitable Funds and to ensure that such resources are being effectively managed in accordance with the investment policy and agreed risk appetite – and consistent with the Trust's social value commitments and promises.

8. Seek, receive and monitor risk on the Charitable Funds risk register in line with the Risk Management Framework.

Membership:
Pauline Vickers, Non-Executive Director – Chair of the Committee
Kath Lavery, Chair
Sarah Fulton Tindall, Non-Executive Director
Kathy Gillatt, Non-Executive Director
Toby Lewis, Chief Executive
Ian Currell, Executive Director of Finance
Sheila Lloyd, Chief Nurse
Jo McDonough, Director of Strategic Development

[It is likely that the committee will propose to the May trustee meeting recruitment of up to two independent members of the committee drawn from the local community with relevant expertise in charitable fund work at scale]

Items may be presented by non-members, but a member will always sponsor and oversee papers submitted to the Committee such that they can introduce and address key recommendations within papers.

Quorum:
The meeting will be quorate with 4 members inc at least two Non-Executive Directors.

Frequency:
The Committee will meet on a quarterly basis on the in line with the corporate calendar.

Standing agenda items:

1. Welcomes, introduction, apologies, declarations of interest and quoracy.
2. Minutes of previous meeting and matters arising.
3. Delivery of the change/transition plan for the charity
4. Current state performance – financial income, investments and expenditure (inc approval of proposed expenditure of +£10,000).
5. Significant areas of concern or non-compliance at Trust level.
6. Areas of good and best practice to explore with reference to wider application.
7. Matters to escalate to the Board of Directors or to advise to other committees.

Reporting Arrangements:

IN: To the extent necessary to fulfil its purpose the Committee will receive reports and information from the Board of Directors, other Board Committees and the working group that will manage the charity's operational work.

IN: The Committee will receive information via management from any individual or organisation appointed to act as Investment Broker; and information from the Charities Commission

OUT: A report summarising each meeting of the Committee will be provided to the Board of Directors (acting as the Corporate Trustee) at the next available meeting (The Corporate Trustee will meet three times per annum – January, May and November).

OUT: Where necessary the Committee will refer escalated matters to the Chief Executive or Chair; to the Audit Committee; or to the Senior Independent Director

Support Arrangements:

Venue: The venue for meetings will normally be via by MS Teams.

Agenda: Set by a meeting involving Chair and Lead Director (JMcD) with due consideration for the Terms of Reference and Annual Workplan.

Papers: Received from authors 6 business days prior to meeting.
Circulated to members/attendees 5 business days prior to the meeting.

Minutes: Draft produced within 1 business week and agreed by the Chair within 2 business weeks.

Monitoring:

The Committee will review its performance annually against its workplan and efforts to improve Trust compliance consistently.

The effectiveness of the Committee and adherence to its terms of reference will be assessed periodically by the Board of Directors

Date approved:
Approved by:

	Promise	Board Committee	Plan	CLE Group
1	Employ peer support workers at the heart of every service that we offer by 2027.	POD	People and teams	P&T
2	Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy	PHPIP	Equity and inclusion	E&I
3	Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer.	PHPIP	Equity and inclusion	E&I
4	Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Quality	Quality and safety	Q&S
5	From 2024 systematically, involve our communities at every level of decision making in our Trust throughout the year, extending our membership offer, and delivering the annual priorities set by our staff and public governors.	Board	Quality and safety	CLE
6	"Poverty proof" all our services by 2025 to tackle discrimination, including through digital exclusion.	PHPIP	Equity and inclusion	OMG
7	Deliver all ten health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.	PHPIP	Equity and inclusion	OMG
8	Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality ("the RDASH 5").	PHPIP	Equity and inclusion	E&I
9	Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities	PHPIP	Equity and inclusion	L&E
10	Be recognised by 2027 as an outstanding provider of inclusion health care, implementing National Institute for Health and Care Excellence (NICE) and NHS England (NHSE) guidance in full, in support of local Gypsy, Roma and Travellers (GRT), sex workers, prisoners, people experiencing homelessness and misusing substances and forced migrants.	PHPIP	Equity and inclusion	E&I
11	Deliver in full the NHS commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and trauma responsive services.	PHPIP	Equity and inclusion	OMG
12	Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	PHPIP	Equity and inclusion	E&I
13	Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, children's home or care home, including older adults.	Quality	Quality and safety	OMG
14	Assess people referred urgently inside 48 hours from 2025 (or under four where required) and deliver a four-week maximum wait for all referrals from April 2026, maximising the use of technology and digital innovation to support our transformation.	Quality	Quality and safety	OMG
15	Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	PHPIP	Equity and inclusion	OMG
16	Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Quality	Quality and safety	R&I
17	Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	PHPIP	Equity and inclusion	E&I

18	From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Quality	Quality and safety	Q&S
19	End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Quality	Quality and safety	OMG
20	Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	PHPIP	Research and Innovation	Digital
21	Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	PHPIP	Equity and inclusion	CLE
22	Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Quality	Quality and safety	OMG
23	Invest in residential care projects and programmes that support long-term care outside our wards: specifically supporting expansion of community forensic, step-down and step-up services.	FDE	Estate and sustainability	Estate
24	Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan	POD	Learning and education	L&E
25	Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	POD	People and teams	P&T
26	Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	POD	People and teams	P&T
27	Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	PHPIP	Equity and inclusion	Estate
28	Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring investment and employment to our local community.	PHPIP	Research and inclusion	R&I

Rotherham Doncaster and South Humber NHS Foundation Trust

Standing Financial Instructions

DOCUMENT CONTROL:	
Version:	7
Ratified by:	Board of Directors
Date ratified:	25 January 2024
Name of originator/author:	Director of Corporate Assurance / Board Secretary
Name of responsible committee/individual:	Board of Directors
Unique Reference Number:	207
Date issued:	
Review date:	31 December 2027
Target Audience	All Staff
Description of Changes	

FOREWORD

1. These Standing Financial Instructions (SFI) provide the Foundation Trust with a business and financial framework. All Executive Directors, Non-Executive Directors and members of staff should be aware of their existence and where necessary, they should be familiar with the detailed provisions. The documents fulfil the dual role of protecting the Trust's interests and assisting staff in fulfilling their roles.

2. The SFIs are further supported by the 'Reservation of Powers to the Board of Directors and Scheme of Delegation' and by Financial Procedures.

3. Once the Board of Directors has adopted the SFIs they become mandatory on all Directors and employees of the Trust.

4. For the sake of brevity the masculine pronoun is used throughout these Standing Financial Instructions.

1 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFI) shall have effect as if incorporated in the Board of Director's Standing Orders (SO) of the Trust.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and the requirements of NHS England, in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservations of Powers to the Board of Directors and Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities, which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance and Estates must approve all financial procedures.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance and Estates must be sought before acting.

1.1.5 Failure to comply with Standing Financial Instructions is a disciplinary matter which could result in dismissal.

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance and Estates as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

"ACCOUNTING OFFICER" means the person who from time to time discharges the functions specified in paragraph 25 (5) in Schedule 7 to the National Health Service Act 2006;

"BOARD" means the Board of Directors of the Rotherham Doncaster and South Humber NHS Foundation Trust, as constituted in accordance with the Trust's Constitution;

"BUDGET" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"BUDGET HOLDER" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

"CHIEF EXECUTIVE" means the chief executive (and accounting officer) of the Trust from time to time;

"CONSTITUTION" means the constitution attached to the Authorisation by the regulator with any variations from time to time approved by the Regulator;

"DIRECTOR" means a person appointed as a Director in accordance with the Constitution.

"DIRECTOR OF FINANCE AND ESTATES" means the chief financial officer of the Trust;

"**EXECUTIVE DIRECTOR**" means a Member of the Board of Directors who holds an executive office of the Trust and who was appointed in accordance with the Constitution;

"FUNDS HELD ON TRUST" means those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006. Such funds may or may not be charitable;

"NHS ENGLAND" means the organisation responsible for overseeing foundation trusts and NHS trusts.

"**NON-EXECUTIVE DIRECTOR**" means a Member of the Board of Directors who does not hold an executive office of the Trust and who was appointed by the Council of Governors in accordance with the Constitution.

"OFFICER" means employee of the Trust or any other person holding a paid appointment or office with the Trust;

"TRUST" means the Rotherham Doncaster and South Humber NHS Foundation Trust.

1.2.2 Wherever the title Chief Executive, Director of Finance and Estates or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) Defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Reservation of Powers to the Board document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to NHS England for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Director of Finance and Estates will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board and employees and all new appointees are notified of and understand, their responsibilities within these Instructions.

1.3.7 The Director of Finance and Estates is responsible for:

(a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are

prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of Directors and employees of the Trust, the duties of the Director of Finance and Estates include:

(d) The provision of financial advice to other members of the Board and employees;

(e) The design, implementation and supervision of systems of internal financial control; and

(f) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 The Board of Directors and all employees, severally and collectively, are responsible for:

(a) The security of the property of the Trust;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources;

(d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation; and

(e) Maintaining effective risk management arrangements.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance and Estates.

2 AUDIT

2.1 AUDIT COMMITTEE

2.1.1 With reference to the Audit Code for NHS Foundation Trusts and the Code of Governance, issued by NHS England, the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference.

The Committee shall:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical) that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of:

    - All risk and control related disclosure statements (in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement or other appropriate independent assurances.
    - The underlying assurance processes that indicates the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
    - The policies and procedures for all work related to fraud, bribery and corruption as set out in Service Condition 24 of the NHS Standard Contract and as required by the NHS Counter Fraud Authority.

- Ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- Review the work and findings of the External Auditor and consider the implications and management's responses to their work.
- Agree the Accounting Policies to be adopted for the preparation of the financial statements and receive the External Auditor's annual governance report prepared in accordance with ISAs 260, 265 and 450. The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board

2.1.2 The Audit Committee must assess the work of external audit on an annual basis to ensure that the work is of a sufficiently high standard. The Audit Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the external auditors. The Trust will undertake market-testing for the appointment of external auditors at least once every five years.

2.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS England via the Director of Finance and Estates.

2.1.4 It is the responsibility of the Director of Finance and Estates to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.1.5 Further detail on the role, responsibility and powers of the Audit Committee are contained it its Terms of Reference.

2.2 DIRECTOR OF FINANCE AND ESTATES

2.2.1 The Director of Finance and Estates is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) A clear opinion on the effectiveness of internal control;
(ii) Major internal financial control weaknesses discovered;
(iii) Progress on the implementation of internal audit recommendations;
(iv) Progress against plan over the previous year;
(v) Strategic audit plan covering the coming three years;
(vi) A detailed plan for the coming year.

2.2.2 The Director of Finance and Estates or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or members of the Board of Directors or employee of the Trust;

(c) The production of any cash, stores or other property of the Trust under a member of the Board of Directors and employee's control; and

(d) Explanations concerning any matter under investigation.

2.3 ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability of financial and other related management data;

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences;

(ii) Waste, extravagance, inefficient administration ;

(iii) Poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance and Estates must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The *NHS Foundation Trust Accounting Officer Memorandum* provides that internal audit should accord with the objectives, standards and practices set out in the *Government Internal Audit Standards,* which states that internal audit is an independent and objective appraisal service within an organisation:

- Internal audit primarily provides an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on risk management, control and governance, by measuring and evaluating their effectiveness in achieving the organisation's agreed objectives. In addition, internal audit's findings and recommendations are beneficial to line management in the audited areas. Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation.
- Internal audit also provides an independent and objective consultancy services specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the

organisation's objectives, and through recommendations for improvement. Such consultancy work contributes to the opinion which internal audit provides on risk management, control and governance.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance and Estates. The reporting system for internal audit shall be agreed between the Director of Finance and Estates, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.4 COUNTER FRAUD, BRIBERY AND CORRUPTION AND SECURITY MANAGEMENT

2.4.1 The Trust Chief Executive and Director of Finance and Estates shall monitor and ensure compliance with best practice to counter fraud, bribery and corruption and the Chief Executive and Director of Finance and Estates shall undertake the same role in respect of security management.

2.4.2 The Trust shall nominate suitable persons to carry out the duties of the Local Counter Fraud Specialist and Local Security Management Specialist.

2.4.3 The Local Counter Fraud Specialist shall report to the Director of Finance and Estates and where necessary, shall work with staff from the NHS Counter Fraud Authority. The Local Counter Fraud Specialist will provide a written report, at least annually, to the Trust on counter fraud work at the Trust.

2.4.4 The Local Security Management Specialist shall report to the Director of Director of Finance and Estates (Nominated Security Management Director) and where necessary, shall work with staff from external agencies. The Local Security Management Specialist will provide a written report, at least annually, which will be reflected in the Self-Review Tool and Security Strategy on security management work at the Trust.

2.4.5 The Director of Finance and Estates is responsible for ensuring that action is taken to investigate all allegations of fraud through the Local Counter Fraud Specialist. The steps to be taken are incorporated in the Trust's Counter Fraud, Bribery and Corruption Policy. The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls and evaluate the implications of the fraud.

2.4.6 The Director of Finance and Estates (SMD) is responsible for ensuring that action is taken to investigate all security incidents through the Local Security Management Specialist. The steps to be taken are incorporated in the Trust's Security Policy.

2.5 EXTERNAL AUDIT

2.5.1 The external auditor is appointed by the Council of Governors following receipt of a recommendation from the Audit Committee and paid for by the Trust. The Trust must ensure that the external auditor appointed meets the criteria included in NHS England's Code of Audit Practice. The external audit manager will normally attend Audit Committee meetings.

2.5.2 If requested by the external auditor, during part of one Audit Committee meeting each financial year, executive directors and others normally in attendance will be excluded from the meeting in order to allow private discussions between the Audit Committee members and the external auditor.

3 ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board of Directors an Annual Plan in line with the requirements set out by NHS England which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:

(a) A statement of the significant assumptions on which the Annual Plan is based;

(b) Details of major changes in workload, delivery of services or resources required to achieve the Annual Plan.

The Annual Plan must take into account the views of the Council of Governors in accordance with the Trust Constitution and be submitted to NHS England.

3.1.2 Prior to the start of the financial year the Director of Finance and Estates will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the Annual Plan and will meet the financial requirements of NHS England' financial regime;

(b) Be in accordance with workload and manpower plans;

(c) Be produced following discussion with appropriate budget holders;

(d) Be prepared within the limits of available funds; and

(e) Identify potential risks.

3.1.3 The Director of Finance and Estates shall monitor financial performance against budget and business plan, periodically review them, and report to Finance, Digital and Estates Committee and the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance and Estates to enable budgets to be compiled.

3.1.5 All budget holders will be allocated their budgets at the commencement of the financial year. The Director of Finance and Estates has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage budgets successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under s75 of the NHS Act 2006. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose(s) of each budget heading;

(c) Individual and group responsibilities;

(d) Authority to exercise virement;

(e) Achievement of planned levels of service; and

(f) The provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total, virement limits or capital programme set by the Board.

Please also refer to the Procedure for Budget Virement held by the Finance department.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.3 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive and Director of Finance and Estates.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance and Estates will devise and maintain systems of budgetary control. These will include:

(a) Bi-Monthly financial reports to the Finance, Digital and Estates Committee and the Board in a form approved by the Board containing:

(i) Trust-wide and Care Group / Directorate income and expenditure to date showing trends and forecast year-end position;

(ii) Monthly balance sheet position and appropriate key indicators;

(iii) Movements in working capital;
(iv) Movements in cash and capital and forecast year end position
(v) Capital project spend and projected outturn against plan;
(vi) Explanations of any material variances from plan;
(vii) Details of any corrective action where necessary and the Chief Executive's and/or Director of Finance and Estates's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) Investigation and reporting of variances from financial, workload and manpower budgets;

(d) Monitoring of management action to correct variances; and

(e) Arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) Any likely overspend or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board;

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.3 The delegated limits of Directors, Care Group Directors and Budget Holders are expected to be maintained under normal business arrangements. Where financial performance of a budget area significantly deteriorates, the Chief Executive has the authority to temporarily or permanently to adjust the delegated financial limits in respect of a budget holder in response and to determine the period where such additional control is deemed necessary. Any such decision should be reported to the Board of Directors.

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's Annual Plan and a balanced budget.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 11.) The Capital Programme and any amendments will be approved in advance by the Board of Directors.

3.5 MONITORING RETURNS

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are approved by the Board of Directors and submitted to NHS England and any requisite monitoring organisation.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance and Estates, on behalf of the Trust, will:

(a) Prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the Trust's accounting policies, and generally accepted accounting practice;

(b) Prepare and submit annual financial reports to NHS England and Parliament in accordance with current guidelines; and

(c) Submit financial returns to NHS England and Parliament for each financial year in accordance with the prescribed timetable.

4.2 The Trust's audited annual accounts must be presented to the Board of Directors for approval and received at a public meeting of the Council of Governors. A copy should be forwarded to NHS England and made available to the public.

4.3 The Trust will publish an annual report, in accordance with the Constitution and present it at the Council of Governors general meeting. The document will comply with NHS England's Annual Reporting Manual.

5 BANK ACCOUNTS

5.1 GENERAL

5.1.1 The Director of Finance and Estates is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by NHS England.

5.2 BANK ACCOUNTS

5.2.1 The Director of Finance and Estates is responsible for:

(a) Bank accounts;
(b) Establishing separate bank accounts for the Trust's non-exchequer funds;
(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and
(d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.3 BANKING PROCEDURES

5.3.1 All funds shall be held in the name of the Trust. No employee other than the Director of Finance and Estates shall open any bank account in the Trust's name.

5.3.2 The Director of Finance and Estates will prepare detailed instructions on the operation of bank accounts that must include:

5.3.3

(a) The conditions under which each bank account is to be operated;
(b) Those authorised to sign cheques, make CHAPS payments, make faster payments or other orders drawn on the Trust's accounts.
(c) The limit to be applied to any overdraft.

5.3.4 The Director of Finance and Estates must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 TENDERING AND REVIEW

5.4.1 The Director of Finance and Estates will review the banking arrangements of the Trust at regular intervals, and at least every five years, to ensure they reflect best practice and represent value for money. Following such reviews the Director of Finance and Estates shall determine whether or not re-tendering for services is necessary.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance and Estates is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance and Estates is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Director of Finance and Estates is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.2 All employees must inform the Director of Finance and Estates promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance and Estates is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures. (See section 13.)

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Director of Finance and Estates is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) Ordering and securely controlling any such stationery;
(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official Trust cash shall not under any circumstances be used for the encashment of private cheques or I.O.U.s.

6.4.3 The opening of post shall be undertaken by two employees together and all cash, cheques and other forms of payment shall be entered in an approved register before handing to the cashier.

6.4.4 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance and Estates.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7 AGREEMENTS FOR PROVISION OF SERVICES

7.1 Legally binding agreements

7.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services. All agreements should aim to implement the agreed priorities contained within the relevant plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

a. The standards of service quality expected;

b. The relevant national service framework (if any);

c. The provision of reliable information on cost and volume of services;

d. That agreements build where appropriate on existing partnership arrangements;

e. Any model contracts issued by the Department of Health and Social Care for use by commissioners; and

f. That contracts are based on integrated care pathways.

7.1.2 Where the Trust makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accounting Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities.

7.1.3 Where it is necessary for the Trust to seek and utilise the specialist advice of brokers and advisors to ensure that the best cover and value is obtained, the Chief Executive will approve their appointment and agree with the respective lead, the terms and scope of the service to be received and any related fees. The arrangements in place must ensure that the broker / advisor undertakes their role in the best interest of the Trust, ensuring that all market and supply options available are considered and where necessary ensuring appropriate competition processes are put in place.

7.2 Commissioning

7.2.1 The Trust has responsibilities for commissioning Adult Eating Disorder Services (In Patient) as the Lead Provider in South Yorkshire ICB. These responsibilities have been delegated by Clinical Commissioners or by NHS England. This will require the Trust to work in partnership with NHS England, partner NHS Trusts, Foundation Trusts, local authority, independent sector, users, carers and the voluntary sector.

7.2.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring Adult Eating Disorder Services (In Patient) are commissioned in accordance with the priorities agreed. This will involve ensuring contracts

are put in place with the relevant providers, based upon integrated care pathways.

7.2.3 Contracts will be the key means of delivering objectives and therefore they need to have a wider scope. The Accountable Officer will need to ensure that all contracts and service level agreements;

a. Meet the standards of service quality and safety expected, escalating any concerns as appropriate (e.g. to the Care Quality Commission, NHS England);
b. Fit the priorities and objectives of the Long Term Plan;
c. Enable the provision of reliable information on cost and volume of services;
d. Fit the NHS Oversight Framework;
e. That contracts build where appropriate on existing Joint Investment Plans;
f. That contracts are based upon cost-effective services;
g. That contracts are based on integrated care pathways.

7.2.4 The Accountable Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast expenditure, quality and activity for each contract.

7.2.5 Where the Trust, as the Commissioner, makes arrangements for the provision of services by non-NHS providers it is the Accountable Officer who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities or services should they be available within South Yorkshire ICB area.

7.2.6 The Director of Finance and Estates must maintain a system of financial monitoring to ensure the effective accounting of expenditure under the contract. This should provide a suitable audit trail for all payments made under the agreements but maintains patient confidentiality.

7.2.7 The Director of Finance and Estates must account for Out of Area Treatments/Non-Contract Activity financial adjustments in accordance with national guidelines.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD AND EMPLOYEES

8.1 REMUNERATION COMMITTEE

8.1.1 The Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility (Currently the Executive Group (EG) (Chief Executive, Executive Directors and Directors) and defined as ‘relevant staff’ in the terms of reference), its composition, and the arrangements for reporting.

8.1.2 The Committee has:

(a) Delegated authority to decide the appropriate remuneration and terms of service for the defined 'relevant staff' including the Chief Executive, Executive Directors and others as defined including:

(i) All aspects of salary (including any performance-related elements/bonuses);
(ii) Provisions for other benefits, including pensions and cars;
(iii) Arrangements for termination of employment and other contractual terms;

(b) Delegated authority to decide the remuneration and terms of service of the defined 'relevant staff' to ensure they are fairly rewarded for their individual contribution to the Trust - having due regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) Oversee appropriate contractual arrangements for defined 'relevant staff' including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Board of Directors will after due consideration and amendment and if appropriate, approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

8.2 COUNCIL OF GOVERNORS / NOMINATIONS COMMITTEE

8.2.1 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board of Directors in accordance with instructions issued by the Council of Governors (following the receipt of recommendations from its Nominations Committee).

8.3 FUNDED ESTABLISHMENT

8.3.1 The workforce plans incorporated within the Annual Plan will form the funded establishment.

8.3.2 The funded establishment of any department may not be varied without the approval of the Chief Executive and the Chief Operating Officer.

8.4 STAFF APPOINTMENTS

8.4.1 No executive director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) Unless authorised to do so by the Chief Executive; and
(b) Within the limit of his approved budget and funded establishment.

8.4.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.5 PROCESSING PAYROLL

8.5.1 The Director of People and Organisational Development is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final determination of pay and allowances;

(c) Making payment on agreed dates; and

(d) Agreeing method of payment.

8.5.2 The Director of People and Organisational Development will issue instructions regarding:

(a) Verification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of the Data Protection Act 2018 (or successor legislation);

(g) Methods of payment available to various categories of employee and officers;

(h) Procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) Procedures for the recall of cheques and bank credits;

(j) Pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) Separation of duties of preparing records and handling cash;

(m) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust;

(n) The payment of pay awards and arrears;

(o) Procedures for the change of bank account details by staff; and

(p) The secure operation of the system for payments by BACS and CHAPS.

8.5.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting time records and other notifications in accordance with agreed timetables;

(b) Completing time records and other notifications in accordance with the Director of People and Organisational Development's instructions and in the form prescribed by the Director of People and Organisational Development; and

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of People and Organisational Development must be informed immediately.

8.5.4 Regardless of the arrangements for providing the payroll service, the Director of People and Organisational Development shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.6 CONTRACTS OF EMPLOYMENT

8.6.1 The Board shall delegate responsibility to the Director of People and OD for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) Dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) The maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's procurement department on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and Estates (and/or the Chief Executive) shall be consulted.

9.2.2 The Director of Finance and Estates shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Director of Finance and Estates will:

(a) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in procedures and regularly reviewed;

(b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Directors / employees (including specimens of their signatures) authorised to certify invoices;
(ii) Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance and Estates of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages;

(b) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance and Estates will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account public procurement rules where the contract is above a stipulated financial threshold); and

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official Orders must:

(a) Be consecutively numbered;

(b) Be in a form approved by the Director of Finance and Estates;

(c) State the Trust's terms and conditions of trade; and

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and Estates and that:

(a) All contracts - other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and Estates in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with all legislation in relation to public procurement enforced from time to time;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
(ii) conventional hospitality, such as lunches in the course of working visits;

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance and Estates on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or on purchase cards;

(g) Verbal orders, should only be used in exceptional circumstance, for example out of normal working hours, if within working hours, contact the Purchasing Department for assistance, if not a requisition number/call off order number or contact details must be provided, so the invoice for these goods or services can be directed to the correct budget holder.

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Director of Finance and Estates;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance and Estates; and

(l) Petty cash records are maintained in a form as determined by the Director of Finance and Estates.

9.2.7 The Chief Executive and Director of Finance and Estates shall ensure that the arrangements for financial control and financial audit of estates related contracts and property transactions comply with the guidance contained within Health Building Note 00-08 and other relevant guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.3 GRANTS AND JOINT FINANCE ARRANGEMENTS WITH LOCAL AUTHORITIES AND VOLUNTARY BODIES

9.3.1 Payments to local authorities and voluntary organisations shall comply with procedures laid down by the Director of Finance and Estates which shall be in accordance with relevant legislation.

10 FINANCIAL FRAMEWORK

10.1 EXTERNAL BORROWING

10.1.1 The Director of Finance and Estates will advise the Board concerning the ability of the Trust to pay interest and make repayments on any proposed new borrowing, within the limits set by the Prudential Borrowing Limit guidance from NHS England. The Director of Finance and Estates is also responsible for reporting periodically to the Board concerning the Public Dividend Capital (PDC) and overdrafts.

10.1.2 Any application for PDC or overdraft will only be made by the Director of Finance and Estates and the Chief Executive or by an employee so delegated.

10.1.3 The Director of Finance and Estates must prepare detailed procedural instructions concerning applications for PDC and overdrafts.

10.1.4 All short term borrowing should be kept to a minimum period of time possible, consistent with the cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance and Estates and Chief Executive or an employee so delegated.

10.1.5 All long term borrowing must be consistent with the plans outlined in the Annual Plan.

10.2 INVESTMENTS

10.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board of Directors and in line with NHS England's guidance, "Managing Operating Cash in NHS foundation trusts".

10.2.2 The Director of Finance and Estates is responsible for advising the Board of Directors on investments and shall therefore report annually to the Board of Directors concerning the performance of investments held.

10.2.3 The Director of Finance and Estates will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

10.2.4 The Trust must comply with all relevant guidance published on investments from time to time in force.

10.3 WORKING CAPITAL FACILITY

The Board will ensure that funds are available for short-term cash flow management which may involve the negotiation of a working capital facility.

11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Annual Plan;

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) Shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) That a business case (in line with the guidance issued by NHS England) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
(ii) appropriate project management and control arrangements;
(iii) the involvement of appropriate Trust personnel and external agencies;

(b) That the Director of Finance and Estates has certified professionally the costs and revenue consequences detailed in the business case.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of NHS guidance and relevant capital investment guidance.

The Director of Finance and Estates shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

The Director of Finance and Estates shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure;

(b) Authority to proceed to tender;

(c) Approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with NHS guidance and the Trust's Standing Orders.

11.1.5 The Director of Finance and Estates shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 PRIVATE FINANCE

11.2.1 When the Trust proposes to use finance that is to be provided other than through its internally generated funds, the following procedures shall apply:

(a) The Director of Finance and Estates shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors.

(c) The proposal shall comply with guidance issued by NHS England/DoH or the Treasury.

11.3 ASSET REGISTERS

11.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and Estates concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health and Social Care.

11.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

11.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.3.5 The Director of Finance and Estates shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Annual Reporting Manual* issued by NHS England.

11.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Annual Reporting Manual* issued by NHS England.

11.3.8 The Director of Finance and Estates of the Trust shall calculate and pay capital charges as specified in the *Annual Reporting Manual* issued by NHS England.

11.4 Assets Used for Commissioner Requested Services

11.4.1 A register of assets used for the provision of commissioner requested services is required to be maintained in accordance with requirements issued by NHS England.

11.4.2 The Trust, as Licensee, shall not dispose of or relinquish control over, any relevant assets except with the consent in writing of NHS England and in accordance with the provisions of the Licence.

11.4.3 An Annual Plan will be produced which will include proposed changes in the treatment of such assets and proposed disposals and acquisitions.

11.5 SECURITY OF ASSETS

11.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and Estates. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Periodic verification of the existence of, condition of, and title to, assets recorded;

(f) Identification and reporting of all costs associated with the retention of an asset; and

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance and Estates.

11.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of the Board of Directors and senior employees to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by the Board of Directors and employees in accordance with the procedure for reporting losses.

11.5.6 Where practical, assets should be marked as Trust property.

12 STORES AND RECEIPT OF GOODS

12.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum;

(b) Subjected to annual stock take;

(c) Valued at the lower of cost and net realisable value.

12.2 Subject to the responsibility of the Director of Finance and Estates for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance and Estates. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil is the responsibility of a designated Estates Manager.

12.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer/Estates Manager. Wherever practicable, stocks should be marked as Trust property.

12.4 The Director of Finance and Estates shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.5 Stocktaking arrangements shall be agreed with the Director of Finance and Estates and there shall be a physical check covering all items in store at least once a year.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance and Estates.

12.7 The designated Manager/Pharmaceutical Officer/Estates Manager shall be responsible for a system approved by the Director of Finance and Estates for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance and Estates any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.8 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store.

The authorised person shall check receipt against the delivery note and shall satisfy himself that the goods have been received.

13 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The Director of Finance and Estates must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance and Estates of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance and Estates;

(b) Recorded by the Condemning Officer in a form approved by the Director of Finance and Estates that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance and Estates.

13.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and Estates who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Director of Finance and Estates must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

Losses are:

- Losses of cash;
- Fruitless payments, including abandoned capital schemes, bad debts and abandoned claims; and
- Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use.

Special payments are:

- Compensation payments made under legal obligation;
- Extra contractual payments to contractors;

- Ex-gratia payments; and
- Extra statutory and extra regulatory payments

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance and Estates or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance and Estates and Chief Executive.

Where a criminal offence is suspected, the Director of Finance and Estates must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies that may indicate fraud, bribery or corruption, the Director of Finance and Estates must invoke the Counter Fraud, Bribery and Corruption Policy.

13.2.3 The Director of Finance and Estates must notify the Counter Fraud Specialist and a report will be received by the Audit Committee of all frauds.

13.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance and Estates must immediately notify:

(a) The Board of Directors, and

(b) The External Auditor.

13.2.5 The Board shall approve the writing-off of losses. The levels of delegation are set out in the Reservation of Powers to the Board and Delegation of Powers.

13.2.6 The Director of Finance and Estates shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations and administrations.

13.2.7 For any loss, the Director of Finance and Estates should consider whether any insurance claim could be made.

13.2.8 The Director of Finance and Estates shall maintain a Losses and Special Payments Register in which write-off action is recorded. Summary details of all Losses and Special Payments will be reported to the Audit Committee in a formal meeting.

14 INFORMATION TECHNOLOGY

14.1 The Director of Finance and Estates, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he is responsible from accidental or intentional

disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 (or successor legislation);

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

14.2 The Director of Finance and Estates shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.3 The Director of Health Informatics shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes of information about the Trust that is made publicly available.

14.4 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance and Estates:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.5 The Director of Finance and Estates shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.6 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance and Estates shall periodically seek assurances that adequate controls are in operation.

14.7 The Director of Health Informatics shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

14.8 Where computer systems have an impact on corporate financial systems the Director of Finance and Estates shall satisfy himself that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) Data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Staff have access to such data;

(d) Such computer audit reviews are being carried out as are considered necessary; and

(e) Appropriate cyber/security measures are in place.

15 PATIENTS' PROPERTY

15.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious, confused or disorientated patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The Chief Operating Officer is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- Notices and information booklets,
- Hospital admission documentation and property records,
- The oral advice of administrative and nursing staff responsible for admissions,

That the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Director of Finance and Estates must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.4 Where instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance and Estates.

15.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

15.6 Where a deceased patient is intestate and there is no lawful next of kin, details of any monies or valuables held should be notified to the Treasury Solicitor.

15.7 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

15.8 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

15.9 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16 FUNDS HELD ON TRUST

16.1 These policies and procedures should be consistent with the NHS Charities Guidance as appropriate and as a minimum should cover the following:

- Receipting and accounting for income donations;
- Investment management (including banking and pooling arrangements); and
- Management of the number of funds and their balances.

16.2 The Reserved Powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action and ensure that commitments against individual funds are consistent with their specific objects. SFI are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

16.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

16.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

Income

16.5 All gifts, donations and proceeds of fund raising activities which are intended for the Trust's use shall be handed immediately to the Director of Finance and Estates or manager/employee nominated by him, to be banked directly.

16.6 All gifts and donations accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific charitable funds. As the Trust can accept gifts/donations only for purposes relating to the NHS, managers/employees shall, in cases of doubt, consult the Director of Finance and Estates before accepting any gifts/donations.

16.7 Where it becomes necessary for the Trust to obtain a grant of representation in order to obtain a legacy due to the Trust under the terms of a will, the Director of Finance and Estates shall be the Trust's nominee for this purpose. Where appropriate the Director of Finance and Estates shall seek legal advice upon the liabilities and other implications for the Trust of obtaining any such grant of representation.

16.8 All managers/employees who receive enquiries regarding legacies shall keep the Director of Finance and Estates, or person nominated by him, informed and shall keep an appropriate record. After the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Director of Finance and Estates who alone will be empowered to legally acknowledge receipt of the legacy on behalf of the Trust.

16.9 The Director of Finance and Estates shall advise the Board of Directors on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

Expenditure

16.10 All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds and expenditure for research purposes, must be for the benefit of patients or staff.

16.11 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Trust which have not been agreed and funded.

16.12 For expenditure up to £1,000 the payment shall be authorised by the nominated fund holder.

16.13 For expenditure above £1,000 but below £5,000 the authorising signatory will be the Director of Finance and Estates.

16.14 For expenditure above £5,000 but below £10,000 the authorising signatory will be the Chief Executive.

16.14 On expenditure over £10,000 the request will require Charitable Funds Committee approval.

Investments

16.15 Charitable funds shall be invested by the Director of Finance and Estates in accordance with the Trust's policy and statutory requirements.

16.16 In managing the investments the Trust shall take due account of the written advice received from its duly appointed Investment Advisors.

16.17 All title deeds to investments and property shall either be deposited with the Trust's nominated bankers / investment advisors or held securely in a safe with suitably restricted access. A record shall be kept of all physical movements of title deeds.

16.18 The Director of Finance and Estates shall be responsible for the maintenance of written instructions covering all aspects of transactions involving charitable funds.

16.19 The Director of Finance and Estates shall maintain such accounts and records as are necessary to record and protect all transactions and funds of the Trust as corporate trustee of charitable funds, including an Investments Register. These accounts and records shall be maintained in accordance with the requirements of the Charity Commission and other legislative requirements, including any directions of the Secretary of State.

16.20 New charitable funds will only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

17 TENDERING AND CONTRACT PROCEDURE

17.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions.

17.2 Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DoH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions.

17.3 The Trust should have policies and procedures in place for the control of all tendering activity carried out through the E-Tendering System.

17.4 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care/NHSI current guidance related to capital investment and “Health Building Note 00-08” in respect of estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS".

17.5 Formal Competitive Tendering

17.5.1 The Trust shall ensure that competitive tenders are invited for:

a) the supply of goods, materials and manufactured articles;

b) for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH);

c) for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

d) for disposals.

17.5.2 Where the Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

17.5.3 Formal tendering procedures need not be applied by officers to whom powers have been delegated by the Chief Executive, without reference to the Chief Executive where:

a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000, or

b) where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with;

c) regarding disposals as set out in Standing Financial Instruction 18

17.5.4 Formal tendering may be waived in the following circumstances:

a) In very exceptional circumstances where the Chief Executive and the Director of Finance and Estates decide that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures.

- The Director of Finance and Estates will approve the waiver up to the limit of £250,000
- The Chief Executive will approve the waiver over £250,000 but up to the limit of £500,000

- The Finance, Digital and Estates Committee (FDE) will approve the waiver over £500,000 but up to the limit of £1,250,000
- In excess of £1,250,000, approval of the Board of Directors will be required following the receipt of a report from the Director of Finance and Estates;

b) Where the requirement is covered by an existing contract;

c) Where NHS Supply Chain agreements are in place and have been approved by the Board;

d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

e) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

f) Specialist expertise is required and is available from only one source;

g) The task is essential to complete the project, **and** arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

h) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

i) Where provided for in the Capital Investment Manual;

j) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Solicitors Regulation Authority for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance and Estates will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

17.5.5 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. Requests for single tender will be approved by the Director and will be submitted to the Chief Executive and Director of Finance and Estates for consideration.

17.5.6 Where it is decided that competitive tendering is not applicable and should be waived by virtue of 17.5.3 or 17.5.4 above the fact of the waiver and the reasons should be documented and reported to the Audit Committee in a formal meeting.

17.5.7 Except where Standing Financial Instructions 17.1 and 17.6 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

17.5.8 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be documented and reported by the Chief Executive to the Board of Directors in a formal meeting.

17.6 Invitation to Tender

17.6.1 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described below.

17.6.2 Every tender for estates related works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or New Engineering Contracts (NEC series) standard forms of contract amended to comply with any specific NHS recommendations or the reasonable requirements of the Trust as approved by the Director of Finance and Estates. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institution of Engineering and Technology (IET). The standard documents should be amended to comply with any specific NHS recommendations, in minor respects, to cover special features of individual projects. The advice of architects/quantity surveyors and specialist consultants should be sought where appropriate.

17.6.3 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice, must not use “cover” prices and must maintain confidentiality.

17.7 Receipt, Safe Custody and Record of Formal Tenders

17.7.1 Formal competitive tenders with a value of £50,000 or more shall be received via the E-tendering system.

17.7.2 All tender returns are electronically audited and date stamped. The Director of Finance and Estates should nominate a Director to electronically unseal tenders – until such time as they are ‘unsealed’, the tenders remain secure and cannot be viewed.

17.8 Opening Formal Tenders

17.8.1 Directors designated by the Chief executive 'unseal' the tender bids received, utilising their individual log-in details.

17.9 Admissibility and Acceptance of Formal Tenders

17.9.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

17.10 Late Tenders

17.10.1 Tenders received after the due time and date, but prior to the unsealing of the other tenders, may be considered only if the Chief Executive or his nominated officer and the Director of Finance and Estates decide that there are exceptional circumstances.

17.10.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the process of evaluation and adjudication has not started.

17.10.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.10.4 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 17.10.

17.10.5 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

17.10.6 Necessary discussions with a tenderer of the contents of his tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

17.10.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and retained on the E-tendering portal.

17.10.8 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.11 Acceptance of formal tenders

17.11.1 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in the contract file and reported by the Chief Executive to the Audit Committee in a formal meeting for approval.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) Experience and qualifications of team members;
(b) Understanding of client's needs;
(c) Feasibility and credibility of proposed approach;
(d) Ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

17.11.2 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

17.11.3 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;
(b) that best value for money was achieved.

17.11.4 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

17.11.5 All Tenders should be treated as confidential and should be retained for inspection.

17.11.6 Where a tenderer alleges an error has been made in a tender submitted if the seal has not yet removed he may ask for the original tender to be withdrawn and may submit a revised tender within the original tender period.

17.11.7 A tenderer seeking to amend his tender, after the date of opening of tenders, will be advised that the original tender must stand unless he wishes to withdraw it.

17.11.8 A tenderer may withdraw his tender at any time before acceptance.

17.11.9 At any time prior to acceptance of a tender by the Trust the Chief Executive, or any officer authorised by him, may authorise post tender clarification if it appears that a marked financial advantage may accrue to the Trust or if subsequently there has been a bona fide change in specification which is not so significant as to warrant abandonment of the procedure and the invitation of further tenders. This should be undertaken with equality for all tenderers.

17.11.10 The time during which all clarifications shall be completed by receipt of written confirmation of any amendments shall be specified in the invitation and may be extended by notice in writing from the Trust to tenderers at any time.

17.11.11 After the responsible officer has examined all tenders received he will prepare a schedule of tenders and prices for submission to the Chief Executive, who will authorise acceptance of the lowest tender if payment is to be made by The Trust or highest if payment is to be received by the Trust, unless there are sufficient reasons to the contrary.

17.12 Verification of supplier/contract/consultant capacity, technical capability and competence prior to placing an order

17.12.1 Prior to placing an order with consultants/contractors the Chief Executive or the nominated officer should ensure that appropriate checks are carried out as to the capacity, technical capability and competence of consultants and contractors and that the Director of Finance and Estates is satisfied that their financial standing is adequate (to be verified immediately prior to a contract being let).

a) In the case of the supply of goods and materials the Chief Executive or the nominated officer is satisfied as to their capacity and capability etc, and that the Director of Finance and Estates is satisfied that their financial standing is adequate (to be verified immediately prior to a contract being let).

b) In the case of the provision of healthcare services to the Trust by a private sector provider, the Director of Finance and Estates is satisfied as to their financial standing and the Chief Nurse is satisfied as to their technical/medical competence.

c) Suppliers/contractors and consultant shall conform at least with the requirements of the Health and Safety at Work Act 1974, and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution or their trading agreement equivalents. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

d) Firms shall conform to all relevant Trust Policies.

17.13 **Quotations** - are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000 but not exceed £50,000.

17.13.1 Where quotations are required they should be obtained from at:

- two firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust for intended expenditure to be between £5,000 and £15,000
- at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust for intended expenditure to be between £15,000 and £50,000

17.13.2 Quotations should be in writing or in electronic form, unless the Chief Executive or his nominated officer determines that it is impractical to do so, in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

17.13.3 Quotations with an estimated value of £15,000 and £50,000 will be returned to the Deputy Director of Finance.

17.13.4 The date and time of receipt shall be endorsed over the flap of the envelope, if received by post, and be given a reference number, which information, together with the contract reference number will be entered in the Finance Control of Quotation and Tenders register. Electronic submissions will be electronically referenced and recorded.

17.13.5 Opening of Quotations - Quotations shall be opened jointly by two of the three officers; Deputy Director of Finance, Head of Financial Management (MH), Head of Financial Planning and Reporting, Head of Financial Management (Children's and Communities) or their nominated Deputies.

17.13.6 The value of the quotation will be recorded in the Quotations and Tenders register. Electronic submissions will be electronically referenced and recorded. The two officers opening the quotations shall sign all entries in the register. When all quotations have been recorded the documentation will be passed to the Head of Estates or Purchasing Manager as appropriate.

17.13.7 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

17.13.8 All quotations should be treated as confidential and should be retained for inspection for 3 years.

17.13.9 Quotations may be sought without a competitive process may be obtained for the following purposes:

a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive and Director of Finance and Estates, possible or desirable to obtain competitive quotations;
b) the goods/services are required urgently.

17.13.10 Where tendering or competitive quotation is not required Trusts should adopt one of the following alternatives:

The Trust shall use the NHS Supply Chain for procurement of all goods and services, if demonstrates value for money, unless the Chief Executive and Director of Finance and Estates deem it inappropriate. The decision to use alternative sources must be documented.

If the Trust does not use the NHS Supply Chain - Where tenders or quotations are not required, because expenditure is below £2,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Trust.

17.13.11 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.14 Contracts - The Board of Directors may only enter into contracts on behalf of the Trust and shall comply with:

(a) These Standing Financial Instructions;
(b) Trade agreement Directives and other statutory provisions;
(c) Any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;
(d) Such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract, as was the basis on which tenders or quotations were invited.

17.14.1 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.14.2 Personnel and Agency or Temporary Staff Contracts - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.14.3 Healthcare Services Contracts – Healthcare Service Contracts made between two NHS organisations, for example, with health organisations for the supply of healthcare services, must be contracts based on model contracts issued by the Department of Health and Social Care.

17.14.4 Cancellation of Contracts: Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him or acting on his behalf shall have committed any offence under the Fraud Act 2006 and other appropriate legislation including the Bribery Act 2010.

17.14.5 Determination of Contracts for Failure to Deliver Goods or Material – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

17.14.6 Contracts involving Funds Held on Trust – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

18 DISPOSALS

18.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Director of Finance and Estates or his nominated officer;
(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
(c) Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually;
(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) Land or buildings concerning which guidance has been issued by NHS England, but subject to compliance with such guidance.

19 ACCEPTANCE OF GIFTS BY STAFF

19.1 The Chief Executive through the Director of Corporate Assurance shall ensure that all staff are made aware of the Conflicts of Interest Policy which refers to the acceptance of gifts and other benefits in kind by staff and that the required registers are in place and maintained. This policy should follow the guidance contained in the Department of Health and Social Care Standards of Business Conduct for NHS Staff.

20 RETENTION OF DOCUMENTS

20.1 The Chief Executive shall be responsible for the management of all NHS records by the Trust, regardless of the media on which they are held.

20.2 The Chief Executive shall ensure that the Trust adopts information governance arrangements which comply with the principles and guidelines contained in the Department of Health and Social Care's "Records Management: NHS Code of Practice Parts 1 and 2 (Part 1: 5 April 2006; and Part 2: 8 January 2009) as may be varied from time-to-time (the "Records Management Code").

20.3 The records held in archives shall be capable of retrieval by authorised persons in accordance with the provisions of the Records Management Code.

20.4 Records held by the Trust under the Records Management Code shall only be destroyed at the express instigation of the Chief Executive. The Chief Executive shall ensure that records are maintained of documents so destroyed in accordance with the Trust's Policy.

21 RISK MANAGEMENT

21.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which must be approved and monitored by the Board of Directors.

21.2 The programme of risk management shall include:

a) A process for identifying, quantifying and prioritising risks and potential liabilities;
b) Engendering among all levels of staff a positive attitude towards the control of risk;
c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) Contingency plans to offset the impact of adverse events;
e) audit arrangements including; internal audit, clinical audit, health and safety review;
f) Decision on which risks shall be insured; and
g) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts.

21.3 The Director of Finance and Estates shall ensure that insurance arrangements exist in accordance with the risk management programme.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – December 2023	**Agenda Item**	Paper N
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jill Fairbank – Head of Contracting, Performance & CQUIN Richard Chillery – Chief Operating Officer		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

In terms of our headline commitments:

- Important to note a monthly "performance clinic" will now be in place, starting 15th January and improvement (or maintenance) trajectories have been developed for those in the big 6, namely Talking Therapies (OP3); Perinatal Mental Health (OP07); CYP (OP13a and OP13b); CMHT access (OP13c). Physical health work closely with the acute sector to maximise opportunities for use of virtual wards and a noted improvement in Out of Area placements (on 31.12.23, this was 12) through local care group oversight but will require a dedicated programme of work in 2024/25.
- While Perinatal is currently on track for delivery it will be important that the RDaSH activity is maintained for Q4. Areas of concern remain the CYP target which has dropped in December; CMHT access but a significant amount of work is under way regarding data validation and quality (a consistent theme in several of the KPI) and Talking Therapies access target. There has been a small improvement in Talking Therapies recovery to 49/9%/50%.
- Following a deep dive there is one individual case of a true absconsion reported for December. This is subject to a serious incident investigation. The other five are not true absconsions, but due to timely return to wards following leave. The "AWOL" policy is being reviewed.
- The MUST target remains well below target (52%) and while there has been a month-on-month improvement since June, the progression is slower than expected. This was a focus within the December delivery reviews (DR), which will be revisited in the January DR for assessment against plans and anomalies have been identified in data reporting and the report logic is to be analysed and will continue to be updated by the end of January.
- Due to targeted work in December the number of Inpatients receiving a falls assessment within 72 hours has increased to 97.50% in December from 88.54% in November.
- For workforce we note the Trust turnover (POD09) has reached the 10% target; at 10.51%, additionally with a small increase in sickness (POD10) from 5.18% to 5.39%. The increase was seen across all areas, except Childrens Care Group (- 0.77%) and Physical Health (- 0.33%). The largest increase was in Rotherham Care Group (+1.81%) and will require a deep dive to investigate. Sickness will impact on continuity of care and increases usage of bank and agency staff to mitigate. This will sit alongside challenges in recruitment, for example the reported 16 consultant vacancies (POD15) which will impact on delivery, reflected in risk registers.
- There is a slight reduction in MAST (POD 19), to 89.38% but a worthy note of the significant improvement in PDR (POD 18) compliance with 96.41% individuals having a PDR within 12 months and achieving the 90% target.
- The financial forecast for 23-24 is a deficit of £4.3m, against a planned deficit of £6.15m. This includes a £3.5m contribution to the South Yorkshire ICB planning gap of £106m as reported to the Board in November. The forecast includes in year investment to address waiting list issues and additional expenditure linked to urgent and emergency care over the winter period.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)							
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services					X		
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings					X		
Business as usual					X		
Previous consideration (where has this paper previously been discussed – and what was the outcome?)							
Clinical Leadership Executive – 16 January 2024 Quality Committee – 17 January 2024							
Recommendation (Indicate with an 'x' all that apply and where shown elaborate)							
The Board of Directors is asked to:							
x	**TAKE ASSURANCE that** the Trust is delivering against the Oversight Framework Compliance Report and against the metrics contained within the Integrated Quality and Performance Report and where action is off track to outline that the Trust have plans in place in order to work towards the required targets.						
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)							
Trust Risk Register	x	O 10/19, O1/23, NQ 12/23, NQ 3/23, DCGMH 1/23, RCG 2/23, NLCG 1/23,POD 2/23, WF 1/20, FP 1/22, TT 3/23, O 1/20,					
Board Assurance Framework	x	SR3					
System / Place impact		Relevant to partnership discussions/Delivery of LTP metrics					
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Appendix (please list)							
None.							

Integrated Quality Performance Report

January 2024 Review

Data as at 31st December 2023

Contents

1.0 Executive Report

This report outlines the December position against the Nationally Mandated Long Term Plan targets (The Big Six) and other key indicators, including quality, workforce and finance data.

The Trust continues to deliver against a number of the key performances metrices but there are areas for development and action to be noted:

Physical health services continue to perform well against (OP05; OP08b) the 1 recorded wait of 73 weeks is currently under investigation to confirm if this is a true wait or a clinical recording / data quality related. The number of available beds on the virtual ward is 60 with average occupancy in December of 38. The occupancy on the ward has peaked at 43 patients and we continue to develop new pathways to expand utilisation, being further encouraged with acute partners. They have also expanded several effective winter schemes. It is noted that from February 2024 virtual ward utilisation will be reported on the 1st, 15th and 30th of the month.

A monthly Performance Clinic which will provide additional oversight and strengthen the rigour around management of the delivery of the Big 6 metrics for Q4. We now have individual improvement plans and performance monitoring and forecasting, except for OAP's. Where there is cause for concern against delivery then weekly task and finish groups are also in place to monitor and drive the improvement actions. At present the focus remains on Talking Therapies Access (OP03) Perinatal Access (OP07) CYP Access (OP13a) and Adults accessing community mental health services with 2 clinical contacts in a rolling 12 months (OP13c).

Within Childrens services there is a reported a deterioration in performance in December 2023 for children and young people (CYP) accessing services (OP13a), as this is a concern, we have initiated an immediate deep dive into the performance around this metric. A weekly task and finish group is to be scheduled from 8th Jan to monitor improvement with a focus on partners at place and to ensure that from an RDash perspective the clinical recording captures all the clinical contacts on referral into service. Data quality, recording of data and its validation is a key issue, in relation to the accurate recording of delivery these services. This is also the case for OP13c; where data validation work in North Lincolnshire has improved the position by approximately 300 and this work will continue.

Eating Disorder service continues to perform well with all most urgent cases received into the service seen within 1 week (OP15) and 94% of our children and young people referred into service are seen within 4 weeks (OP14).

A continued concern remains around Talking Therapies access rates where we are forecasting not to achieve the year-to-date access target (OP03), but considerable work is under way. Weekly monitoring meetings are in place. The concern raised last month with the recovery rates has improved to 49.9% in December, remaining just below the 50% target. This is reflective of the improvement in recovery rates in North Lincolnshire (52.46% in December) and Doncaster (49.15% in December). The identified actions taken to focus on improving clinical recording and completeness has supported this improvement however, this metric will be continued to be monitored to ensure the improvement is sustained.

There has been a continuing reduction in out of area placement 14 as at the 4th of Jan 2023 through focused efforts of Care groups and the flow team (this is likely to go up in January due to the Christmas period) however, this remains an area of concern and will require a significant work programme in 24/25 to address the whole patient pathway – with the quality measure of out of area placements.

The percentage of Venous thromboembolism assessments (QS08) completed within 24 hours has increased this month from 84.62% in November to 90.32% in December however remains below the 95% target. Despite this improvement it is noted that there is a drop in performance in our Rotherham locality from 93% in November to 77.78% in December. The other 2 localities are both reporting a month-on-month improvement with North Lincolnshire reporting performance of 90% and Doncaster 94.25%. A deep dive is to take place in North Lincolnshire to understand the significant drop in performance this month and remedial action.

1.0 Executive Report

The metric in relation to seclusion (QS31) has recently been amended to report the number of episodes of seclusion receiving an internal MDT assessment within 5 hours. The baseline performance for December has improved slightly and is reported as 64.71% of patients receiving assessment within timescale. The risk is highlighted on the risk register for each Care Group and whilst it is acknowledged that it is likely to be an ongoing risk, patients are given regular reviews as per policy and within the legal framework to meet the Mental Health Act requirements. This is documented on the electronic patient record and compliance is monitored by the Mental Health Act Manager.

There is a month-on-month improvement in patients commenced with falls assessment in 72 hours with performance reported in December as 93.75% remaining just slightly below the 94% target (QS37), there remains a strong focus on improving this and all 5 patients have been reviewed for learning.

The number of MUST assessments (QS36) has continued to slowly improve month on month since June 2023 however remains low at 55.65%. This will continue to be a focus of improvement for the senior leadership teams and a pilot around data recording is being tested out and will be followed up in the January delivery reviews.

It is important to note in the workforce domain that there has been a slight deterioration in absence levels from 5.19% to 5.39%. This increase was seen across all areas except for Children's Care Group (0.77% decrease in month) and Physical Health and Neurodiversity Care group (reduction of 0.33%). The largest increase was in Rotherham Care Group at 1.81%. This will sit against a small increase in turnover (10.51%) and vacancies, such as the 16 Consultants vacancies. A creative attraction package and campaign is required.

Similarly, Mandatory and Statutory training (MAST) compliance has seen a slight deterioration on last month from 92.23% to 89.38% but a potential causative factor is the Olive McGowan has bene introduced which may affect December's targets. However, Performance and Development Review compliance has achieved the 90% target with the specific focus identified last month with Care Groups and corporate services has had a positive impact with 96.41% of individuals having a completed performance and development review in the last 12 months.

The financial position is reporting a deficit in month 9 of £0.5m which is £2.85m better than plan. Although returning to recurrent financial balance remains a significant challenge this could enable some targeted in year investment to address waiting list and other performance issues.

The financial forecast for 23-24 is a deficit of £4.3m, against a planned deficit of £6.15m. This includes a £3.5m contribution to the South Yorkshire ICB planning gap of £106m as reported to the Board in November. The forecast includes in year investment to address waiting list issues and additional expenditure linked to urgent and emergency care over the winter period.

2.0 - Performance – In Focus

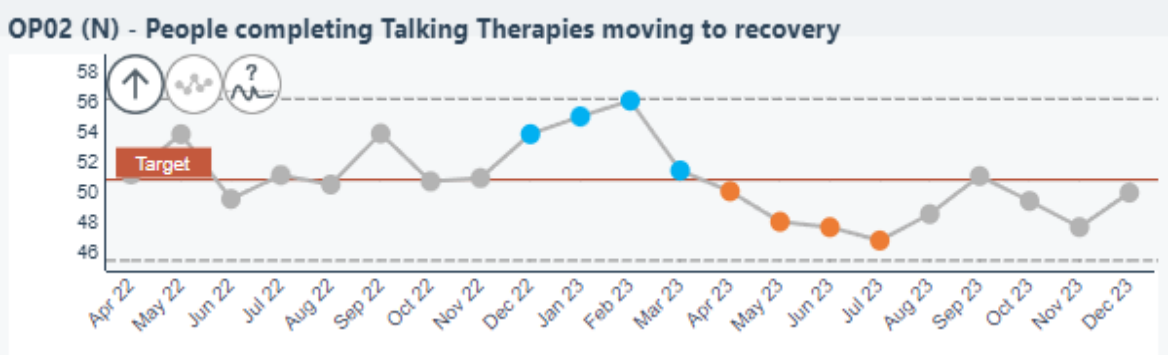
Indicators for December 2023/2024 Trust — Performance

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)	People first episode in psychosis started treatment in 2 wks		7/8	87.50%		83.00%	>= 60%	85.00%
OP02 (N)	People completing Talking Therapies moving to recovery		255/507	50.30%		49.00%	>= 50%	49.00%
OP03 (N)	People accessing Talking Therapies			888		3766	>= 16939	12016
OP05 (N)	People in physical health crisis assessed within 2 hours		62/75	82.67%		83.00%	>= 70%	89.00%
OP07 (N)	Women receiving support from perinatal mental health service			0		72	>= 469	405
OP08a (N)	18 Wks RTT for consultant led Learning Disabilities		32/35	91.43%		90.00%	>= 92%	86.00%
OP08b (N)	18 Wks RTT for consultant led Physical Health		274/293	93.52%		97.00%	>= 92%	98.00%
OP10a (N)	>65 Wks wait for consultant led Learning Disabilities			0		0	= 0	0
OP10b (N)	>65 Week waits for consultant led physical health services			1		1	= 0	1
OP12 (N)	People discharged from MH inpatients followed up in 72 hrs		42/51	82.35%		86.00%	>= 60%	85.00%
OP13a (N)	People accessing CYP services with >= 1 contact			7351		7351	>= 9003	7351
OP13b (N)	People accessing CYP services >= 2 contacts and paired score		714/4041	17.67%		18.00%	>= 20%	16.00%
OP13c (N)	Adults accessing community mental health services							
OP14 (N)	People (CYP) with routine eating disorders seen within 4 wks		151/160	94.38%		94.00%	>= 95%	93.00%
OP15 (N)	People (CYP) with urgent eating disorders seen within 1 wk		6/6	100.00%		100.00%	>= 95%	100.00%
OP17 (N)	Inappropriate out of area acute mental health bed days			639		2284	<= 915	5491
OP19 (N)	MHSDS score for data quality maturity index (DQMI)		985/1000	98.50%		99.00%	>= 95%	99.00%
OP54 (L)	People cared for on virtual wards			60		60	>= 130	60

Narrative

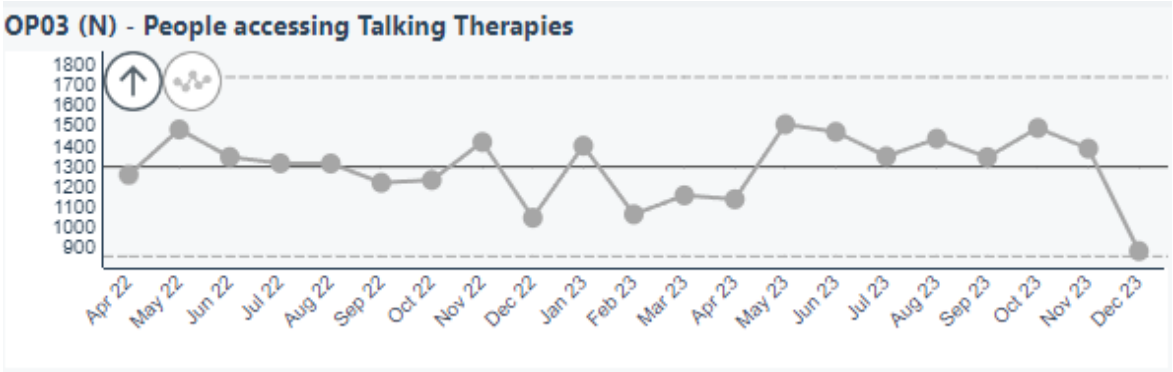
OP02 – TT Recovery, recovery has improved this month primarily in our Doncaster and North Lincs localities. Reporting in December at 49.90% just below 50% target.
OP03 – This is a place target and once Ieso (994) and RDaSH (12,013) activity is factored in actual YTD performance is 13,007. This remains below the YTD target of 16,939. Focus is on the achievement of the Q4 target.
OP07 – Performance is meeting the required year to date target and is forecasting to meet the 23/24 Long Term Plan target This is the place target RDaSH (405) and Maternal Mental Health Service (SHSC) (95) activity is factored in the YTD performance is reported as 500 above the YTD target of 469.
OP08a – The 3 breaches are currently under investigation. To establish if they are true waits or relating to data quality.
OP13a – There has been a slight deterioration in performance this month when compared to last month. When place activity is factored into the actual value YTD is 8220 (RDaSH 7351, Kooth/Mind 869) and remains below the YTD target of 9003.
OP13b – There is a slight deterioration in performance this month to 17.67%. Deep dive is to be instigated to be completed by the 15th Jan 2023.
OP13C – Performance for this metric is not available until the 12th of January.
OP14 – Children and young people with urgent eating disorders are being seen in a timely way performance against the 4 week target remains static at 94.38% just below the 95% target. (OP15) Urgent cases are seen within 1 week with performance remaining at 100%.

2.1 Performance In Focus - Exceptions



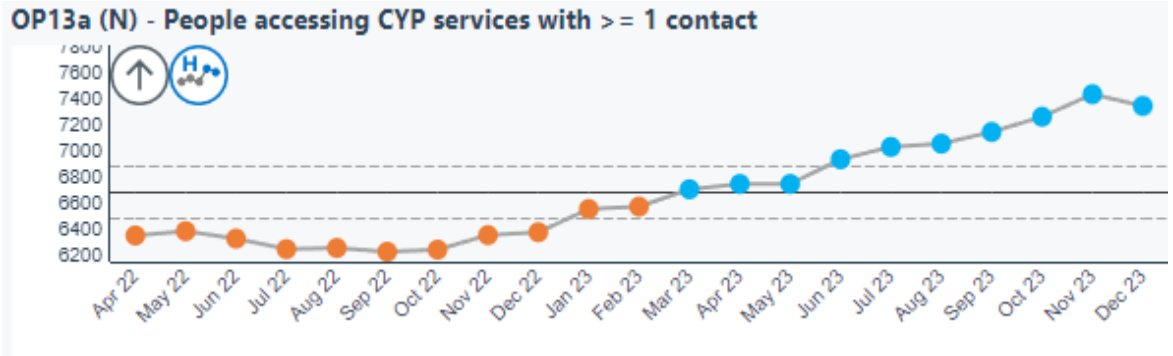
Trend, Reason and Action

Performance in December has improved on November 2023 for individuals moving to recovery with the main improvement within our North Lincolnshire and Doncaster localities. Recovery support meetings in January will continue with individual staff members to support with caseload management, and our communications and engagement officers are continuing to work with our GP's/primary care colleagues and our Primary Care Mental Heath hub team to look at suitability of patients and the service referral criteria. Within North Lincolnshire the actions taken to focus on improving clinical recording and completeness have resulted in an impact in performance for December.



Trend, Reason and Action

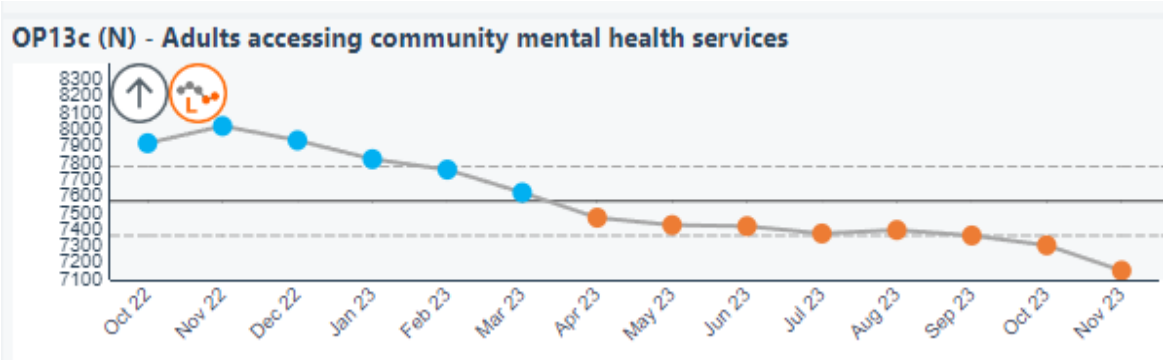
The Talking Therapies access rate (OP03) remains below the national target. A workshop held on the 5th December considered a range of options to improve this target for Q4, with a focus on groups not currently accessed such as substance misuse. Weekly monitoring meetings will commence from the 8th Jan and a detailed improvement plan is in development to support with delivery as we move into Q4. A Performance clinic will be held on the 15th January to discuss the improvement planning, forecasting and delivery of the required Q4 target.



Trend, Reason and Action

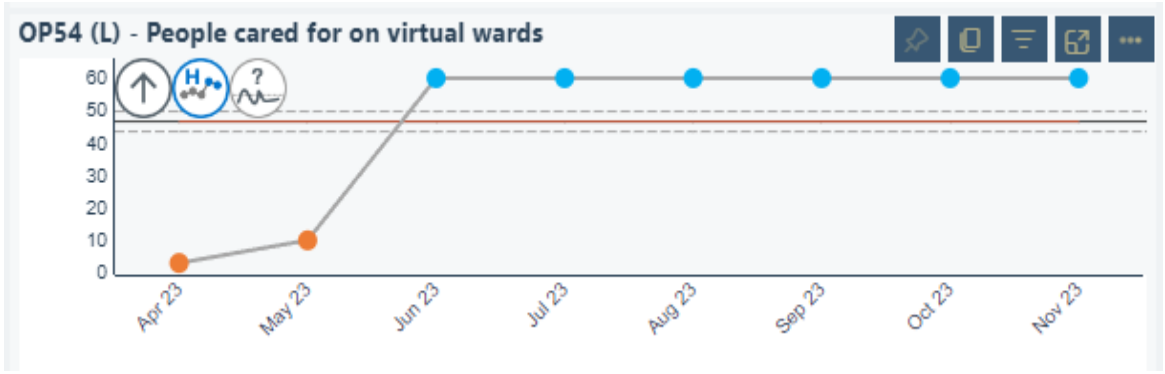
The children and young people access rate (OP13a) is the place target and activity needs to reflect all NHS funded activity across the 3 places. The place activity for Doncaster and North Lincolnshire is not included in the graph however, when factored into the actual activity the YTD position is 8220 and remains below the target of 9003. A task and finish group is in place to monitor improvement actions and performance. There is a focus on partners at place and to ensure that from an RDaSH perspective the clinical recording captures all the clinical contacts on referral into service. A Performance clinic will be held on the 15th January to discuss the improvement planning, forecasting and delivery of the required Q4 target.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

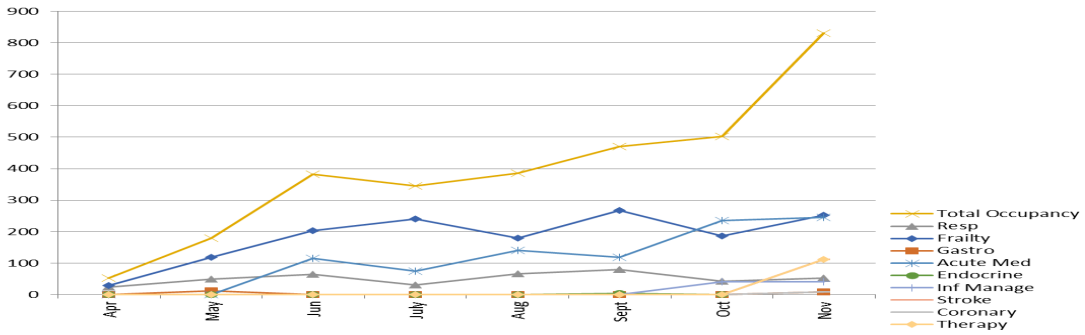
The reporting for December month is not available until the 12th January however the focus for the delivery of the metric is primarily around clinical recording. As a result the Improvement actions focus on two key areas, firstly the rectification of historical recording where the work commenced in December with an upturn in performance of around 300. This analysis continues with a view to having completed all historical corrections by the end of January. The second focus is on current recording by our clinicians and will focus on communication/training and ongoing monitoring and support to our Care Groups. A Performance clinic will be held on the 15th January to discuss the improvement planning, forecasting and delivery of the target.



Trend, Reason and Action

The number of available beds on the virtual ward is 60 with occupied beds remaining with average occupancy in December as 38 and a peak of 43 at the end of December. OP54a provides a detailed breakdown of the increasing occupancy for our virtual wards. There is continued engagement with the DRI SLT (via COO) to further expedite referrals from DRI consultants, along with increased number of clinical pathways into VW.

OP54a (Total Monthly Occupancy – Virtual Wards, Bed days



Trend, Reason and Action

The monthly total of occupied beds on the virtual ward has seen a increasing month on month trajectory since opening in April 2023. The occupancy on the ward has peaked towards 43 patients and we continue to develop new pathways and to utilise pathways consistently from a step down perspective. There is limited step up capacity as we are only able to utilise one consultant geriatrician.

From February 2024 virtual ward utilization will be reported on the 1st, 15th and 30th of the month.

3.0 Quality & Safety In Focus

Indicators for December 2023/2024 Trust — Quality & Safety

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS04 (L)	% Patient Safety Alerts completed by the required deadline.	= 100%	100/100	100.00%		100.00%	= 100%	100.00%
QS05 (N)	Number of MRSA infections	= 0		0	Q3 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections	= 0		0	Q3 = 0	1	= 0	1
QS07 (N)	Number of gram-negative bloodstream infections	= 0		0	Q3 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	113/124	91.13%	Q3 >= 95%	87.00%	>= 95%	86.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		16/18	88.89%		82.00%	>= 90%	82.00%
QS19 (L)	Number of AWOL's from low secure units (Amber Lodge)			0		0	= 0	0
QS20 (L)	No detained patients absconded acute adult/OP inpatient MH			6		12	= 0	29
QS21a (L)	Physical aggression incidents mod or above to staff		1/132	0.76%		1.00%		1.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats		1/132	0.76%		1.00%		1.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		0	Q3 = 0	0	= 0	0
QS27 (L)	Ligature incidents mod or above all inpatient areas		1/23	4.35%		10.00%	<= 10%	8.00%
QS29 (L)	Number of racist incidents against staff members			6		13	= 0	37
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		11/17	64.71%		69.00%	= 100%	62.00%
QS36 (N)	Inpatients that have a completed MUST assessment		69/124	55.65%		55.00%	= 100%	52.00%
QS37 (L)	Inpatients commenced with falls assessment in 72 hrs		78/80	97.50%		96.00%	= 100%	95.00%
QS38 (L)	Moderate/high falls subject to a Structured Review	= 100%	1/30	3.33%	Q3 = 100%	4.00%	= 100%	5.00%

Narrative

QS06 –The one incident being reported is not an RDaSH acquired infection.

QS08 - The percentage of VTE assessments completed within 24 hours has shown an increase month on month in the previous three months. It has increased to 91.13% in December from 84.62% in November and 82.22% in October. Although this remains below the year-to-date trust target of 95%.

QS15 – Safer staffing performance remains at 88.89% with 16/18 wards reporting compliance

QS20 – The total number of detained patients who abscond from acute adult and OP inpatient mental health units has breached the zero target. Following a deep dive there is one individual case of a patient absconding from the ward reported for December. The other five are patients that are going on leave and failing to return in a timely way.

QS29 –The number of racist incidents against staff members bas shown a slight increase in December to 5 from 3 reported in November.

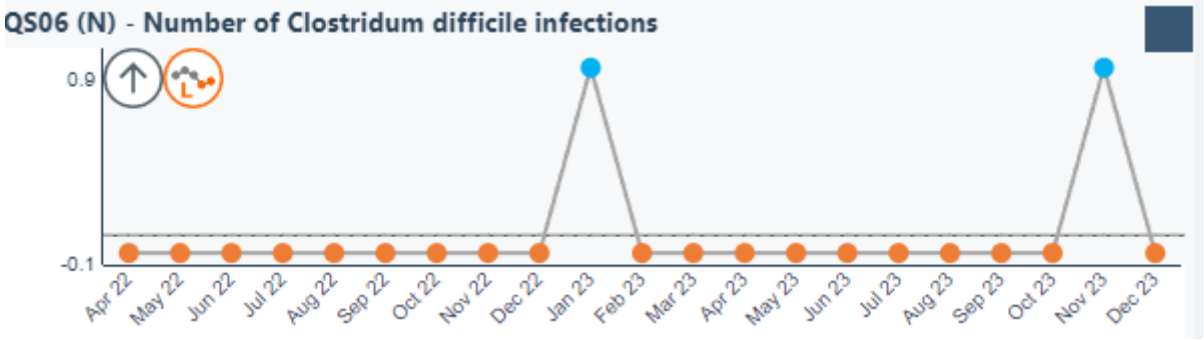
QS31 – The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for December with 94% of patients receiving assessment within timescale.

QS36 – There is an acknowledgement that current reporting is significantly below Trust target. However, there has been a month-on-month improvement since June onwards.

QS37 – The number of Inpatients receiving a falls assessment within 72 hours has increased to 97.50% in December from 88.54% in November

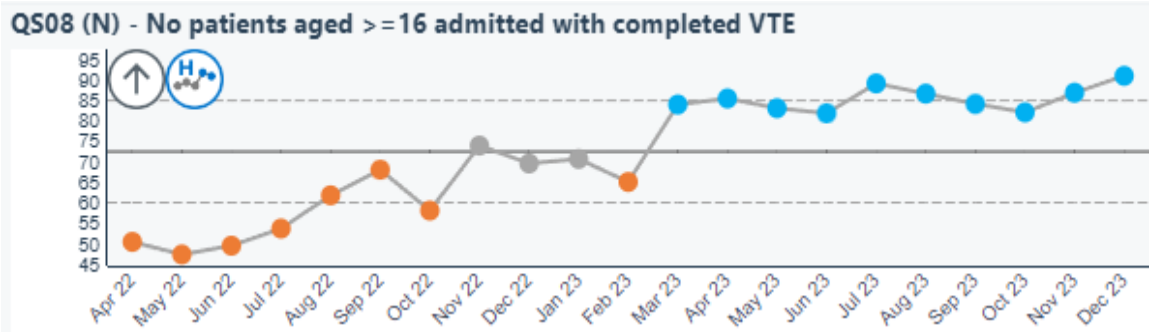
QS38 - Has maintained an upwards trajectory. It has been identified that 1 fall was reported as being moderate or above for December having been identified by the falls panel as requiring a structured review

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

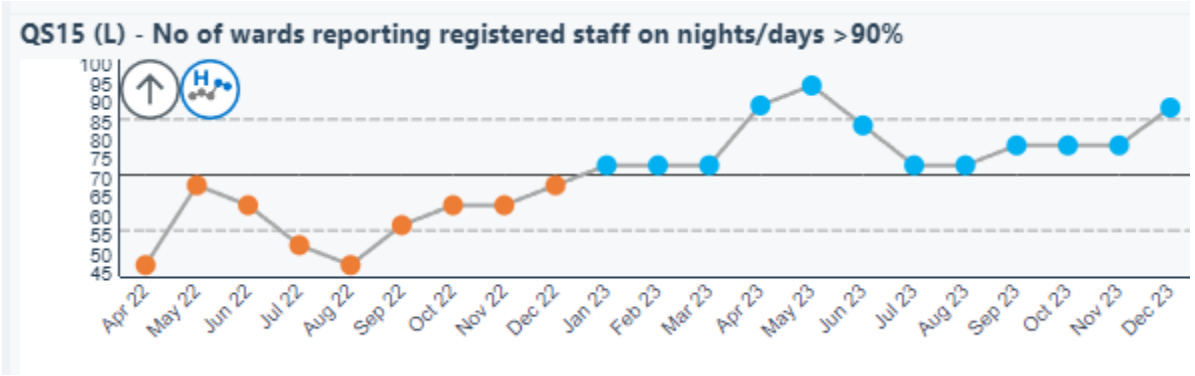
The total number of patients with a Clostridium difficile infection has breeched the zero target for November with one incident being reported. Following a deep dive this patient has been recorded on the IPC HCAI Report (under questionnaires) as having C.diff infection. However as the patient tested positive less than 72 hours after admission this episode of infection is not RDaSH acquired and therefore not attributed to RDaSH. It will not be recorded on the IPC quality dashboard for this reason.



Trend, Reason and Action

The percentage of VTE assessments completed within 24 hours has shown an increase month on month in the previous three months. It has increased to 91.13% in December from 84.62% in November and 82.22% in October. Although this remains below the year-to-date trust target of 95%. there has been ongoing work to improve compliance with targeted work being completed to improve performance and the sharing of good practice.

Physical health wards have conducted a deep dive and are conducting weekly audits which are acted on if the VTE assessment is not fully completed. Issues are discussed with the staff on the discharging ward through supervision with individual staff members. Any gaps in assessment or appropriate actions are escalated to the GP or the ACP on duty to address. Deep dives are taking place in Rotherham and North Lincs.



Trend, Reason and Action

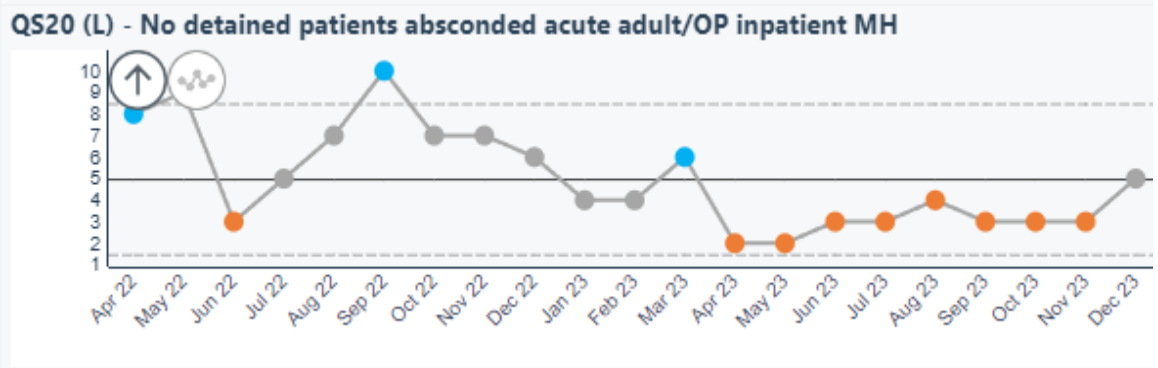
Safer staffing performance remains at 88.89% with 16/18 wards reporting compliance. However, there have been no incidences where business continuity plans have been enacted due to staffing as per escalation process in the safe staffing policy.

All Care Groups are currently reviewing and updating risk registers in relation to workforce and systems are in place to dynamically assess staffing using daily meetings and staff movement.

The second phase of MHOST Data collection has been completed. Findings have been disseminated to the respective Care Groups for data validation. Further work is required to support the use of the tool and a plan is in development for biannual reviews. This will then lead into the next phase of establishment assessment in ward-based staffing.

Any quality and safety impacts are identified, and local hotspots are triangulated in the safer staffing report presented at Quality Committee bi-monthly.

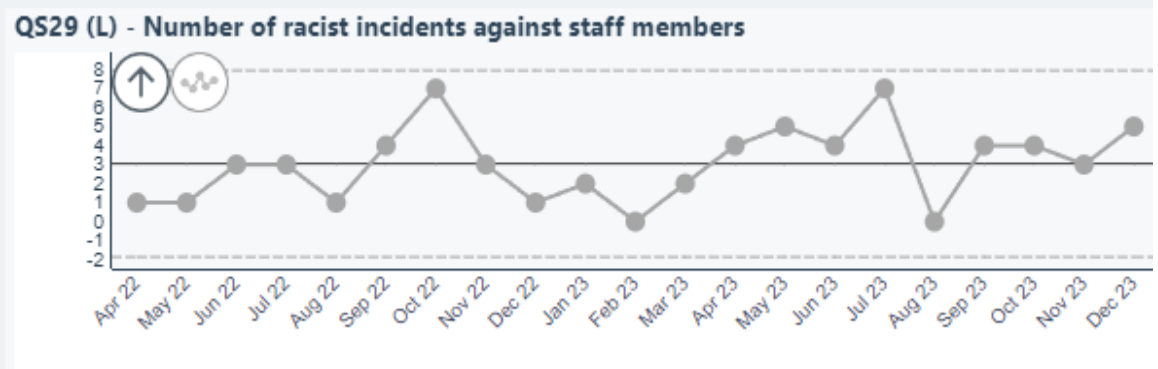
3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

The total number of detained patients who abscond from acute adult and OP inpatient mental health units has breached the zero target. IQPR is showing six cases.

Following a deep dive there is one individual case of a true absconsion reported for December. This is subject to a serious incident investigation. The other five are not true absconsions

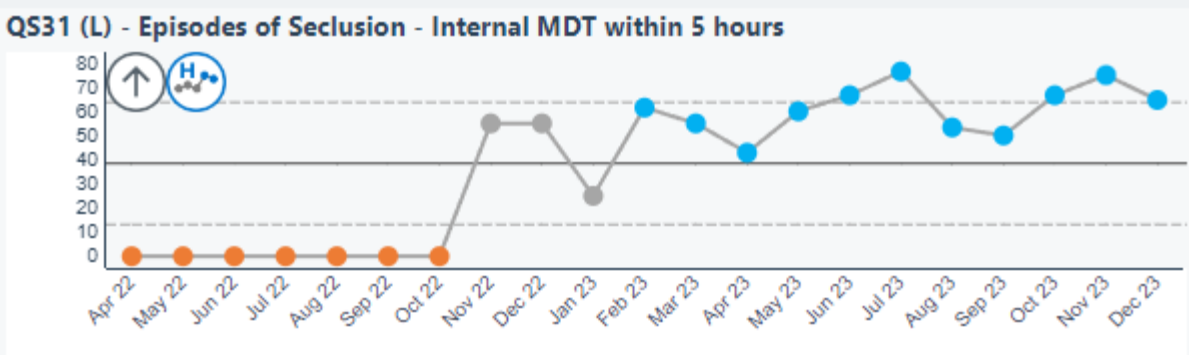


Trend, Reason and Action

The number of racist incidents against staff members has shown a slight increase in December to five from three reported in November.

All incidents are reported via IR1 and discussed individually with staff members and warnings are issued where appropriate to patients. At ward level staff are supported by managers and encouraged to discuss issues and concerns during supervision. This measure is currently being explored to be owned jointly by HR and Quality and Safety.

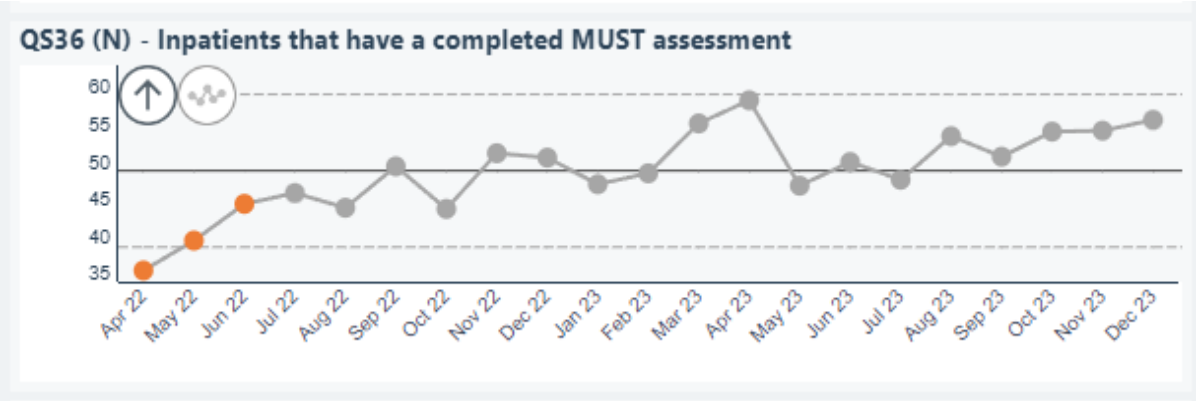
3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

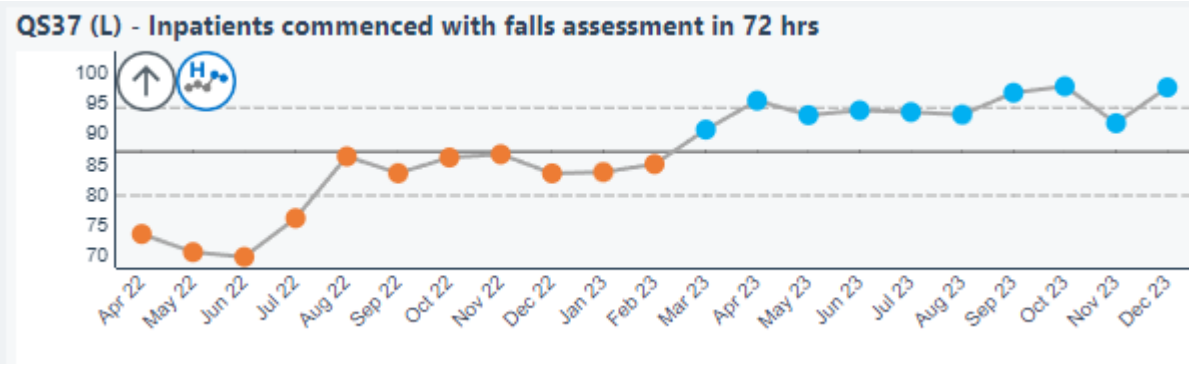
This new metric for November to report the number of episodes of seclusion receiving an internal MDT assessment within 5 hours. The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breeched the Trust's 100% target with 64.71% of patients receiving assessment within timescale.

The risk is highlighted on the risk register for each Care Group and whilst it is acknowledged that it is likely to be an ongoing risk, patients are given regular reviews as per policy and within the legal framework to meet the Mental Health Act requirements. This is documented on the electronic patient record and compliance is monitored by the Mental Health Act Manager.



Trend, Reason and Action

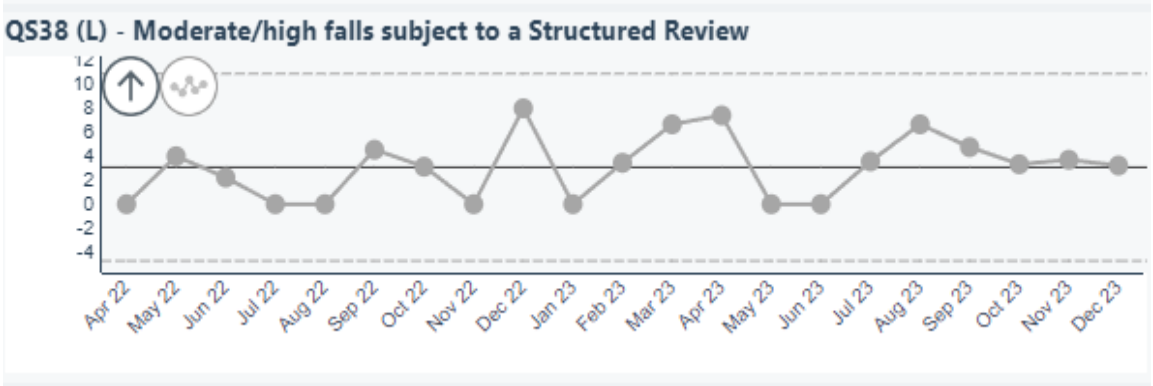
Performance has improved month on month since May 2023 and the introduction of the Trust wide metric from the parameters of the CQUIN where only a small number of wards were included. There is an acknowledgement that current reporting is significantly below Trust target. Anomalies have been identified in data reporting and the report logic is to be analysed and will continue to be updated by the end of January.



Trend, Reason and Action

The number of Inpatients receiving a falls assessment within 72 hours has increased to 97.50% in December from 88.54% in November. Two patients didn't receive a falls assessment within 72 hours in October, and eight patients for November. Four of these were on Hawthorn Ward. This is being investigated by the falls lead to see if there are any themes and trends relating to this. It is recognised this data is a snapshot as of the 1st of December 2023.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

Has maintained an upwards trajectory. It has been identified that 1 fall was reported as being moderate or above for December having been identified by the falls panel as requiring a structured review. The fall on Windermere resulted in a hip fracture and the date for the panel review is to be scheduled. This one moderate harm fall is being managed within the SJR process to ensure compliance with target. Discussions are underway and a meeting took place in November with the Falls Lead to review reporting parameters

4.0 People and Organisational Development – In Focus

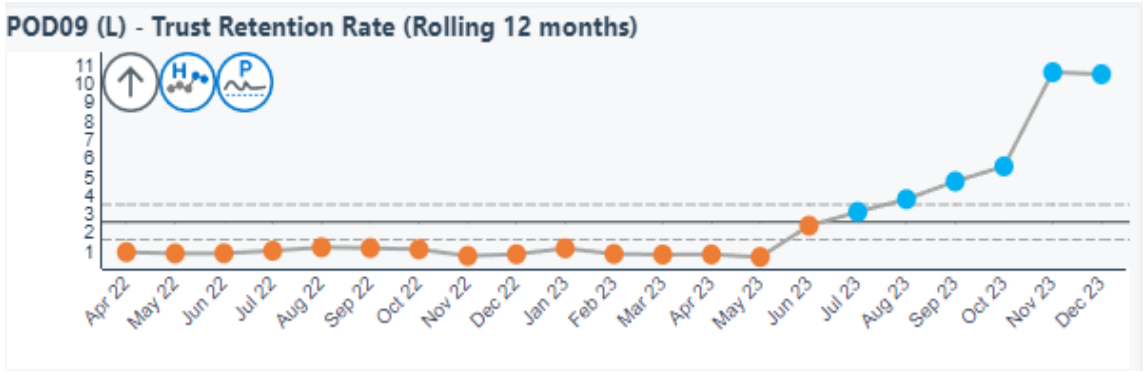
Indicators for December 2023/2024 Trust — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	10.51%		11.00%		11.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.39%		5.00%		5.00%
POD12 (L)	Number staff who have had an annual flu vaccination		2341		2341	= 0.7	2341
POD15 (L)	Number of Consultant Vacancies	<= 10	16		16		16
POD16 (L)	Qualified nursing vacancies	<= 10%	7.99%		8.00%		9.00%
POD17 (L)	Support worker vacancies	<= 10%	0.00%		4.00%		3.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	96.41%		96.00%		96.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	89.38%		89.00%		89.00%
POD23 (L)	Number of individuals currently suspended from employment		3				
POD24 (L)	Average suspension length in calendar days	<= 150	85		85		85
POD25 (L)	Recruitment completed within 12 weeks		88.89%				
POD26 (L)	Compliance for safeguarding children's training		87.57%				
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		86.83%		85.00%		85.00%

Narrative

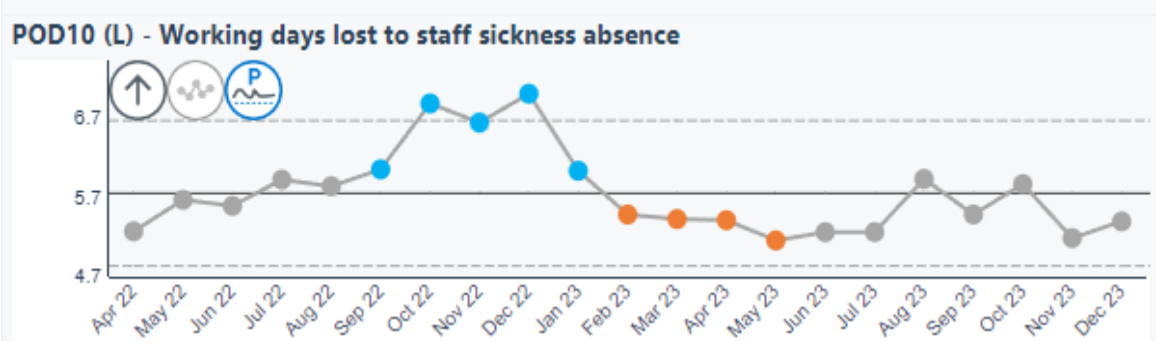
POD09 – Trust turnover has reached the 10% target and is reported at 10.51%
POD10 - In December the in month sickness absence % increased 5.18% to 5.39%. The increase was seen across all areas with the exception Childrens Care Group (reduction of 0.77% in month) and Physical Health and Neurodiversity Care Group (reduction of 0.33%). The largest increase was in Rotherham Care Group with an increase of 1.81%
POD12 – At the end of December the Trust had vaccinated 2341 individuals
POD15 – The Trust continues to experience challenges recruiting to Consultant vacancies. This will again be a priority next year.
POD 18 – Significant improvement in PDR compliance with 96.41% individuals having a PDR within 12 months and achieving the 90% target
POD19 – Mandatory and statutory training reported slightly reduced with 89.38 % compliance slightly below the 90% target.
POD 23 and POD 24 - The suspension data is within the Trust target but has increased from the 2 reported last month to 3 colleagues currently suspended. All Disciplinary Investigations are progressed timely, but two of these cases link to situations outside of our employment and as such we are liaising with external agencies to ensure the cases are progressed appropriately and timely

4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

The Trust target for 12 month rolling turnover is 10.5%. There continue to be a number of hotspots areas (AHP's and Additional Clinical Support) - this information is shared within the Care Groups to identify any areas of concern of work which may be required. Using data from exit strategies will be key.



Trend, Reason and Action

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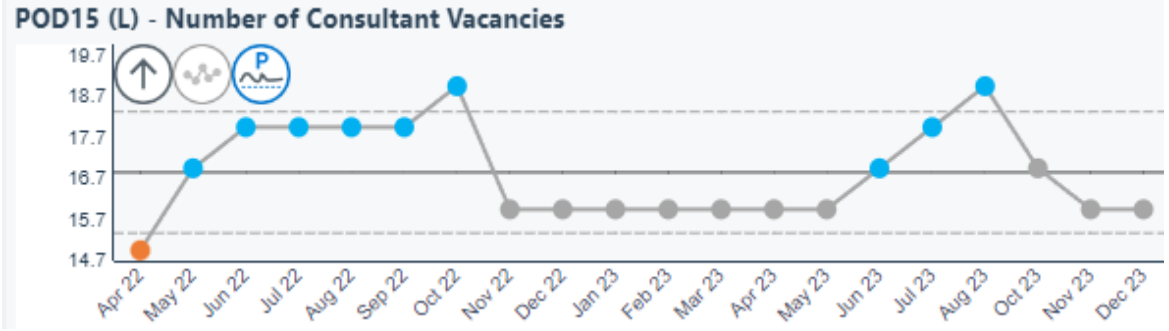
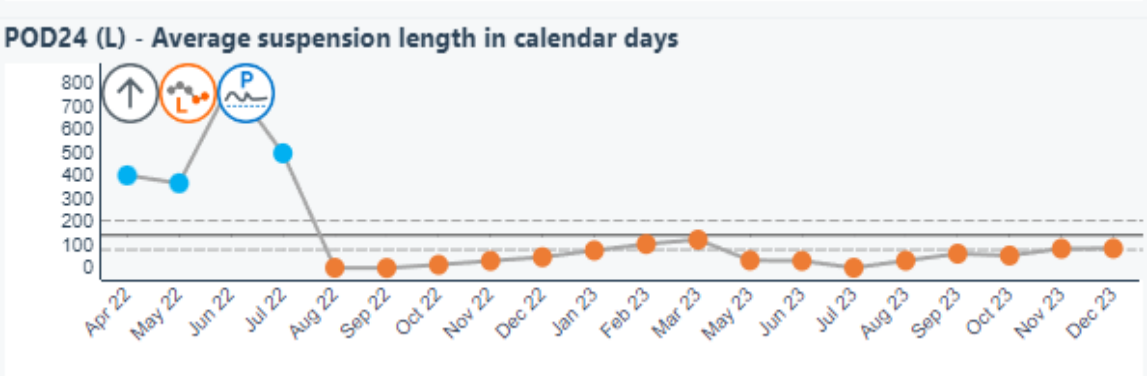


Trend, Reason and Action

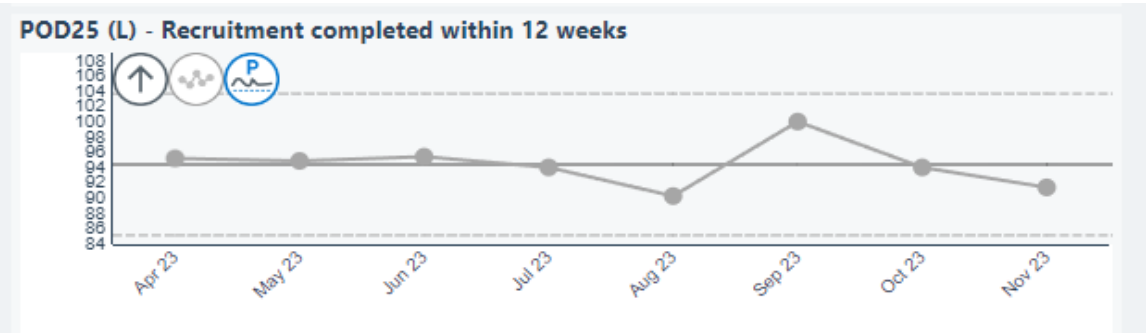
The Trust continues to experience challenges recruiting to Consultant vacancies

4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

The suspension data is within the Trust target but has increased from the 2 reported last month to 3 colleagues currently suspended. All Disciplinary Investigations are progressed timely, but two of these cases link to situations outside of our employment and as such we are liaising with external agencies to ensure the cases are progressed appropriately and timely



Trend, Reason and Action

Recruitment completed within 12 weeks is reported as 88.89%.

5.0 Finance – In Focus

Finance				
Indicator	**Metric**	**Target £000**	**Actual £000**	**Variance £000**
FIN01	YTD Actual vs Budget	3,339	485	- 2,854
FIN02	Forecast Outturn vs Budget	6,150	4,300	- 1,850
FIN03	In month actuals vs In Month forecast	1,148	642	- 506
FiIN04	YTD efficiency target vs actual savings	7,500	4,980	- 2,520
FIN05	Annual savings target vs forecast savings (R&NR)	10,000	9,156	- 844
FIN06	Annual savings target vs forecast savings (R only)	10,000	9,096	- 904
FIN07	Agency spend % of total pay bill (YTD)	3.6%	4.7%	1.1%

Narrative

FIN01 – At the end of December we are reporting a deficit position of £0.5m, £2.85m better than plan.
FIN02 – he trust is forecasting a deficit of £4.3m at year end. This includes £3.5m of system support to help close the SY ICB planning gap of £106m.
FIN03 – The in month variance to forecast is favourable due to a delay in incurring Talking Therapy catch up costs, a review of prior year accruals and a reduction in agency and bank costs in month 9
FIN04 - The Trust has continued to adopt a structured and measured approach to making financial savings, a programme of work is supporting the identification and delivery of saving opportunities.
FIN05 T- he total value of the savings forecast to be delivered against the plan on a full year effect basis is £9.2m.
FIN06 - The vast majority of savings identified on the full year effect basis are recurrent (£9.1m).
FIN07 - An agency cap has been set at a system level in 23/24, with the Trusts share being £6.3m, a reduction of 6% from last years figure. We are currently incurring costs over the agency cap of £2.0m.

Appendix 1`

SPC Icon Description

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(common)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
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(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Month 9 Finance Report	**Agenda Item**	Paper Ni
Sponsoring Executive	Ian Currell, Executive Director of Finance		
Report Author	Amy Denning and Rob Kirkby, Assistant Directors of Finance		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

At the November Public Board meeting we reported increased confidence that the planned deficit would be achieved. At month 9 the position continues that trajectory, with a £0.49m deficit, £2.85m better than plan. The forecast year end position is a £4.3m deficit against a planned £6.15m deficit.

Despite the good in year progress returning the Trust to a longer-term balanced position is dependent upon achievement of the £10m savings target in full. At month 9 the full year value of schemes delivered so far is £7.42m.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
Business as usual	X

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

N/A

Recommendation
(Indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**Review** and **Note** the issues raised in the Financial Report.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register	x	FP 1/22, FP 36/23, CA 5/23, DCGMH 11/23, HI 12/23, POD 7/23, RCG 26/23					
Board Assurance Framework	x	SR3					
System / Place impact							
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	

Appendix (please list)

None.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

FINANCE REPORT
FOR THE PERIOD ENDED 31 DECEMBER 2023

1 Introduction

This report sets out the financial position of Rotherham Doncaster and South Humber NHS Foundation Trust as of 31 December 2023, month 9 of the 2023-24 financial year.

Below is a summary of the key financial indicators the Trust is measured against:

31/12/2023	Executive Summary / Key Performance Indicators					
No.	Performance Indicator	NHSE Annual Plan	NHSE YTD Plan	NHSE YTD Actual	Year end Forecast	Narrative
		£'000	£'000	£'000	£'000	
1a	Control Total	£6.15m	£3.34m	£0.49m	£4.30m	The Trust position at the end of December is a deficit of £0.49m, £2.85m better than plan. The position includes a surplus of £0.05m for Flourish. The year to date underspend on the Adult Eating Disorder Provider Collaborative has now been fully utilised but have recieved an additional £0.75m from NHSE to continue providing enhanced care packages.
1b	Income	£209.73m	£157.38m	£163.11m	£213.43m	Year to date income is higher than the plan submitted to NHSE at the beginning of the year by £5.73m. This is linked to additional pay award funding & other additional income received which is in part offset with additional expenditure.
1c	Expenditure	£215.88m	£160.72m	£163.60m	£217.73m	Expenditure at the end of December is £2.88m higher than the original plan, this relates to additional costs for the pay award and is offset in income.
2	Agency Cap	£6.30m	£4.57m	£5.93m	£8.09m	NHSE guidance for 2023/24 states that the agency spend within a system should not exceed 3.4% of the total pay bill. This equates to an annual cap of £6.30m for the Trust. At the end of December the Trust is £1.36m behind the target year to date. The savings plan contains schemes to significantly reduce agency usage, work is ongoing to deliver these schemes by the end of 2023/24
3	Cash	£46.59m	£43.58	£39.50m	£40.00m	At the end of December the Trust cash balance is £39.50m. Cash for the remaining quarter to 31.3.24 has been reforecast to £40.00m.
4	Capital	£6.66m	£4.29m	£4.68m	£6.66m	Capital Programme expenditure has an overspend at the end of December due to phasing which is anticipated to reverse by 31.3.24 since the 23/24 actuals are forecast to be the plan of £6.66m for full year.
5	Savings Programme	£10.00m	£7.50m	£5.60m	£7.42m	The trust has delivered £5.56m of recurrent savings to date, the full year effect of which is £7.42m. £10.3m of plans have been identified and we are forecasting to achieve £7.42m in 23/24.
6	Better Payments	95%	95%	84.3%	95%	The Better Payment Practice Code is a measure of the number of invoices that are paid within the 30 days. At the end of December the Trust was paying 84.3% of invoices within this timescale against a target of 95%. This expected deterioration was reported to FPIC in April 2023.
7	NCCI	1	1	0.67%		The National Cost Collection (NCC) uses an indexing methodology to provide a comparative measure of cost effectiveness of different NHS organisation's services, from an index centred around 100. The latest 2021/22 publication provides the Trust with an index of 68, (94 for Community and 60 for Mental Health). Please note this excludes Mental Health Inpatient spells due to a national discrepancy with the data. This suggests the Trust costs are 32% lower than the national average for delivering clinical activity in scope. However, this will vary between services.

Red	Adverse Variance from Plan greater than 15%
Amber	Adverse Variance from Plan ranging from 0% to 15%
Green	In line, or Greater than Plan

2 Income and Expenditure Position

The financial position at month 8 was a surplus of £0.2m, this has now deteriorated at month 9 to a deficit of £0.5m, £2.85m better than plan. The in-month deterioration was expected, and is due to £875k of system support, to help close the SY ICB planning gap. (FYE of this will be £3.5m)

2.1 Care Group and Corporate Service Positions

The budgets for 23-24 have been aligned to 22-23 actuals, with adjustments made for any underspends linked to transformation and service development funding. Funding for approved cost pressures and business cases has been allocated to relevant areas, and savings targets set based on actual spend. Pay & non pay inflation funding has been allocated out to department budgets. The table below provides a summary of the position by directorate as at the end of month 9.

Directorate	YTD Budget £'000	YTD Actuals £'000	Variance £'000
Doncaster Mental Health	34,078	33,872	-206
Doncaster Physical Health	27,373	26,886	-487
Rotherham	21,197	21,035	-162
North Lincs	16,440	15,879	-561
Children's	21,094	20,614	-480
Total Operations	**120,182**	**118,286**	**-1,896**
Corporate departments	25,787	25,231	-556
Trust Central & Reserves	5,951	6,681	730
Contract Income	-148,581	-149,661	-1,080
Flourish CIC	0	-53	-53
AED Provider Collaborative	0	0	0
Group Position	**3,339**	**484**	**- 2,855**

Operational services continued to underspend at the end of December, North Lincs is still incurring high levels of cost for the care of a complex LD patient in our seclusion suite, but agreement has been reached that these costs will be picked up by the ICB from the 16 January. The costs are offset by underspends in talking therapies which now sits within the North Lincs care group. Additional costs expected to be incurred to support additional activity within Talking Therapies hasn't impacted in M9.

The key themes being reported in month 9 continue to be staffing challenges in inpatients services and challenges in recruitment across various services. Following a review of prior year accruals, expenditure positions have improved. Work is ongoing to triangulate the pay budgets, with WTE and safer staffing levels. All block contracts have been paid in line with agreed block values including the pay award uplift. The overtrade on the contract income line predominantly relates to additional income received from the ICB. The expected reduction in income from the ICB to support the system planning gap will result in the favourable variance on contract income reducing in the remaining months.

Year End Forecast

The year end forecast position ranges from a deficit of £4.3m to £3.5m, and includes a £3.5m system support income reduction from South Yorkshire ICB to help reduce the system planning gap of £109m.

Slippage Reporting 23-24

The 23-24 budgets include significant levels of funding linked to transformation and service development. The Trust anticipates underspends associated with this funding throughout the financial year as roles are recruited to and services are mobilised to support and deliver pathway changes for our patients.

At month 9 we are seeing an underspend of £1.7m against these schemes, broken down as below.

	£000	£000
Description of investment above 22/23 outturn	Budget given above 22/23 outturn	YTD Slippage
Doncaster MH - Transformation	603	438
Doncaster MH - Crisis & Liaison Vacancies	800	472
Doncaster MH - Drugs & Alcohol Service Grant	314	16
Doncaster MH - ADHD Staffing	125	0
Doncaster MH - Rough Sleepers Initiative	46	21
Doncaster PH - Ageing Well	1,190	87
Doncaster PH - Virtual Ward	837	136
Doncaster PH - District Nursing Vacancies	400	0
Rotherham - CMHT Transformation	664	109
Childrens - Neuro Vacancies	533	149
Childrens - Crisis	469	60
Childrens - Epilepsy Staffing	51	21
North Lincs - Crisis & Liaison Vacancies	400	0
North Lincs - Inpatient Staffing	318	177
Total	**6,750**	**1,686**

Care Group	Budget given above 22/23 outturn	YTD slippage	YTD expected slippage	YTD variance to expected slippage
Doncaster MH	1,888	947	636	-311
Doncaster PH	2,427	223	603	380
Rotherham	664	109	239	130
Childrens	1,053	230	290	60
North Lincs	718	177	405	228
Total	**6,750**	**1,686**	**2,174**	**488**

* YTD planned slippage based on slippage forecast used for budget sign off meetings with CEO in July 23

2.2 Agency Staffing

An agency cap has been set at a system level in 23-24, with the Trust's share of this being £6.3m, a reduction of 6% from last year's figure.

- In total the Trust has spent £5.93m on agency in 23-24 which is 4.8% of the pay bill. This is a further increase in agency usage compared to the prior year.
- The Trust is over the agency cap by 30% (40% in month 8) or £1.3m year to date.
- Medical pay makes up 9.8% of the Trusts total pay bill but 55.1% of agency spend. 28.0% of the pay bill for medical staff has been spent on agency.
- The main drivers for nursing & medical agency are vacancies and rota gaps.
- A key element of the savings programme is a reduction in agency usage, plans are being developed to reduce this spend in year, any changes to the spend profile will be reported through the forecast spend in future months.

2.3 Savings

The Trust has commenced a structured and measured approach to making financial savings. With a target of £10m worth of savings, a programme of work has been created to support the identification and delivery of savings opportunities, improving monitoring of savings, and establishing a process for ensuring that quality of services and patient safety isn't impacted negatively because of any savings plans.

Over the past nine months the Trust has gone through a process for Care Groups and Corporate departments to formally identify savings schemes which will be signed off alongside budgets for the year. The full-year-effect of the plans that have been identified by teams totals £10.0m and we are forecasting to achieve £7.4m in 23/24.

Throughout December there has continued to be dedicated focus on reviewing each savings scheme for any quality and safety impacts that may occur from delivering the savings. To date the quality and safety impact assessment panel have reviewed and supported 91% of all scheme assessments. There are 11 impact assessments still to be reviewed, and a further 8 assessments are either awaiting submission for review or have outstanding questions.

To date £5.57m worth of savings have been delivered recurrently, the full-year-effect of these is £9.1m. Figure 1 below provides a split of these savings by directorate:

Figure 1: A display of Care Group and Directorate allocated savings target and delivery.

Workstream	23/24 Target	YTD Target	YTD Recurrent Delivery	YTD Variance	FYE Savings Delivered to Date	FYE Recurrent Variance
Doncaster Physical Health	£ 1,168,906	£ 876,680	£ 692,930	-£ 183,750	£ 923,906	-£ 245,000
Doncaster Mental Health	£ 2,098,075	£ 1,573,556	£ 933,720	-£ 639,836	£ 1,244,960	-£ 853,115
Rotherham Care Group	£ 1,666,229	£ 1,249,672	£ 1,075,083	-£ 174,589	£ 1,433,438	-£ 232,791
North Lincolnshire Care Group	£ 801,466	£ 601,100	£ 331,994	-£ 269,106	£ 442,688	-£ 358,778
Childrens Care Group	£ 1,073,119	£ 804,839	£ 792,154	-£ 12,685	£ 1,056,206	-£ 16,913
Talking Therapies	£ 250,591	£ 187,943	£ 188,250	£ 307	£ 251,000	£ 409
Finance	£ 180,956	£ 135,717	£ 150,889	£ 15,172	£ 201,185	£ 20,229
Estates & Facilities	£ 509,523	£ 382,142	£ 150,890	-£ 231,253	£ 201,186	-£ 308,337
Governance	£ 174,060	£ 130,545	£ 126,664	-£ 3,881	£ 168,885	-£ 5,175
Operations Management	£ 121,581	£ 91,186	£ 64,186	-£ 27,000	£ 85,581	-£ 36,000
Medical	£ 228,743	£ 171,558	£ 148,499	-£ 23,058	£ 197,999	-£ 30,744
People & OD	£ 308,949	£ 231,712	£ 202,534	-£ 29,178	£ 270,045	-£ 38,904
Nursing & Quality	£ 190,012	£ 142,509	£ 118,910	-£ 23,599	£ 158,547	-£ 31,465
Health Informatics	£ 253,243	£ 189,932	£ 190,447	£ 515	£ 254,000	£ 757
Strategy	£ 32,936	£ 24,702	£ 24,750	£ 49	£ 33,000	£ 65
Depreciation & Interest Costs	£ 500,000	£ 375,000	£ 375,000	£ -	£ 500,000	£ -
Consultancy Reduction	£ 441,612	£ 331,209	£ -	-£ 331,209	£ -	-£ 441,612
Total	**£ 10,000,000**	**£ 7,500,000**	**£ 5,566,898**	**-£ 1,933,102**	**£ 7,422,625**	**-£ 2,577,375**

3.0 Debtors

Outstanding debtors ageing for the Trust (including Flourish) to 31 December 2023 was as follows:

Debtor Collection Period	Dec-23	Nov-23
	Debtors	Debtors
Up to 30 Days	193	1,299
31 - 60 Days	614	212
61 - 90 Days	189	55
Over 90 Days	422	422
Unallocated credit	-1210	0
Totals	208	1,988

December 23 debtors were lower in total than November 23. The unallocated credit included £1200k owed back to DMBC which is a timing difference.

3.1 Creditors

The Trust's overall Better Payment Practice Code (BPPC) for NHS and Non-NHS creditors for December 2023 is summarised below. The payment performance has been affected by the change in accounting system from Integra to Centros. There were invoices that took long to be uploaded as systems were stabilised and this affected payment runs through into December 2023. This was expected and has been shared with FPIC in April, recovery against the BPPC is expected throughout 2023/24.

Public Sector Payment Policy	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
NHS - % by value paid within 30 days	92.08%	99.99%	94.50%	89.64%	85.29%	83.23%	85.14%	86.74%	87.18%
Non-NHS - % by value paid within 30 days	90.22%	91.32%	90.00%	84.69%	84.10%	83.27%	83.54%	84.05%	83.69%
Combined PSPP by value	**90.53%**	**92.50%**	**90.70%**	**85.41%**	**84.29%**	**83.27%**	**83.81%**	**84.51%**	**84.29%**
NHS - % number paid within 30 days	99.19%	99.20%	96.60%	91.88%	89.95%	89.71%	89.84%	90.07%	90.56%
Non-NHS - % number paid within 30 days	92.63%	87.16%	86.70%	83.43%	81.37%	80.75%	81.09%	80.93%	81.16%
Combined PSPP by number paid	**93.43%**	**87.72%**	**87.40%**	**84.04%**	**81.96%**	**81.34%**	**81.67%**	**81.52%**	**82.00%**
Cumulative % value paid within 30 days	**90.53%**	**91.47%**	**86.80%**	**85.4%**	**84.30%**	**83.27%**	**83.81%**	**84.51%**	**84.29%**
Target	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**

The Creditors ageing is shown below.

Creditors Ageing Report	Dec-23	Nov-23
	Creditors	Creditors
Up to 30 Days	211	786
31 - 60 Days	174	652
61 - 90 Days	60	226
Over 90 Days	99	368
Totals	**544**	**2,032**

3.2 Liquidity

At 31 December 2023, the Trust had £39.50m (£38.83m excluding third party funds) in cash against a plan of £43.5m. The original cash plan, including phasing, is subject to a detailed review and has therefore been excluded from the table below. Flourish Enterprises had a cash balance of £440k.

£'000	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Actual Cash	39,923	38,432	36,634	43,885	39,312	37,677	36,192	38,504	39,015	39,507

3.3 Bank / Investment Policy

Total interest earned year to date is £1,369k. Interest earned on deposited funds decreased marginally from £180k for the month of November to £178k for December. The decrease is due to higher daily balances throughout the month on deposit since the Bank of England base rate did not change from the previous month.

	Dec-23	Interest	Nov-23	Interest
	£'000	Rate	£'000	Rate
GBS Account	**38,751**		**38,108**	
National Loan Fund				
NatWest accounts				
Collaboration Bank	**485**		**627**	
Instant access deposit account	**150**		**18**	
Current accounts - RDaSH	**67**		**111**	
Current accounts - Flourish	**440**		**534**	
Lloyds Bank Cash investment	**270**		**271**	
Petty cash interest total:	**19**		**19**	
	40,182		**39,688**	
Less Third-Party Funds	**-675**		**-673**	
	39,507		**39,015**	
Interest Earned				
GBS	178	5.14%	180	5.14%
	178		**180**	

A total of £675k held within the cash balances for the Trust are third party funds mainly held on behalf of patients and former patients who require financial assistance to manage their own funds.

3.4 Capital Expenditure

Total capital spend to 31 December 2023 was £4,684k against a plan of £4,286k. The full year forecast versus annual plan is detailed in the table below. Capital allocations are determined by the ICB and the overall system cannot exceed the plan value. Finance are working with estates and IT to ensure the plan is not exceeded at a Trust level and the Trust will work with other providers to utilise any capital underspends.

Performance at M9	YTD Plan	YTD Actuals	YTD Variance
	£'000s	£'000s	£'000s
Capital Programme	4,286	4,684	-398

Forecast Performance	Annual Plan	Forecast	Forecast Variance
	£'000s	£'000s	£'000s
Capital Programme	6,660	6,660	000

4.0 Charitable Funds

The current Charitable Fund balances at 31 December 2023 market valuation were £2,600k. The book value balance is £2,368k and unrealised gain is £232k.

Charitable Funds are invested through Investec. The investments are monitored regularly by the Charitable Funds Committee.

5 Recommendation

The Board is asked to:

Review and note the issues raised in this Financial Report.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Eliminating out of area placements target	**Agenda Item**	Paper Oi
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Martina Clark, Head of Flow Manager Jill Fairbank, Head of Performance Contracting and CQUIN		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

Please note this paper is aligned to the paper relating to Section 136 usage also on the agenda. There is a relationship between them in terms of patients accessing RDaSH Health Based Pace of safety and needing to access local beds, in a timely way. The lack of access to beds is leading to high levels of Out of Area Placements (OAP's).

This paper provides:

- Data on number of bed days, and number of patients that are deemed "out of area" placement, for Q1 – Q3 in 2023/24
- To note the distinction between the formal definition of out of area placement; and internally monitoring when a person is not cared for within their Place.
- To see initial data regarding Admission rates, Length of Stay (LoS) and Clinically Ready for Discharge numbers – which will affect "flow" and timely access to RDaSH inpatient beds.
- To note that the current bed stock will not reflect the local need in terms of "specialist" and rehabilitation placements.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

Previous Board meeting has discussed the need for more information on HBPoS (s136) and Out of Area Placements.

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**RECEIVE** and **NOTE** the contents of the report and the work underway to provide better oversight of OAP's at a Care Group level
x	**AGREE** and **SUPPORT** the recommendation that in 2024/25 a larger clinically led improvement programme will be required to be able to deliver on Promise 19 and the eradication of OAP's.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register		
Board Assurance Framework	x	SR3
System / Place impact	x	Relevant to partnership discussion / Delivery of LTO metrics

Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
None							

NHS
Rotherham Doncaster
and South Humber
NHS Foundation Trust

Out of Area Placements Target
Report to Board of Directors

Richard Chillery
Chief Operating Officer

January 2024

RDaSH nurturing the power in our communities

1. Introduction

This paper identifies the current position and pressures in relation to our out of area placements for acute mental health. The focus is on Q1 – Q3 for 2023 – 2024.

2. Background

Out of area placements (OAPS)

In certain circumstances - when clinical demand for an in-patient bed exceeds the Trust bed stock availability, RDaSH patients may need to be accommodated in an out of area hospital placement, either in an alternative NHS setting or in the Private Sector. These placements are recorded and reported as "inappropriate" out of area placements as the person has been admitted to a unit that does not form part of their usual local network of services. This means an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service, and where the person cannot be visited regularly by their families, friends, carers and loved ones, and Care Co-ordinator/ Lead Professional to ensure continuity of care and effective discharge planning.

The national definition indicates an 'out of area placement' for acute mental health in-patient care happens when: A person with assessed acute mental health needs who requires adult mental health acute inpatient care [footnote 2], is admitted to a unit that does not form part of the usual local network of services. Sending providers (in this case RDaSH) are to determine if a placement is classed as an OAP. The definition necessarily allows providers to apply knowledge of local catchment arrangements and the patient's circumstances in taking a decision if a placement is an OAP. Placements may occasionally be considered appropriate, for example such as for Safeguarding reasons and there are national algorithms to support this. However, as a Trust we also need to consider when a patient is not in a unit at "Place" (for example a Rotherham patient in North Lincolnshire), and unless they are out of their immediate area for clinical reasons, or patient choice then they may also be deemed as "inappropriately" placed as they are away from their community and local teams.

A patient is determined as OAP's at the point of placement by the patient flow team but this categorisation is then reviewed weekly by the patient flow, performance and informatics team. These are reported to the ICB's monthly, by the Performance Team. There is also an annual audit conducted by David Smiths team.

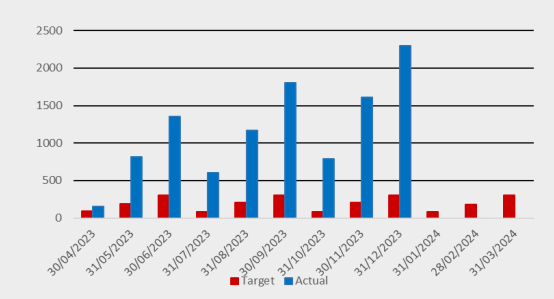
Working closely with the Directors of Nursing, the Patient Flow Team maintain regular contact and oversight of any patients inappropriately out of area and ensure they are returned to an RDaSH inpatient setting as soon as possible. We need to also focus more on repatriating patients from other RDaSH inpatient units back to their Place, unless clinically counter indicated.

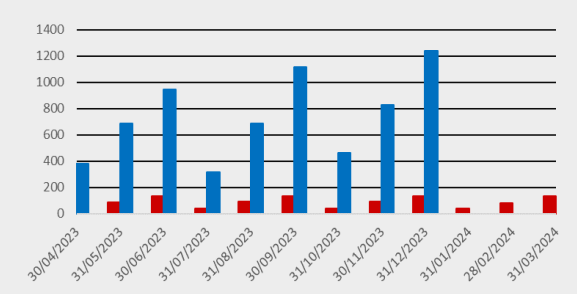
The following data indicates the continuing challenges with the bed pressures across the Trust. The red line is the target level of OAP that was agreed between RDaSH and the ICB for 23/24 and blue is the actual. This is described in bed days.

(*RDaSH Promise 19 states, End out of Area placements in 2024, as part of supporting people to be cared for as close to home as safely as possible)

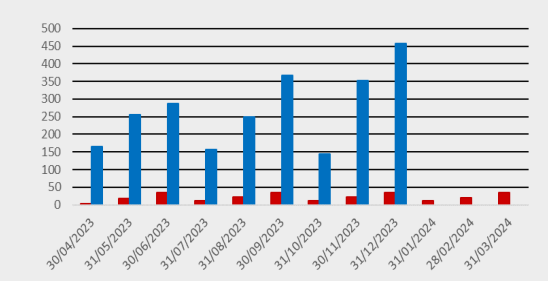
The total number of days adults inappropriately spend in out of area non specialist acute mental health beds.

Trust Wide **Doncaster Mental Health & LD Care Group**

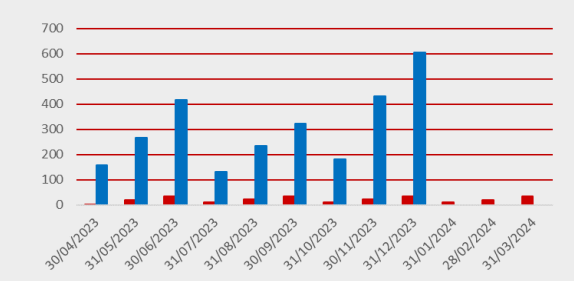




Rotherham Care Group



North Lincs Care Group



Locality	Indicator	30/04/2023	31/05/2023	30/06/2023	31/07/2023	31/08/2023	30/09/2023	31/10/2023	30/11/2023	31/12/2023
Doncaster	Total bed days in month	381	688	943	316	688	1115	462	829	1238
Rotherham	Total bed days in month	166	255	287	156	249	367	145	353	458
North Lincs	Total bed days in month	158	268	416	131	233	324	181	432	605
Trust wide	Total bed days in month	705	1211	1646	603	1170	1806	788	1614	2301
Trust wide	No of patients placed OOA at month end	23	15	14	20	16	20	31	28	13

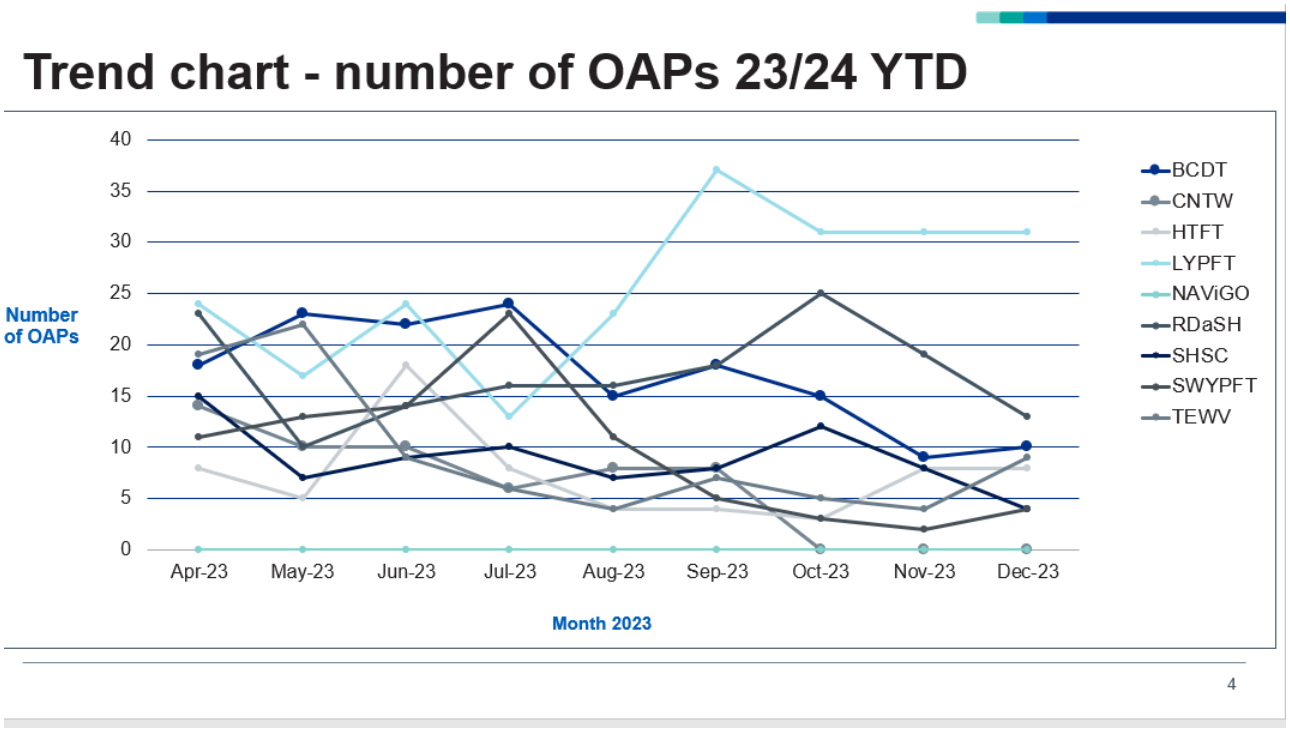
When compared with our nearest neighbours the pressures placed on inpatient services can be evidenced across some of our other localities. Future investigations will want to look at the differences and variations across Care Groups and the reasons for this.

The table below shows the number of patients placed out of area at the end of the month for the period of review.

Provider OAPs placements – at end December 2023

MH provider	Apr-23	May-23	June-23	July-23	Aug-23	Sep- 23	Oct-23	Nov-23	Dec-23
Bradford District Care NHS Foundation Trust (BDCT)	18	23	22	24	15	18	15	9	10
Cumbria Northumberland, Tyne and Wear Partnership NHS FT (CNTW)	14	10	10	6	8	8	0	0	0
Humber Teaching NHS Foundation Trust (HTFT)	6	5	18	8	4	4	3	8	8
Leeds and York Partnership NHS Foundation Trust (LYPFT)	24	17	24	13	23	37	31	31	31
Navigo	0	0	0	0	0	0	0	0	0
Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)	23	10	14	16	16	18	25	19	13
Sheffield Health and Social Care NHS Foundation Trust (SHSC)	15	7	9	10	7	8	12	8	4
South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)	11	13	14	23	11	5	3	2	4
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)	19	22	9	6	4	7	5	4	9

Monthly data submission link (by 15th of each month with data as at the last working day of previous month):
https://forms.office.com/Pages/ResponsePage.aspx?id=kp4VA8ZyI0umSq9Q55Ctv3fUiw4KJPpLIZIoOKqYSP1UN0VPVlY1MUtSSjZGQkNLUVFQUEYzQVJVNy4u



While it is positive to note the marked improvement in December the number of patients who are in OAP's, seeing a reduction to 13, RDaSH still remain the second highest Trust. This improvement was due to significant progress being made within the Rotherham Care Group specifically who managed to achieve zero inappropriate out of area placements ahead of the festive period. The total increased to 17 over the New Year period but is again down to 12 at the time of this report, due to the continued focus by Care Groups.

Internal "out of area" placements

An RDaSH patient, may on occasion be cared for in an alternative Care Group. This may be down to patient choice, safeguarding, or lack of bed availability in their local area at the time of admission. As these placements are within RDaSH bed stock they are not technically reported to the ICB at Place (like the other out of area placements are), however, we would want to still note this as a patient may still be away from their families and communities. Working closely with the Community Teams, the Patient Flow Team maintain regular contact and oversight of all internal out of area placements to ensure a safe discharge or when possible "repatriation" back to Place. At times a move back to Place can be disruptive and counterproductive to recovery for a patient, so the focus needs to be ensuring we retain patients within their communities.

As of the 12th of January 2024, the Trust has 13 patients who are admitted into a bed across the Trust locality however which is outside of their place of residence.

Position as at the 12th January 2024	No of patients	Total LOS
Doncaster patients in a North Lincs bed	2	15
Doncaster patients in a Rotherham bed	4	80
Rotherham patients in a Doncaster bed	2	110
North Lincs patients in a Doncaster bed	2	73
North Lincs patients in a Rotherham bed	2	47

Specialist Placement Beds

There are occasions when our patients in Rotherham, Doncaster and North Lincolnshire require a bed out of area because we don't provide the service/type of setting they require. For example, a CAMHS Tier 4 bed for a young person requiring a specialist in-patient admission. Other examples would be for Eating Disorder Specialist in-patient provision; learning disability, secure rehabilitation and MH Forensic Care.

When this happens, we work with the Commissioning Hub in South Yorkshire who manage the commissioning and access of these services and they source a bed for our patients. There is some specialist provision within South Yorkshire and North Lincolnshire provided by other NHS organisations or the independent sector, so patients can remain close to our patch. However, if those providers are full or cannot meet the needs of the patient they can be placed anywhere in the country. It is worth noting that due to the expediential increase in Adult and Child Eating Disorders post COVID 19 pandemic which has resulting in an ever increasing number of patients being referred for inpatient admission. Each referral goes through a clinical access assessment to determine whether inpatient admission is the least restrictive and most appropriate care offer. However, due to this demand then several patients are not placed within the South Yorkshire boundary due to lack of specialist placement availability.

There are also some patients who require specialist or long-term MH rehab who would go to providers outside of Rotherham, Doncaster and North Lincolnshire.

All the above placements are not classed as inappropriate out of area placements and are therefore not reported in our Trust figures. Specialist placements are monitored by each ICB at Place. As part of the preparation of this report there is now noted work to do with the ICB's to improve the oversight of these specialist patients to ensure RDaSH receive regular updates relating to the number of patients in specialist patients and their length of stay.

In summary there are 2 broad areas for reasons why people are placed in OAP's. The first is due to the lack of availability of beds within the Trust. The other factor will be due to the type of bed not being available, so this may relate to a specialist placement or some form of rehabilitation environment.

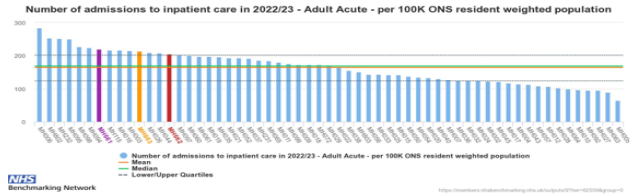
Availability of beds within inpatient wards will be down to several factors but broadly speaking relate to:

1. Gatekeeping – so admission rates and alternatives to supporting people in the community.
2. Ensuring a purposeful admission to an inpatient ward; a therapeutic intervention and active plans for safe discharge
3. To ensure we have clear discharge process – and ensuring that we engagement with partners when we have patients who are deemed, "clinically ready for discharge".

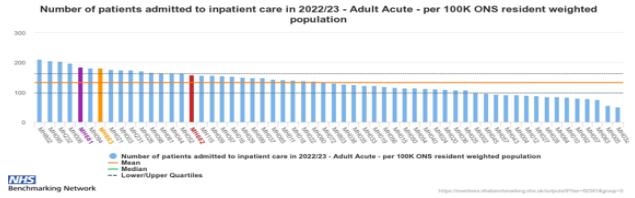
Admission Rates

The national benchmarking data below suggest that RDaSH are in the upper quartile for admission rates. This may relate to local populations, demand and levels of complexity and acuity. It may signpost differences in local provision as alternatives for admission, such as Crisis Houses, and enhanced community offer or it may be a variation in gatekeeping assessment and tolerance of levels of risk. It is likely to be an element of all these factors and potentially others and will require further analysis within a larger programme of improvement work.

Benchmarked Bed Demand: Adult Acute Care

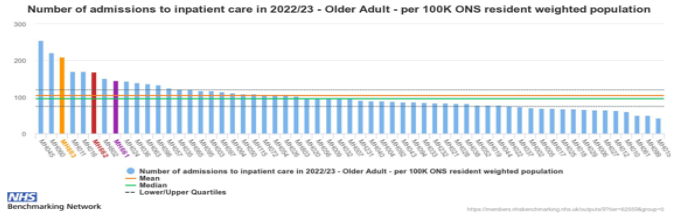


Rotherham – MH661 Doncaster – MH662 North Lincs – MH663

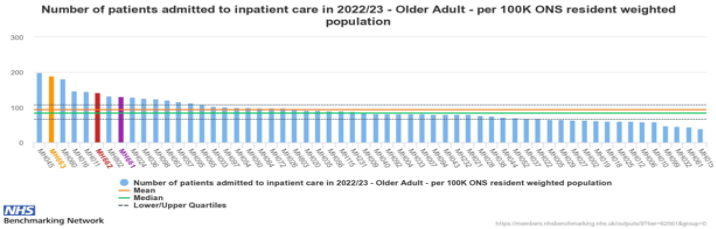


- Admissions include admissions to OAPs.
- Adult Acute admission rates are:
  - 30.8% higher in Rotherham than the median national admission rate.
  - 21.6% higher in Doncaster than the median national admission rate.
  - 26.8% higher in North Lincs than the median national admission rate.
- The number of individuals admitted is:
  - 40% higher than the benchmark median in Rotherham.
  - 19.7% higher than the benchmark median in Doncaster
  - 36.6% higher than the benchmark median in North Lincs.

Benchmarked Bed Demand: Older Adult Acute Care



Rotherham – MH661 Doncaster – MH662 North Lincs – MH663



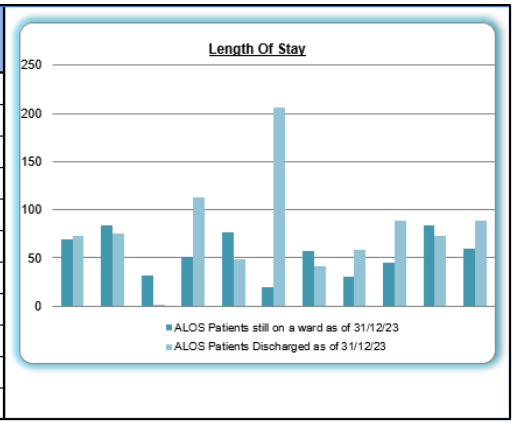
- Admissions include admissions to OAPs.
- Older Adult Acute admission rates are:
  - 52.8% higher in Rotherham than the median national admission rate.
  - 77.6% higher in Doncaster than the median national admission rate.
  - 121.3% higher in North Lincs than the median national admission rate.
- The number of individuals admitted is:
  - 58.7% higher than the benchmark median in Rotherham.
  - 72.1% higher than the benchmark median in Doncaster
  - 129% higher than the benchmark median in North Lincs.

Length of Stay

Length of stay on RDaSH mental health inpatient units can vary widely, from just a couple of days to over a year when people are acutely unwell with treatment-resistant severe mental illnesses. Taking this into account, the NHS Mental Health Implementation Plan 2012/20 – 2023/24 sets out an ambition to reduce average length of stay on mental health wards to 32 days or less.

The table below details the average length of stay (ALOS) on the adult, PICU and older person's acute mental health wards over the last from 1 January 2023 to 31 December 2023, broken down to highlight those patients still on the ward at the end of each month and the average length of stay for those patients who have been discharged.

Care Group	Ward	Ward Type	ALOS Patients still on a ward as of 31/12/23	ALOS Patients Discharged as of 31/12/23
Doncaster	Brodsworth	Adult	69.5	72.6
Doncaster	Cusworth	Adult	83.45	75.3
Doncaster	Skelbrooke	PICU	32.2	1
Rotherham	Sandpiper	Adult	51.39	112.7
Rotherham	Osprey	Adult	76.44	49.3
Rotherham	Kingfisher	PICU	20	206
North Lincs	Mulberry	Adult	56.67	41.8
Doncaster	Windermere	Older People	31	58.3
Rotherham	Brambles	Older People	45.48	88.2
Rotherham	Glade	Older People	83.33	72.5
North Lincs	Laurel	Older People	59.38	88.3



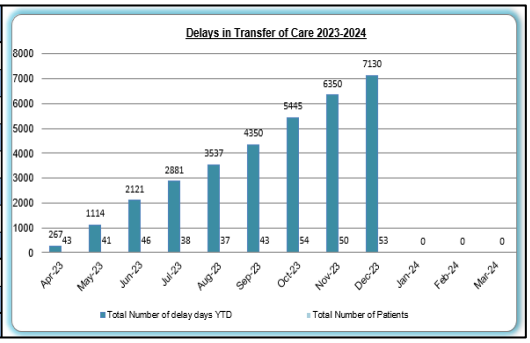
On briefly reviewing National Benchmarking data RDaSH LoS is in the middle to lower quadrant, so demonstrates for adult and older people wards a reasonable LoS.

Clinically Ready for Discharge (but delayed)

The graph below shows the total number of Clinically ready for discharge (CRFD) bed days Trust-wide for Adult and Older Peoples Wards from 01 April 2023 to 31 December 2023.

At the time of writing the report, the total number of patients CRFD (but delayed) across the Trust is 36 (11 Doncaster, 12 Rotherham and 13 in North Lincs). Most of these patients are waiting for 24 care placements in nursing homes or specialist placements (high dependency rehab).

DTOC - Trustwide - TOTAL	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	SUB TOTAL
Delay Days - **NHS**	496	515	567	463	406	359	455	349	258	0	0	0	**3868**
Number of patients - **NHS**	25	23	26	20	24	17	21	19	13	0	0	0	
Delay Days - **Social Care**	214	267	310	221	171	289	458	360	222	0	0	0	**2512**
Number of patients - **Social Care**	12	13	14	14	8	19	25	19	16	0	0	0	
Delay Days - jointly to **NHS & Social Care**	4	0	13	0	0	65	32	30	45	0	0	0	**189**
Num of patients - jointly to **NHS & Social Care**	1	0	1	0	0	3	2	1	2	0	0	0	
Delay Days - **Housing**	50	80	139	116	79	100	177	189	255	0	0	0	**1185**
Number of patients - **Housing**	5	6	6	7	5	4	7	12	22	0	0	0	
Total Delay Days	**764**	**847**	**1007**	**760**	**656**	**813**	**1095**	**905**	**780**	**0**	**0**	**0**	**7627**
Total Number of Patients	**43**	**41**	**46**	**38**	**37**	**43**	**54**	**50**	**53**	**0**	**0**	**0**	
Total Number of delay days YTD	**267**	**1114**	**2121**	**2881**	**3537**	**4350**	**5445**	**6350**	**7130**				



To maintain effective governance and oversight of the position of each Care Group in relation to those patients who are CRFD (but delayed) and those who have been placed out of area, bi-monthly meetings are chaired by the head of patient flow. Senior representatives from the local authority, ICB and housing at Place attend the meetings to ensure appropriate escalation and system wide investment to address delays and reduce or prevent the likelihood of delays occurring in the first place.

This brief cross section of data suggests that RDaSH is in the upper quartile for admission rates; that LoS is reasonable and there are about 30 patients in beds at any one time who are clinically ready for discharge but due to complexity, then there are real delays in discharge, Please note this is not a detailed analysis of the data – more a signal for highlighting areas for improvement and focus to reduce OAP's but improvements in all these areas will potentially result in the greater availability of beds.

3. Conclusion

The demand for mental health inpatient services has remained higher than forecasted across the Trust. The Trust position is aligned to the national picture where there is increased demand on inpatient services along with a rise in the complexity of the mental health needs of the people presenting to services after the pandemic. There is comorbidity with a range of other physical, cognitive and social needs. This is echoed in the findings of the CQC's MHA reviewer visits, where many mental health services reporting that they had been busier since the COVID-19 pandemic, both in terms of volume and acuity of cases presenting to them. In line with last year's report, we have continued to see many services running close to or above bed capacity. https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022/pressures-services-patient-pathways

Working with our partners at place and across the ICB, everything we do is aimed at increasing capacity and reducing demand to avoid out of area placements, - from prevention initiatives, crisis alternatives, community teams, crisis transformation, the mental health community hubs, changes to pathways, better flow and early discharge, community housing, and recovery at home.

There is continued worked to do to reduce the average length of staff across all our inpatient wards and reduce the number of patients who are clinically ready for discharge (but delayed) to increase capacity on the wards to admit patients to the right place, at the right time, first time thus avoiding out of area placements.

There also needs to be a deeper ICB analysis of regional population needs to better understand and deliver against what may be deemed “specialist placements” or rehabilitation needs.

Recognising that the challenges described above are multi-factorial, we have made the commitment to eliminate out of area placements by 2024.

Clinical accountability and shared ownership between inpatient and community teams will be key to improving our position. Out of area figures are now shared with the senior leadership teams daily by the Patient Flow Team and over the past 8 weeks, there has been a significant improvement on reducing out of area placements, particularly within the Rotherham Care Group who achieved a 0 position just before the festive period and have managed to sustain this at the time of the report. This improvement has been due to the systems and process put into place by the Directors of Nursing, and we would want to ensure all Care Groups are following the Rotherham methodology. However, this improvement in oversight and clinical accountability is unlikely to address all the issues relating to the reasons for OAPs and for a sustainable position which eradicates OAP’s, will require further sustained work.

4. Next Steps

1. To ensure consistent process of oversight of inpatient flow (and OAP’s) across all the Care Groups – overseen by the Care Group DoN’s
2. To support a robust, clinically led, improvement programme which focuses on Gatekeeping, Therapeutic inpatient environment, and timely and safe discharge process
3. To implement a Complex Case Management Forum with Local Authority Partners to review CRFD, initially Chaired by the Chief Operating Officer
4. To ensure we are part of system plans where we may choose to commission and deliver specialist placements, but in the local environments.

5. Recommendations

1. Receive and note the contents of the report and work underway to provide better oversight of OAP's at a Care Group level.

2. Agree and support the recommendation that in 2024/25 a larger clinically led improvement programme will be required to be able to deliver on Promise 19 and the eradication of OAP’s.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Health Based Place of Safety (S136 suites) usage review	**Agenda Item**	Paper Oii
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Helen Moran, Mental Health Act Manager Wendy Fisher, Clinical Strategic Advisor		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

The purpose of this report is to bring to Board:

- Data relating to numbers of patients accessing RDaSH HBPoS.
- To highlight the different staffing models for the 3 HBPoS.
- To highlight some of the challenges, such as reasons for closure, or "repurposing" when on a S140 or no bed available and subsequently patients can remain in S136for an extended period of time.
- To highlight the patterns of movement of patients across the system when accessing HBPoS and concerns raised by North Lincolnshire.
- To highlight that current position for S136, is adding to number of patients accessing Out of Area Placements.
- To propose that we continue to concurrently continue to improve on systems internally but also precipitate more collaborative systems work for a more sustainable solution, which will take time and leadership from RDaSH with system partners.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2. Create equity of access, employment and experience to address differences in outcome.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

The Chief Executive's Report to the Board in September 2023, noted the absence of a finalised plan to improve S136 availability and that an update would be provided to the Board in January 2024.

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x **RECEIVE** and **NOTE:**

- the contents of the report
  that there is ongoing work across the current suites and with the flow team, to ensure suites remain open.
- that we will need to review the different staffing models and develop a consistent approach
- the work of the SY MHLDA collaborative – and as a Trust to continue to support actions for improvement which will require a system approach.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register	x						
Board Assurance Framework							
System / Place impact	x						
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
None							

Rotherham Doncaster and South Humber NHS Foundation Trust

Health Based Places of Safety (S136 Suite) usage overview

Wendy Fisher, Clinical Strategic Advisor & Helen Moran, MHA Manager

January 2024

RDaSH leading the way with care

The following report is provided in response to a request from Richard Chillery, Chief Operating Officer, to understand the Trust's use of its Health Based Places of Safety (HBPoS) which are often referred to as Section 136 suites or the suites. The request was for information relating to Q1 – Q3 for 2023. This may be an initial report which will require further key lines of enquiry following discussion.

Situation

There have been several concerns raised in relation to the provision of Mental Health Act (MHA) assessments in the Trust following a section 136 detention and the use of the Trust's HBPoS.

Previously, concerns have been raised by Trust staff across all localities, with a FTSU concern raised in the Rotherham Care Group on 10 February 2023 which highlighted ward staff concerns about the volume of activity in the HBPoS, including the number of people who were brought to Rotherham for assessment who had not been detained there as well as the number of patients who had been admitted to the suite under s140 of the MHA. As a result of this concern, the Trust held a "Big Conversation" with acute pathway colleagues on 19 April 2023. An action plan was developed and implemented at this meeting and its progress was monitored through the previously titled, "Operational Management Meeting". Actions included:

- The development of guidance for ward staff and assessing clinicians in relation to s140 MHA.
- A rota system for staffing the s136 suites across the wards.
- A review of the Patient Flow Procedures.
- Consistent application of safety huddles and hot debriefs during periods of high acuity and following incidents.

Most of the actions were completed as planned and those that are outstanding have been incorporated into the Trust's Safe and Therapeutic Bed Base Framework.

Concerns have also been previously raised by Humber and North Yorkshire Integrated Care Board (HNYICB), North Lincolnshire Council (NLC), and Humberside Police about the number of South Yorkshire residents who are taken to the North Lincs HBPoS.

Most patients are brought to the S136 are by the relevant Police Department (approximately 85%) and the others are brought by an ambulance such as Yorkshire Ambulance Service (YAS). YAS do have a dedicated mental health vehicle, but this is only staffed by paramedics, so there are limitations to this model and works between set hours daily.

Background

The Trust has 3 HBPoS, 1 in Rotherham, 1 in Doncaster and 1 in North Lincs. These are attached to the Trust's mental health inpatient wards and are a statutory provision for people over the age of 16 years who have been detained by the police under s136 MHA for the purposes of a MHA assessment, or who are requiring an MHA

assessment following the execution of a s135 warrant. The Trust has different staffing models in place for the HBPoS and these are described later in this paper.

It is worth noting that both South Yorkshire and North Lincolnshire do not have a dedicated suite for the under 18 years old. Sheffield Childrens NHS Trust are commissioned to provide a suite, at the Beckton Wing, for this age group but this suite has remained closed for the last 2 years due to Sheffield Childrens being unable to staff the model. Currently the position for RDaSH is that the suites will admit 16/17-year-olds, as there is access to CAMHS but Sheffield Health & Social Care do not admit under 18-year-olds, as they do not provide CAMHS.

Although not routinely, the HBPoS have previously been used for under 16s who have been detained under s136 in exceptional circumstances. There has been a recent update to the RDaSH policy, just about to go onto the intranet, where the policy previously stated U16's place of safety was preferred to be A&E. The updated policy has now removed preferred and states U16 Place of Safety is A&E. This update has been communicated to teams.

Following an inquest in 2018 where a Regulation 28 Prevention of Future Deaths notification was issued in Leicestershire in relation to the provision of inpatient beds in cases of special urgency (MHA s140), subsequently, there has been an increased national and local profile around cases of special urgency. Due to the mental health bed pressures in the Trust, there has been an increase in the numbers of patients who have been admitted to the HBPoS, under s140, in the last 12 months as there has been no bed available to admit the patient into. Details of this are shared later in this paper by Care Group.

There has also been an increase in the numbers of people who have been admitted to the HBPoS following a s136 MHA assessment as there are no beds in the Trust, or elsewhere, to admit the person to. People can stay in the suite for a few hours or at times for several days depending on bed availability. Details of this are shared later in this paper by Care Group.

In both North Lincs and Rotherham, there are some additional, funded staff specifically for the HBPoS but it is not sufficient to provide 2 staff per shift, so ward staff have to support. Due to the risks associated with the people being brought into the HBPoS, it is recommended by the National Association of Psychiatric Intensive Care Units (NAPICU) that a minimum of 2 staff are present in the suite when it is occupied. There must be a qualified member of staff for clinical oversight and management.

In Rotherham, the s136 staff are called Urgent Care Support Workers and they are based and managed within the PICU. The Urgent Care Support Workers support the inpatient areas when the suite is not in use. There are always 2 staff in the Rotherham suite when it is in use with the additional staff member being provided, on a rota basis, from the wards. The additional posts were funded by the Care Group in response to the level of demand being placed on the PICU staff in supporting the HBPoS.

In North Lincs, the s136 staff are called Acute Care Workers and are based and managed within the Crisis and Liaison services. The Acute Care Workers support crisis, home based treatment, and inpatient services when the suite is not in use.

There are always 2 staff in the North Lincs suite when it is in use with the additional staff member being provided from the wards. The Acute Care Workers are funded by HNY ICB in response to the implementation of Right Care Right Person in 2020.

North Lincs Care Group also has a unique arrangement with Humberside Police in relation to staffing concerns, whereby they can restrict access to the suite. In practice, this means that rather than closing the suite, Humberside Police can use it, if they remain with the person until either the assessment is complete or there are sufficient staff available to release the officers.

The implementation of Right Care Right Person by Humberside Police in 2020 for North Lincs and 2023 by South Yorks Police for Rotherham and Doncaster has meant that the police do not expect to stay in the suite for more than 1 hour when they bring a person for assessment unless there is a significant risk of violence that requires them to manage. To date, there has been no detrimental impact on our services reported in relation to this change, but this is being closely monitored and a data set established.

There are no additional staff for the s136 suite in Doncaster. When the suite is occupied, it is staffed by ward staff based on a risk assessment of the individual. There are between 1-2 staff in the Doncaster suite when it is in use based on the person's assessed risks. The decision not to increase staffing for the HBPoS was made by previous leaders based on demand at that time.

In January 2020, the Consultant Psychiatrists in Doncaster gave notice to the then Clinical Commissioning Group (CCG) that they were intending to stop undertaking MHA assessments out of hours unless it was in relation to patients in hospital. The reasons for this were extensive, including recruitment and retention of consultants, improving work life balance due to the volume of work, that there were insufficient s12 doctors in the locality to undertake the MHA work which was a commissioning responsibility to ensure and that it is not a contractual arrangement for consultants to do this work. The notice to withdraw includes s136 assessments. The consultants in Rotherham and North Lincs followed suit and served notice to their respective CCGs, with North Lincs being the last in July 2020.

This action has resulted in it being more challenging for AMHPs to obtain s12 doctors for the purposes of assessment and consequently people staying in the HBPoS longer than they did previously due to the availability of suitably qualified doctors. The Medical Director is currently writing guidance in relation to s12 work for Trust doctors, however this will not change the current position.

The Trust does have a s136 report (Portal 235) however, this is complicated and does not currently report automatically when a s136 suites are "repurposed" i.e., closed to other patients when a patient is in due to a s140 and/or there is no bed available, and for how long this is for. This currently captured manually by the Mental Health Act Office but need a more integrated automatic solution. There are monthly meetings per Care Group to review the local data regarding S136's activity.

Data & Assessment

To assess the current practice, concerns, and challenges in relation to the HBPoS provision, the following data has been reviewed and analysed:

- 2023/24 Q1, Q2 and Q3 HBPoS closure information per locality
- 2023/24 Q1, Q2 and Q3 s136 assessment data per locality
- S136 staffing model data supplied by the Patient Flow Team

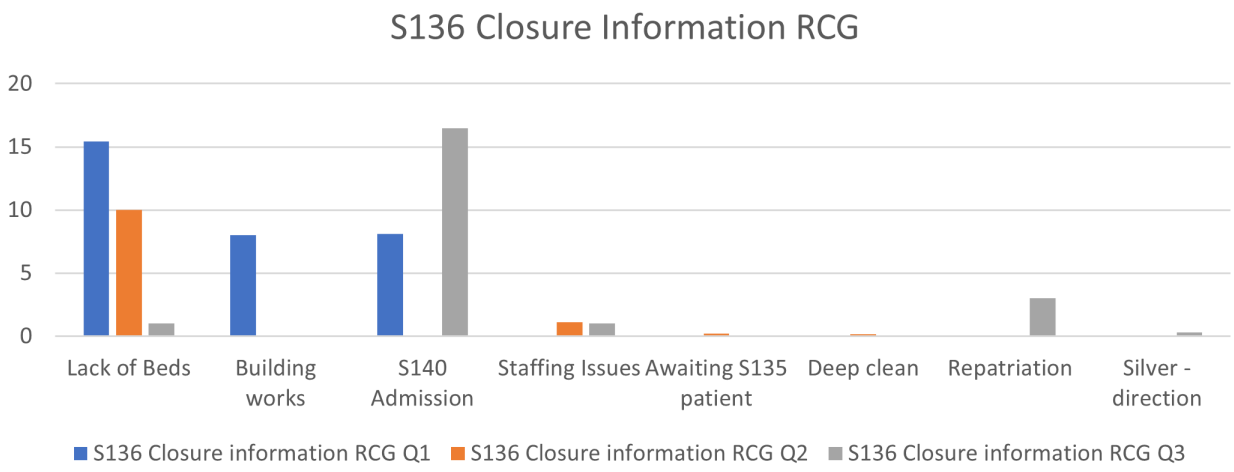
It is essential to note that the MHA reporting requirements in SY ICB and HNY ICB differ and therefore the data in relation to HBPoS closures in North Lincs is not as detailed as that in Rotherham and Doncaster and there were some reasons for closure missing from the Doncaster data. There is currently no way to record HBPoS closures on SystmOne, so the Trust is currently reliant on manual reporting. This does not significantly change the findings of this report.

HBPoS Closures Analysis

The following tables and graphs identify the HBPoS closures per Care Group from 1st April – 31st December 2023 and the reasons for the closures.

Rotherham Care Group:

S136 Closure information RCG			
	Q1 (Days)	**Q2 (Days)**	**Q3 (Days)**
Lack of Beds	15.45	10	1
Building works	8	0	
S140 Admission	8.11	0	16.5
Staffing Issues	0	1.11	1
Awaiting S135 patient	0	0.2	
Deep clean	0	0.16	
Repatriation			3
Silver Command direction			0.33

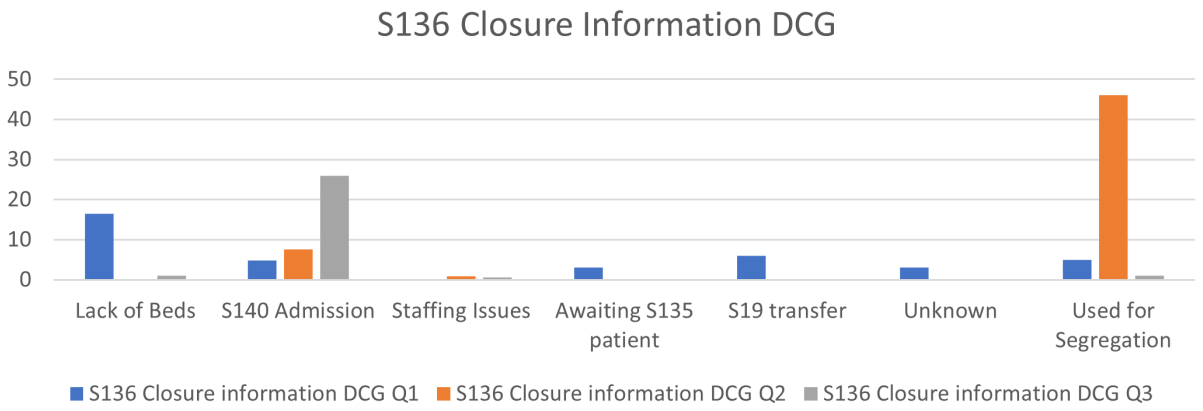


The Rotherham HBPoS was closed a total of 64.95 days which represents 23.6% of the available resource.

The top 3 reasons for the suite being closed (to other patients) are due to patients being admitted there following a s136 assessment as no beds were available, building works which was a one- off event but for 8 days and people being admitted under s140.

Doncaster Care Group:

S136 Closure information DCG			
	Q1 (Days)	**Q2 (Days)**	**Q3 (Days)**
Lack of Beds	16.5	0	7.58
S140 Admission	4.75	7.6	26
Staffing Issues	0.2	0.85	0.62
Awaiting S135 patient	3	0	
S19 transfer	6	0	
Unknown	3	0	
Used for Segregation	5	46	1



The Doncaster HBPoS was closed a total of 128.1 days which represents 46.6% of the available resource. It is important to note that following discussions directly with the Care Group about regularity of closures in October, we are now seeing an improving trend in Q3.

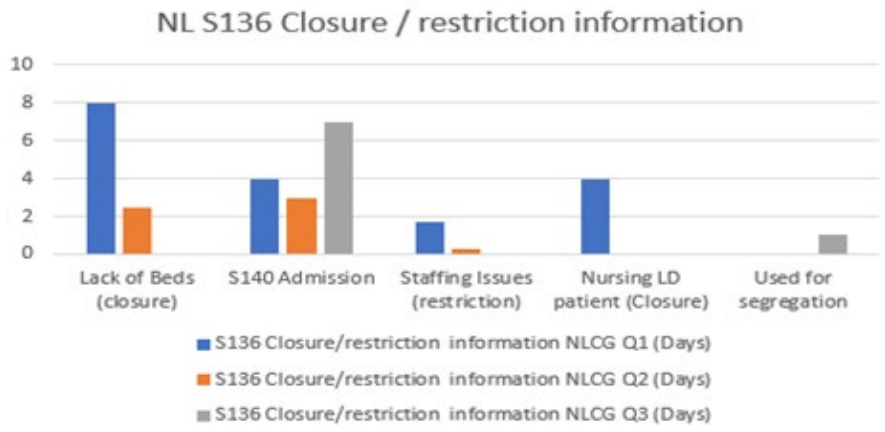
Doncaster's suite was closed on 10 occasions during the period to provide care away from others (segregation) which is a practice that is not evident in the other Care Groups. In September, the suite was closed for a total of 20 out of the 30 available days to provide care away from others. Segregation resulted in 28% of the total days that the Doncaster HBPoS was closed that month, and this was the main reason for closures in Doncaster.

The next most common reasons for closure of the suite were patients being admitted there following a s136 assessment as no beds were available and people being admitted under s140. In Q3, while use as segregation and availability of beds, we note the increase in s140 admission and delay. The Care Group supported a patient whose placement in Nottingham broke down. The patient's s117 responsibility lay with Doncaster and no bed could be identified for him in Nottingham so he was admitted to the Doncaster suite. This resulted in the suite being closed from 27th November 2023 until 7th December 2023. While infrequent when there is a placement

breakdown, patients can remain in S136 for periods of time while a further placement is being sought.

North Lincs Care Group

S136 Closure/restriction information NLCG			
	Q1 (Days)	Q2 (Days)	Q3 (Days)
Lack of Beds (closure)	8	2.5	0
S140 Admission	4	3	7
Staffing Issues (restriction)	1.75	0.25	0
Nursing LD patient (Closure)	4	0	0
Used for segregation	0	0	1



The North Lincs HBPoS was closed a total of 31.5 days which represents 11.5% of the available resource. As previously identified, North Lincs has a unique arrangement with Humberside Police in relation to restricting the HBPoS when there is insufficient staffing.

As with Rotherham and Doncaster, closing the HBPoS for people who have been assessed as requiring admission but there are no beds and people admitted under s140.

There was a 4-day period where a patient with a Learning Disability and Autism was admitted to the seclusion suite on Mulberry and due to the number of staff that were required to care for him, the HBPoS was closed for a period of 4 days.

Summary

In the reporting period, the HBPoS in the Trust were closed for 23.6% of the available time in Rotherham, 46.6% of the time in Doncaster and 11.5% of the time in North Lincs.

The main reasons for closing the suites are due to the unavailability of beds for people to be admitted to after they have been assessed under s136 and people who require to be admitted under s140 special circumstances where there is no bed available.

This accounted for 78.6% of the HBPoS closures in Rotherham, 22.5% of the closures in Doncaster and 55.6% of closures in North Lincs.

Doncaster's HBPoS was closed on 10 occasions to provide care aware from others (segregation) which accounted for 40.6% of Doncaster closures and is a practice that is not evident in the other care groups during this period.

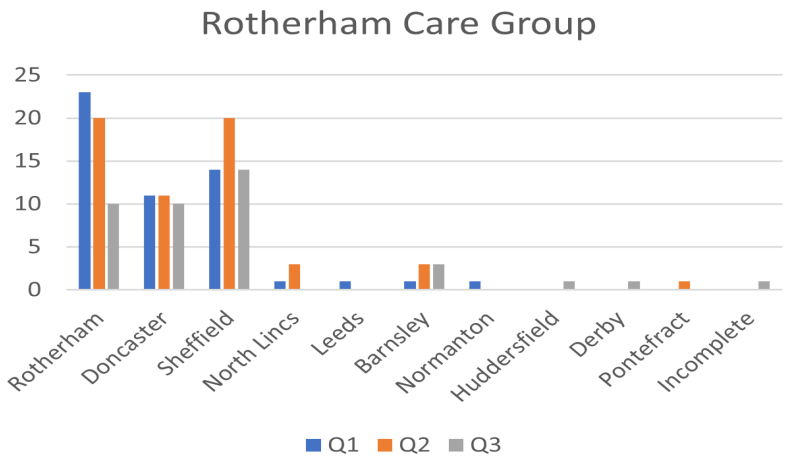
The current process for approving closure of a HBPoS in the Trust is that it must be approved by an Executive or gold on-call if out of hours. There is no evidence that this process is being followed in every case.

S136 Detention and Assessment Analysis

The graphs below identify the numbers of people who were detained under s136 across the Trust footprint and how many MHA assessments following s136 detention were undertaken in each HBPoS, including where the individuals were originally detained in Q1, Q2 and Q3.

Rotherham Care Group

RCG S136 Suite Usage Q1/Q2/Q3 2023			
Detention location	**Q1 No. Patients detained**	**Q2 No. Patients detained**	**Q3 No. Patients detained**
Rotherham	23	20	10
Doncaster	11	11	10
Sheffield	14	20	14
North Lincs	1	3	0
Leeds	1	0	0
Barnsley	1	3	3
Normanton	1	0	0
Huddersfield	0	0	1
Derby	0	0	1
Pontefract	0	1	0
Incomplete	0	0	1
Total S136 assessments	52	58	40

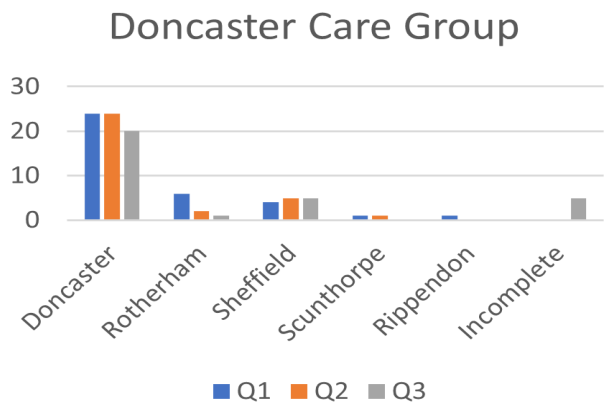


There were 150 people assessed in the Rotherham HBPoS in the period. Of these, 53 people were detained in Rotherham which means that 97 people, or 64.6%, who were assessed in the Rotherham suite were not detained in Rotherham. 21.3% of the people assessed were detained in Doncaster and 32% were detained in Sheffield.

There were 13 people who were detained in Rotherham who were taken to another of the Trust's HBPoS to be assessed.

Doncaster Care Group

Doncaster S136 Suite Usage Q1/Q2/Q3 2023			
Detention location	**Q1 No. Patients detained**	**Q2 No. Patients detained**	**Q3 No. Patients detained**
Doncaster	24	24	20
Rotherham	6	2	1
Sheffield	4	5	5
Scunthorpe	1	1	0
Rippendon	1	0	0
Incomplete	0	0	5
Total S136 assessments	35	31	31

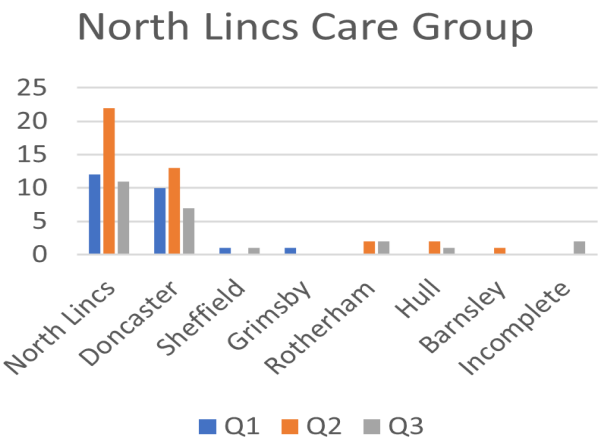


There were 97 people assessed in the Doncaster HBPoS in the period. Of these, 68 people were detained in Doncaster which equals 70.1%. 9.2% of the assessments that took place were for people who were detained in Rotherham and 14.4% were for people detained in Sheffield.

There were 62 people who were detained in Doncaster who were taken to the another of the Trust's HBPoS to be assessed. This equates to 47.7% of the people who were detained in Doncaster.

North Lincs Care Group

NLCG S136 Suite Usage Q1/Q2/Q3 2023			
Detention location	**Q1 No. Patients detained**	**Q2 No. Patients detained**	**Q3 No. Patients detained**
North Lincs	12	22	11
Doncaster	10	13	7
Sheffield	1	0	1
Grimsby	1	0	0
Rotherham	0	2	2
Hull	0	2	1
Barnsley	0	1	0
Incomplete	0	0	2
Total S136 assessments	24	40	24



There were 88 people assessed in the North Lincs HBPoS in the period. Of these, 45 people were detained in North Lincs. This means that 43 people, or 48.9%%, of the people assessed in North Lincs were detained elsewhere. 34% of the people assessed were detained in Doncaster.

There were 4 people detained on a s136 in North Lincs who were taken to the Rotherham HBPoS for assessment and 2 who were taken to the Doncaster HBPoS.

The reasons for people being assessed out of their own localities is because the HBPoS in their own area was unavailable for the reasons outlined above. There has been a significant increase in the Trust of people being admitted to the HBPoS both following assessment in the suite and there is no bed available for them and from the community under s140 special measures. This is having a significant impact on the availability of the HBPoS when they are needed.

Summary

Doncaster had the highest number of days when their HBPoS was unavailable and also has the highest number, 47.7%, of people who were assessed out of their own locality. Both Rotherham and North Lincs had higher than expected numbers of people from out of area who were assessed in their HBPoS, 64.6% and 48.9%. Only 29.9% of the people assessed in the Doncaster HBPoS were from out of area by comparison.

Rotherham also had a significantly higher number of assessments undertaken in its HBPoS, with 44.8% of the total s136 assessments across the Trust taking place in Rotherham while only 19.7% of the people assessed in the Trust were detained there.

There were 68 people assessed in the Trust who had been detained in Sheffield which has been an ongoing concern raise. Both the Trust and HNY ICB have raised this with SY ICB but there has been no resolution to date. The number of Sheffield people constituted 20.3% of the Trust's s136 assessments.

Impact and Risks

The challenges outlined above result in the following:

- **Patients:** several patients, particularly from Doncaster and Sheffield, have been transported, while in a mental health crisis, to other areas in order to be assessed under the MHA. This is a poor experience for people and increases the risks of incidents happening or an increase in unnecessary admissions as the teams involved in the assessment do not know the person or the services that are available in their community to support them.

- **Staff:** staff have expressed concerns about the increase in activity in the HBPoS, including the numbers of assessments and the numbers of people being admitted into the suites. Admissions into the suites due to beds not being available are the highest reasons for HBPoS being closed across the Trust followed by use of patients on a s140.
- **Partners:** Concerns have been raised by partners such as the local authorities and the ICB that patients are not being assessed at Place, which will often be the preferred assessment place for best care.
- **Out of Area Placements:** Several patients remaining in S136 due to "lack of beds" are subsequently placed in an OAP provision. This is not good care, and it is unclear if all providers undertake a consistent approach to use of OAP's when in a S136.

Provider Collaborative

It is important to note that the improvement regarding the utilisation and flow regarding s136 suites is one of the South Yorkshire MHLDA Provider Collaborative workstreams. This is overseen by the South Yorkshire MHLDA - HBPoS 136 Suite Steering Group, who have a series of ambitious objectives many with a longer-term aim.

Areas for consideration and improvement:

- To review the variation in RDaSH staffing models and to understand if this does impact on delivery and needs changing
- To ensure we have an accessible Dashboard for s136 – which automates data, including when S136 are repurposed, why, and how long for.
- To ensure we have the right governance and oversight regarding s136 utilisation and capacity including when suites are asked to be "closed"
- To support a larger programme in the future which focuses on "flow" – to ensure that beds are more available in a timely way
- To work with the system regarding the YAS MHV and to consider if this can be used in a more integrated way with mental health services, and potentially a different model is potentially proposed
- To work with the system regarding flow of patients across the different ICB's and providers, to ensure patients are cared for within their Place in a timely way.
- To reduce the number of patients, from a S136 going to an Out of Area placement

Recommendations

- To note the contents of this report
- To note that there is ongoing work across the current suites, and with the flow team to ensure suites remain open. Part of this will be to increase the visibility of the data.
- To note that we will need to review the different staffing models and develop a consistent approach
- To note the work of the SY MHLDA collaborative – and as a Trust to continue to support actions for improvement which will require a system approach.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Objective 5	**Agenda Item**	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jo McDonough, Director of Strategic Development		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

Strategic Objective 5 is sets out to "Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**RECEIVE** and note the focus of Strategic Objectives 5 and promises.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register	x						
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	April 2024
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

None

Rotherham Doncaster and South Humber NHS Foundation Trust

Strategic Objective 5 - Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations

Spotlight

Jo McDonough
Director of Strategic Development

January 2024

RDaSH nurturing the power in our communities

What is the Board being asked?

All Board members have contributed to developing the strategy, and its objectives. We have agreed to use each meeting to re-discuss and explore each of the objectives. This is part not of changing or adapting the specific objectives but having time to consider the real meaning and intent. Colleagues understanding of the objective will evolve, and new ideas will become important or have greater salience.

The Board is being asked to discuss the five promises and consider what is difficult in each.

Why we have agreed this as one of our Strategic Objectives

This objective is about what kind of organisation the Trust is and wishes to continue to be. How we work is at least as important as what we do. The Trust has an influence and impact upon its communities, that goes beyond delivering services. Positive examples include employing people in local communities and spending money through local organisations and thereby contributing to local economies. We can contribute to better places to live and work for example by working with communities to reduce our carbon footprint.

We can also show leadership in tackling discrimination in parts of our community, including our workforce, patient experience and in promoting inclusion. Communities and other organisations can get involved in some of the great research we do and research needs to be more mainstream in our core services. Finally, we can offer hope and opportunities for young people including those who might want to be part of the NHS workforce now and in the future. These things are sometimes referred to 'social value' and / or the Trust being an 'anchor institution'.

What our Promises are under this Strategic Objective and what we are doing

There are five Promises that fall under this Strategic Objective. Delivery of each of the Promises will be overseen by 8 delivery and enabling plans and overseen by associated sub groups to the Clinical Leadership Executive. Committees of the Board have oversight on the development and progress of allocated Promises. This is shown in the table below.

Promise No.	Promise	Committee being reported to	Group overseeing development and progress	Which plan the Promise is in
24	Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan	POD Committee	Learning and Education	Learning and Education
25	Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	POD Committee	People and Teams	People and Teams
26	Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	POD Committee	People and Teams	People and Teams
27	Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	PHPIP	Estates and Sustainability	Equity and Inclusion
28	Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring investment and employment to our local community.	PHPIP	Research and Innovation	Research and Innovation

(Promise 24) Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan

This Promise will show how we invest in our people (in our organisation and communities). We want to be a supportive employer who privileges all. This will be beneficial for the community, for our current and future workforce and also for the wider health economy. Our specified areas of focus take into account public health information and also information from our patients, families and communities.

To achieve this, we will review our current expenditure and gap. We will reflect upon the population who have accessed apprenticeships through use of our levy over the past 5 years. We will engage our staff and communities and explore how we improve access for excluded communities such as Care Leavers by working more closely with education providers and other partners. We will create enabling opportunities for people to access courses using our Apprenticeship Levy. We will monitor, and promote progress to encourage others to join. To do this right will mean engaging and co-producing with a range of people over the next few years, and to be delivered in a distributed way within directorates.

Where is the challenge?

The national LTWP remains a published yet to be delegated item. The challenge of joining up workforce planning and finance, which we experience as RDaSH, is magnified at a local/regional level. We need to engage positively with the LTWP but not be boundaried by it.

Developing educational pathways for students and postgraduates has traditionally been university and regulator led. Stepping into taking responsibility for procuring and coordinating these pathways will require us to think and work differently as a Trust and at place. It will cause us to think creatively about what our learning and career offer could be. If we succeed it should be possible for this differentiate RDaSH from neighbours seeking to recruit, and also become outstanding in drawing talented children and students from this local community in to the service.

(Promise 25) Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities

The Real Living Wage is the only UK wage rate based on the cost of living. It is voluntarily paid by over 14,000 UK businesses who believe their staff deserve a wage which meets every day needs – like the weekly shop, unexpected bills or a surprise trip to the Dentist. According to the Living Wage Foundation, over 460,000 employees have benefitted from the Real Living Wage, giving them effectively a 'pay rise'. The Real Living Wage is reviewed each year, with changes effective from the October and accredited employers then have 6 months until the 1st May to implement the changes. The Real Living Wage is currently £12.00 per hour, outside of London. It is based upon a 'basket of goods' based upon what people need to get by.

Work has already begun to identify the number of colleagues who would benefit from receiving a Real Living Wage in the Trust. Within our workforce, 90% of the affected colleagues also live within our local communities. The Promise supports the Trust as an anchor institution, by increasing the entry salary into RDaSH this impacts positively on the local communities, including from deprived areas. We know from previous cost of living initiatives that we have colleagues having challenges to make ends meet on a day to day basis, so will be looking at how soon we can meet this Promise.

Those affected includes just over 300 Clinical Support Workers (CSWs). Work by the NHS Staff Council Job Evaluation Group would indicate that these CSWs may be due a re-banding of their roles from a Band 2 to a Band 3. This change would take these colleagues on a step towards the Real Living Wage.

As we transition more of our spend to local suppliers, and look at what we already spend locally, we will be assessing our suppliers about their own commitments to the Real Living Wage. This will be part of assessing what social value our own spend benefits our local communities.

Where the challenge?

It is assumed that the affordability challenge has been accepted by the Board in making the promise. Nonetheless, there are implementation challenges because removing below RLW pay rates will concertina together pay bands. This can cause difficulty with employees banded just above the RLW.

Shifting our spend both to local suppliers and to those who themselves meet the RLW is a significant procurement change. It will be critical during 2024 that we support our procurement team to make these changes.

(Promise 26) Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion

We know that racism is not just part of our society, but happens in the Trust as well. Our staff survey shows that colleagues from minority communities experience racism and therefore we have prioritised being an anti-racist organisation. It is not acceptable that our NHS people experience any form of discrimination from other employees, people who use our services or the public at work.

We know there is a real Board commitment to addressing any forms of racism in the Trust and this is a Promise that we will be making sure that we get some positive momentum and clear action in the short-term.

Over the summer 2023, we established an Anti-Racism Alliance to provide both a strategic and operational direction to support the delivery of the Anti-racism Framework within the Trust (which is being co-ordinated through Shirley Kirkland, our Head of Equalities). This includes members of the Executive, services as well as colleagues from minority communities, and members of our community. There is work to do on the development of the alliance, as well as on a plan to deliver the promise.

Where are the big challenges?

A commitment has been given already by 2026 to have a leadership community above band 8a that reflects our population as a whole. This demands change in who we hire, how we hire, and who we develop. The launch of our reverse mentoring programme, further support for FNF programmes, and revision of some policies in relation to recruitment will all make a contribution.

As the Chief Executive's latest vlog suggests, the management needs to refine and then insist on a consequences regime both for staff and patients were racism is experienced. Implementation of a consistent response to unacceptable behaviour is a critical step in making real our work to change.

Much of the difficulty is sublimated, unreported, tolerated – tackling the stigma associated with this and creating trust in the organisation as an employer that acts, acts fairly, and acts fast, will take concerted effort over coming months.

Tackling racism and discrimination also has to have a positive promotional character to it – reinforcing the merit of diversity. We need to be arguably more determined in how we do this, role model this, and extend this to all excluded and relevant groups. For example, the city of Doncaster has over 5% of its population that is white but does identify as British – many from central Europe. We have work to do to support those communities to believe that RDaSH is with them.

(Promise 27) Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change

We recognise the enormous challenge in becoming a net zero carbon organisation for direct emissions by 2040 but we are passionate as an organisation in continuing our journey towards net zero carbon. The Trust has been successful in reducing its carbon emissions by over 50% in the last 10 years. This success has been largely down to improvements in the Trust's estate efficiency, reduced dependency on fossil fuels and carbon reduction of the national grid. We recognise that more can be done across all departments and by encouraging sustainable development in all forms, the Trust can continue to take positive steps to mitigate the effects of its activities on the environment.

A comprehensive Sustainable Action Plan (that delivers our Green Plan) has been developed, with a number of actions underway. This includes establishing green champions, social value being part of all tenders, and continued expansion of solar panels and energy-efficient lighting.

We will also be undertaking actions with our communities and other organisations to address climate change and adaptation. We see this as positive opportunity to involve and support the community in things such as green social prescribing, sustainable food initiatives, and general health and wellbeing.

Where are the big challenges?

Reducing our carbon footprint will require the Trust to become serious about our staff and patient travel plans. This is difficult territory in a space where many regard driving to work as the only or best option. We have work to do to sort out our five-year remote working plans, which presently reflect legacy choices and the hangover of the pandemic.

Climate adaptation features in the promise. The UK HSA have become the latest national advisory body to raise concerns about the imbalance of the national climate change response – with too little focus on adaptation. We can only do this work with local and regional leaders, but in imagining health services locally in 2035 or 2050, we need to consider a very different landscape and risks to the resilience of critical infrastructure.

(Promise 28) Extend the scale and reach of our research work every year: creating partnerships with industry and universities that bring investment and employment to our local community

We believe that research can, and should, involve everyone. We want research questions to come from our communities, be relevant to our communities and be adopted by our communities. We also want research to be more mainstream across the Trust and in our services, to improve the future health and wellbeing of our communities.

To help us do this we take research into the field, visiting participants in their homes, in churches, schools and shopping centres. We take our community health bus to unusual locations and events. We also have good relationships with industry (including internationally) and universities that we will build upon and grow. Our existing expertise in the Trust, including through Grounded Research, gives us a solid foundation to build upon.

We will our network of patient research ambassadors, who have lived experience of both care and research activity. We will also develop a pathway for Trust-based projects, such as service evaluations, to be delivered with the support of academic partners, with the ultimate aim of developing some of these ideas into health and social care research projects.

Where are the big challenges?

NIHR funding for research is constrained and reflects nationally set priorities. Commercial research funding is often not focused on mental, older people or children. We therefore need to continue to be imaginative to bring in income for some of our activities.

The promise implicitly accepts that the Trust will undertake research that helps us to deliver our strategy but that may not be directly funded. In wanting to grow the number of researchers, we also accept some service activity trade off in recruiting those who are dual interested.

Despite the strength of our research base, we have a very definite group of researchers, and those who do not. Broadening our base is a not a more of the same approach.

We want to contribute to 'health services research'. This will be a new departure for RDaSH and we need to ensure we have the infrastructure in place to do that to standard, and to not damage our broader 'clinical' reputation for research quality.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	NHS Professionals update and proposal	**Agenda Item**	Paper Q
Sponsoring Executive	Nicola McIntosh, Executive Director of People and OD		
Report Author	Carlene Holden, Deputy Director of People and Learning Izaaz Mohammed, Deputy Director of Finance		
Meeting	Board of Directors	**Date**	25 January 2024

Suggested discussion points (two or three issues for the meeting to focus on)

In November 2021 the Board determined we should transfer our bank staff to NHS Professionals (NHSP). The implementation of this was paused in May 2022, and with time having elapsed, and with changed personnel involved, this paper invites the Board to reconsider the direction of travel. **We need to decide if this is the right step and if so whether it is a priority in 24/25 or for future years.**

Bank workers, who are our flexible atypical resource for patient care and backbone services, remain a key part of RDaSH. Under all options existing bank workers retain present terms and conditions of service (Agenda for Change Terms and Conditions of Service).

The question for the Board is whether an RDaSH led or an NHSP led, or another option best supports those workers and the Trust management of this key support. The key specific benefit of the NHSP proposal are:

A tailored and fully managed service

- 100% compliant flexible workforce across all skill sets (Nursing, Medical, Admin and Clerical, AHPs etc).
- A decrease in agency expenditure.
- An increase in bank fill rates.
- A reduction in unfilled shifts and overall demand.
- Recruitment programmes to attract high quality bank and substantive staff.
- Strong clinical governance and compliance with NHS Employment Check Standards.
- Interface with our current Rostering solutions

It is proposed that we commence a consultation to transfer our bank workers to NHS Professionals. The report considers any risks associated with the decision to commence the transfer, the associated timescales and resources required to successfully implement this change.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
Business as usual.	x

Previous consideration
(where has this paper previously been discussed – and what was the outcome?)

N/A

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**CONSIDER** the next steps
x	**AGREE** to delegate a proceed decision to the Chief Executive, Director of People and OD and Director of Finance on the basis of agreed terms of trade with NHS Professionals.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)							
Trust Risk Register							
Board Assurance Framework	x						
System / Place impact							
Equality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	Completed as part of original Business Case, to be updated March 2024
Quality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	
Appendix (please list)							
Appendix1 - Business Case							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

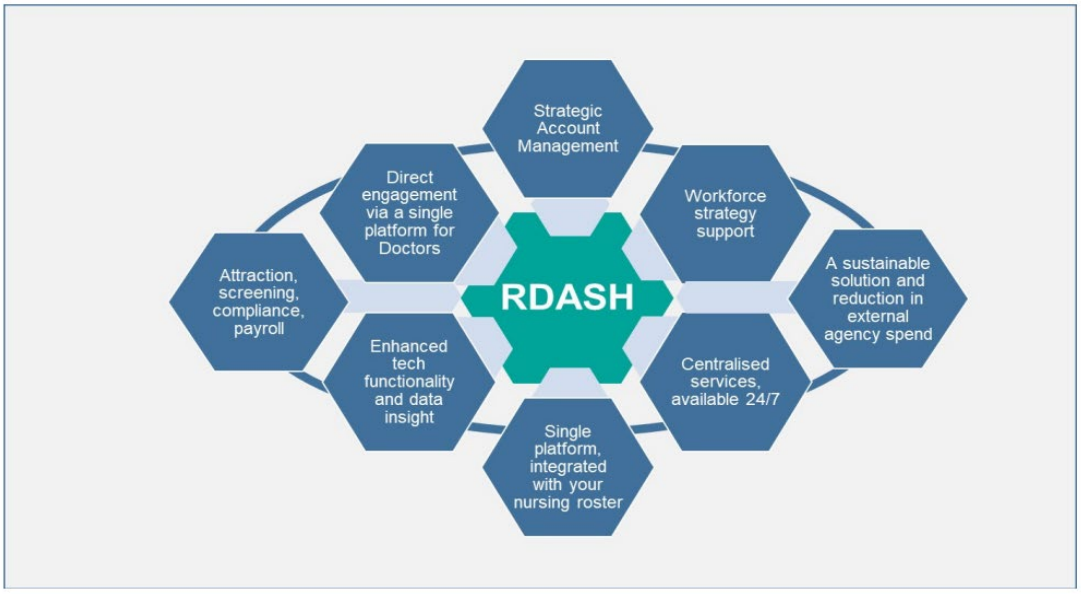
NHS Professionals Update and Proposal

1.0 Introduction

As Board members will recall the Business Case which proposed the transfer of our bank workers and associated banks, (except for Estates and Facilities bank) was presented to Board in November 2021 and the decision made to transfer our bank workers and associated banks to NHS Professionals (NHSP).

The purpose of this paper is not to revisit the original business case (which is included at Annex One), the associated benefits and risks, but with time having elapsed, and with changed personnel involved, this paper invites the Board to reconsider the direction of travel. We need to decide if this is the right step to transfer our bank workers and associated banks to NHSP, another provider or retain an in-house provision.

As a reminder the temporary staffing solution offered by NHSP covers the following



With the following key specific benefits

- A tailored and fully managed service
- 100% compliant flexible workforce across all skill sets (Nursing, Medical, Admin and Clerical, AHPs etc).
- A decrease in agency expenditure.
- An increase in bank fill rates.
- A reduction in unfilled shifts and overall demand.
- Recruitment programmes to attract high quality bank and substantive staff.
- Strong clinical governance and compliance with NHS Employment Check Standards.
- Interface with our current Rostering solutions

The transfer of our Bank workers to NHSP was paused in May 2022. The pause was initiated to review the working arrangements of several bank workers who at the time were working regular hours in the same area/unit for several months, which may have led to a claim for employment rights rather than worker rights and to ensure full disclosure to the questions colleagues posed about the possible transfer.

2.0 Updates May 2022 – January 2024

In late 2022/early 2023 a review was undertaken on the working patterns of all bank workers to understand where bank workers had been working in the same area/unit for several months, which may lead to a claim for employee rights rather than worker status, linked to mutuality of obligation. In these situations, colleagues have been offered employment with the Trust. A number have accepted this offer and moved from bank worker status to an employee, whilst a number have also declined the offer as they wish to retain the flexibility as a bank worker, to accept or decline shifts. Where bank workers have declined this offer, the potential employment risk which led to the pause has been mitigated.

In the same time period, late 2022/early 2023 bank workers received clarity on several questions which they posed during the initial consultation period and thereafter. This has been further supported via regular communication with staff side/trade union colleagues via Trust Staff Council and to date, staff side/trade union colleagues have not raised any further concerns.

Historically, we also provided an on site covid vaccination clinic which further increased our demand for bank workers, providing this service to Doncaster communities and surrounding areas, but following the closure of the covid vaccination centre, alongside others in the local communities, our demand for bank workers for this workstream has ceased, which has reduced our overall bank worker demand.

Whilst we have a centrally dedicated team, via the Procurement team, for two of our banks, the team operate 9am-5pm Monday-Friday and are based on the Doncaster site, with limited travel, the transfer to NHSP offers an onsite provision, across our geographical footprint with a 24/7, 365-day support service to support clinicians/managers out of hours.

Following the Trust restructure and the move to the 22 Directorates in late 2023 we continue to have a mixed economy with the management of our bank workers. We currently have 531 bank only workers, 444 of who work within the centrally managed bank. Centrally, the Procurement Team support the management of the following banks

- Administrative & Clerical
- Nursing – inpatient only

Whilst Directorates maintain the responsibility for the following banks

- Estates and Facilities
- Childrens – Vaccination & Immunisation
- Community Nursing Adults
- Community Nursing Childrens
- AHP

This has led to continued inefficiencies in the management of bank workers, the oversight of their supervision & training compliance and the ability to move bank workers across the Trust, where there is a pressing demand. This is compounded out of hours as the central service managed by the Procurement Team offers a Monday -Friday, 9am-5pm service which creates pressure out of hours, for the clinician in charge and the on-call provision to support and remedy any staffing shortfalls, whist maintaining safe and effective care.

We have continued to recruit to the banks during time, but recruitment has not been on the scale of previous recruitment campaigns and as such further work is required to enhance the bank provision and the availability of bank workers. The recruitment field remains competitive and bank workers being an atypical workforce are often registered on multiple banks which has led to some bank workers choosing shifts in other Trusts, often via NHSP where there offer a premia payment.

Since the initial work commenced to transfer our banks to NHSP, the availability of bank workers across different staff groups has been further improved by NHSP and they have enhanced their provision within for example Talking Therapies. Should we transfer our banks to NHSP, this would support the Trust in accessing colleagues in staff groups/areas other than those listed above to enhance our service provision and to manage any waiting lists/fluctuations in demand.

NHSP continue to be the predominant provider on temporary staffing solutions across our ICB's and therefore provide the opportunity to access the collaborative bank share arrangement. This allows bank workers, who are subject to the correct level of checks and hold the relevant training to support bank placements within RDaSH, with this also comes a risk that bank workers who have previously primarily supported RDaSH bank shifts could access bank/temporary staffing shifts in other Trusts, but this has been a risk for some time as colleagues are registered on multiple banks. By having one temporary staffing provider this provides enhanced monitoring of the hours worked and the identification of excessive hours worked outside of the Working Time Directive, which may negatively impact on patient care and colleagues' health and wellbeing.

The 22 Directorates will have the opportunity to continue to encourage new starters/students to join the bank, but if this is provided by a sperate provider, such as NHSP then there are likely to be different systems and processes to facilitate their inclusion on the bank. In the short term, whilst managers become familiar with the revised ways of working then this may increase the processing time for a colleague to join the bank.

NHSP continue to pay colleagues on a weekly basis, whereas RDaSH pay monthly. This is a positive for colleagues as they receive a payment each week, rather than once per month. For those colleagues who work bank shifts alongside substantive employment offers additional payments rather than waiting until the month end to access their salary/payments. In the current cost of living crisis and the financial demands we know our colleagues and others experience, this is a significant benefit.

In relation to the required resources to support the implementation, this remains the same as the original business case (Page 15) except for the Medical Staffing Lead as the Direct Engagement aspect of the project for medics has been managed separately and is near completion. Therefore if we commit to this change, we will have a consistent approach for all bank colleagues across all professional groups.

There has been recent coverage of Trusts having an unexpected VAT bill associated with bank workers supplied by NHSP, as part of our financial modelling VAT costs have been incorporated, where required and as such we are not anticipating any unexpected costs in this area.

The original business case referred to anticipated savings of £0.87m. NHSP have updated their projected savings based on changing levels of demand and current spend and this equates to a maximum saving opportunity of £1.49m over a 4 year period. This is based on the level of savings that NHSP have helped organisations with a similar spend profile deliver in the past. This does not account for any future changes in demand, pay rates or NHSP charges.

3.0 Areas for consideration

We need to consider whether we wish to continue with the previously agreed transfer of our bank workers and associated banks to NHSP, or to another temporary staffing solution provider or retain an in-house provision.

Following a detailed business case, presented to Board in November 2021 the benefits associated with the proposed transfer remain and have been further strengthened by the developments to access further staff groups and to provide continuity and robust management of the banks across the 22 Directorates.

However, it should be recognised that other temporary staffing solution providers are able to offer a fully managed temporary staffing solution, the benefits associated with NHSP are they are the predominant temporary staffing solution provider across our ICBs which provides collaboration at place/region and possible economies of scale.

The in-house bank management is a mixed economy with some banks being centrally managed and others being managed within operational services which leads to inefficiencies and different approaches. Should the decision be to retain an in-house bank provision, further detailed work is necessary to understand the resources which are required to support all our banks in a consistent manner across the Trust geographical footprint and to offer extended support hours, as the demand/pressure is often outside of the Monday-Friday 9am-5pm, current hours of work.

If the decision is made to continue with the transfer of our bank workers and associated banks to NHSP or another temporary staffing solution we need to determine whether this is a priority for 2024/25 or for future years. Given the mixed economy and the challenges associated with this, should a decision be made to support a transfer in 25/26 or later years then consideration needs to be given to the current management arrangements for the banks and how this can be strengthened.

4.0 Next steps to implementation for preferred option

1. The transfer of our bank workers and associated banks to NHS Professionals is initiated, acknowledging this will result in a TUPE consultation. The final Terms and Conditions of the Contract with NHSP will be agreed and signed off by Toby Lewis, Ian Currell and Nicola McIntosh.

2. The transfer to commence and complete in 2024/25 to offer clarity to our bank workers and provide stability in the management of the bank provision. Service implementation typically takes 16 weeks, allowing for consultation with Trust bank only workers before they transfer, in accordance with TUPE, to NHSP.

3. An enhanced communication campaign to our bank workers to notify them of the transfer and the ongoing engagement during the consultation alongside a communication to Trust managers to support the implementation and the affected colleagues.

4. The identification of the resources detailed in the original business case, with the exception detailed above to support the successful transfer and implementation.

5.0 Recommendations

The Board of Directors is asked to:

- Consider the next steps and
- Agree to delegate a proceed decision to the Chief Executive, Director of People and OD and Director of Finance on the basis of agreed terms of trade with NHS Professionals.

Rotherham Doncaster and South Humber NHS Foundation Trust

Business Case

NHS Professionals Limited Managed Bank Solution

Leah Tennent & Carlene Holden alongside NHS P

November 2021

DOCUMENT CONTROL:
Author: Kathryn Grayson
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RDaSH leading the way with care

Contents

1. Executive Summary

The Trust currently has in-house staff banks to manage its temporary workforce through filling vacant rostered shifts using bank and agency staff. The bank management process and centralisation differs across the Inpatient Bank and Admin Bank which are centrally supported and managed whereas the Community Bank and the Vaccination & Immunisation bank, both of which are managed within the operational services, which creates inconsistencies with the overall bank management processes. The Trust has two principal strategic drivers triggering the need for a business case to review the potential of partnering with NHS Professionals (NHSP):

1. Significant and ongoing spend on agency supply for temporary staffing with long-term use of medical locums, causing higher costs, with reduced compliance and governance.
2. The need to deliver the people promise per the NHS People Plan.

This business case will detail the risks and benefits of partnering with NHSP. The status quo option will also be considered, where if no action is taken, there is a continued high cost of agency use, and the associated risk with compliance of the temporary staffing workforce.

A partnership with NHSP offers a cost beneficial mechanism to drive the change from agency usage to bank. NHSP is an NHS organisation created before 2000 with long-term partnerships at many adjacent Trusts who work in a regional collaborative. NHSP are a partner committed to the people promise.

The NHSP temporary staffing solution - across all staff groups including the use of direct engagement - would generate forecast cost reductions over the four-year partnership of £871,180.

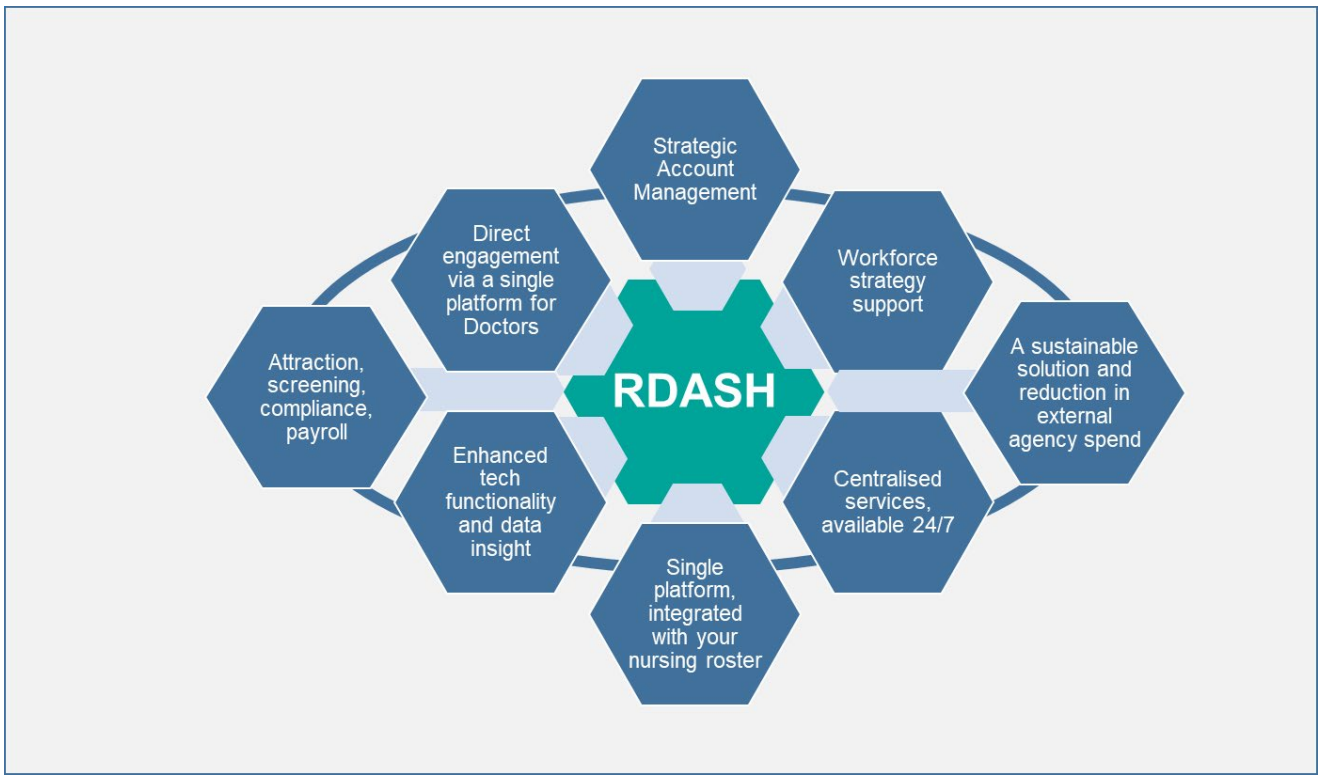
This project is a significant piece of work with implementation taking approximately 16 weeks and requiring wide engagement across the Trust to be fully successful. A Project Manager will be required for six months alongside other roles, and a designated Trust representative acting as a primary contact for NHSP during the partnership with strategic and operational capacities (See resource table in 7.2).

NHSP separated the financial modelling to show each staff group, on review the most compelling cost reductions come from outsourcing all staff groups with a net cost reduction of £871,180 over the four-year partnership.

<u>NHSP service overview</u>

NHSP are able to deliver a high-quality Managed Bank solution that delivers assurance in clinical governance compliance and improved client care and safety through:

- A tailored and fully managed service
- 100% compliant flexible workforce across all skill sets (Nursing, Medical, Admin and Clerical, AHPs etc).
- A decrease in agency expenditure.
- An increase in bank fill rates.
- A reduction in unfilled shifts and overall demand.
- Recruitment programmes to attract high quality bank and substantive staff.
- Strong clinical governance and compliance with NHS Employment Check Standards.



NHSP can demonstrate 100% compliance of its bank only staff through a quarterly audit report with which CQC is familiar and will assist any future inspections. Wholly owned by the Department of Health and Social Care, NHSP share strategic objectives of reducing agency usage and costs while increasing client care through enhanced compliance and governance.

Operational efficiencies from the NHSP include 24/7/365 service centre and a 5-day payroll service - helped by NHSP having a unique two-way live interface with our e-rostering supplier, Allocate, enabling the Trust to make better use of our existing system, support new functionality, and regional collaboration with our partner Trusts.

Delivering services widely across the NHS and regionally, NHSP can demonstrate through peer references and case studies evidence to support significant results in achieving cost reduction and agency migration, which back up assertions that forecasts are based on the conservative side.

Service implementation typically takes 16 weeks, allowing for consultation with Trust bank only workers before they transfer, in accordance with TUPE, to NHSP. As systems are cloud based, no Trust IT investment is needed; the other implementation resources required are outlined in section 7.2 .

2. Background

Programme Outline

The NHSP Managed Bank Solution proposes to deliver the following:

Features	Benefits
24 Hours / 365 Days a Year, Manned National Service Centre	• Trust staff and flexible workers have access to out-of-hours support with a Trust dedicated phone line • User support for access to the secure booking management system
Dedicated onsite trust services team	• Access to experienced client relations and recruitment professionals • Highest level of service closest to the customer • Regular strategic and operational reviews • Annual account plans • All supported by the National Service Centre
Agency Controls and Management	• Controlled agency cascade – multi-level authorisation • Agency migration to reduce spend • Agency invoice validation and self-billing • Accrual reporting – total control and audit
Bank-Only and Substantive Recruitment	• Dedicated field recruitment teams • Bank-only face-to-face interviews • Roles advertised through local partnership website / NHS Jobs / social media – supported by NHSP specialist marketing team • Safeguarding and NHS Employment Check Standards • On-site training and engagement days for new recruits • Registration of Trust substantive staff onto NHSP Bank
Innovative Workforce Initiatives	• Harnessing the support of substantive workers to work additional hours • Opportunity to utilise NHSPs Care Support Worker Development Programme, supplying new Trust workers
100% Compliant Flexible Workers	• Workers fully compliant with NHS Employment Check Standards • Mandatory training, occupational health, Right to Work, DBS – all valid and up to date • Surveillance to ensure 100% compliance throughout the worker life cycle
Clinical Governance Assurance	• Trust Board assurance – 100% compliant workers • Performance evaluations / appraisals • Systematic controls – complaints and incidents management
Comprehensive Management Information	• Data feeds and Power BI – providing full visibility of bank and agency activity, enabling control and management of demand and cost • Online reports available 24 hours a day, 365 days a year • Expert analysis and intelligence to support Trust strategy
Secure Integrated IT Platform	• Secure booking management system(s) – cloud-based platform • Internet-based – no IT investment required or upgrade costs • Full IT specification, shared at implementation, directly with our IT

Features	Benefits
	• Interface with the Trust's e-rostering system for non-medical areas • Disaster recovery / business continuity • ISO 9001 accredited; Cyber-Essential Plus accreditation

We have been assured that all elements of this solution can be tailored to RDASH's specific needs and the implementation will be fully supported by an experienced and dedicated Implementation Team.

Case for Change

The Trust has two principal strategic drivers triggering the need for a business case to review the existing model for engaging with flexible workers and bank staff.

1. The high cost of agency supply for temporary staffing and long-term use of medical locums.
2. The need to deliver on the NHS People Promise.

If no action is taken, high cost of agency use will continue, and the Trust will continue to bear the risks associated with compliance of the temporary staffing workforce.

We also have an obligation to deliver against the people promise as best we can and two crucial elements of that promise are the commitments to "work flexibly" and be "safe and healthy". An enhanced Managed Bank offering will allow us to offer that to our flexible workforce and NHSP, as an NHS organisation have a very strong alignment to the People Promise that we will benefit from. It is worth noting that NHSP are a wholly owned entity of the Department for Health & Social Care (DHSC), and as such, are part of the NHS family. NHSP provides a unique proposition; they have the relevant expertise and motivation to support RDASH in delivering high quality solutions, all whilst keeping funds within the NHS family. In 2019/20 they saved their clients over £79m in external outsourced spend, and each year re-invest 100% of their surplus revenue back into frontline health services. In 2019/20 this amounted to £11m being redirected back into the NHS.

Operational Benefits

Efficiency

- Transactional pricing model offers certainty of cost throughout the term of the contract.
- Removes need to invest in tech/people/process.
- Hard and soft savings from demand management and process automation.

Scalability

- Resources which can flex and scale depending on demand.
- 24/7 service centre for worker queries.
- Off-site centres of excellence for back/middle office activities.

Expertise

- Access to dedicated talent acquisition, marketing and agency management functions.
- Enhanced expertise for HR and clinical regulatory, industry and legislative requirements.
- Economies of scale derived from NHSP's buying power (e.g. media spend).

Innovation

- A single enhanced and functionally rich technology solution across multiple Trusts.

- Market insight and innovations from across the flexible worker landscape.
- Investment in new worker career pathways and tech products.

Cost Benefits

Structural savings:

- NHSP employment savings:NHSP has lower on-costs and WTD due to their scale. Example Trust on-cost 20.63% vs NHSP on-costs 15.25%.
- Bundling of non-pay costs: Provision of occupational health services, worker HR, uniforms, recruitment advertising, mandatory training, 24/7 service centre.
- NHSP dedicated team:Scalable workforce operating pan-region or in a shared service environment reduces direct headcount cost.

Partnership savings:

- Demand management: Insight into booking behaviours, trends, with total visibility of agency hours. Trusts average 8% reduction by outsourcing.
- Automated Agency Cascades: national buying power, negotiating best rates, with agency bumping automating efficiencies (modelled at 5%).
- Migration of agency to bank: Reduce off-framework spend. Potential for DE to build a locum bank.

NHSP Alignment with the NHS People Plan

NHSP are creating a Bank Member Engagement Programme and Digital Platform, which will enhance member experience and increase Trust engagement levels, helping to promote, attraction, retention, and utilisation of the bank to RDASH.

The key elements of NHSP provision includes:

- Working with trusts to ensure that Bank members experiences on shift are positive and embrace the overall values of the NHS.
- Ensuring all Bank Members experience Equality Diversity and Inclusion. (EDI).
- Ensuring all Bank Members understand EDI within the workforce and address any unconscious bias or discrimination.
- Provide Bank Members with continuous development and career pathways addressing the existing skills gap.
- Developing and procuring new technology to support streaming of processes and increase engagement of with Bank members.
- Development of a proprietary Care Support Worker Development plan, with additional investment to add new staff groups and learning pathways.
- Creation of a personalised service with added value for the Bank members, ensuring all developments are impactful.

The NHS People Promise

We are 1.3 million strong.
We are all walks of life, all kinds of experiences.
We are the NHS.

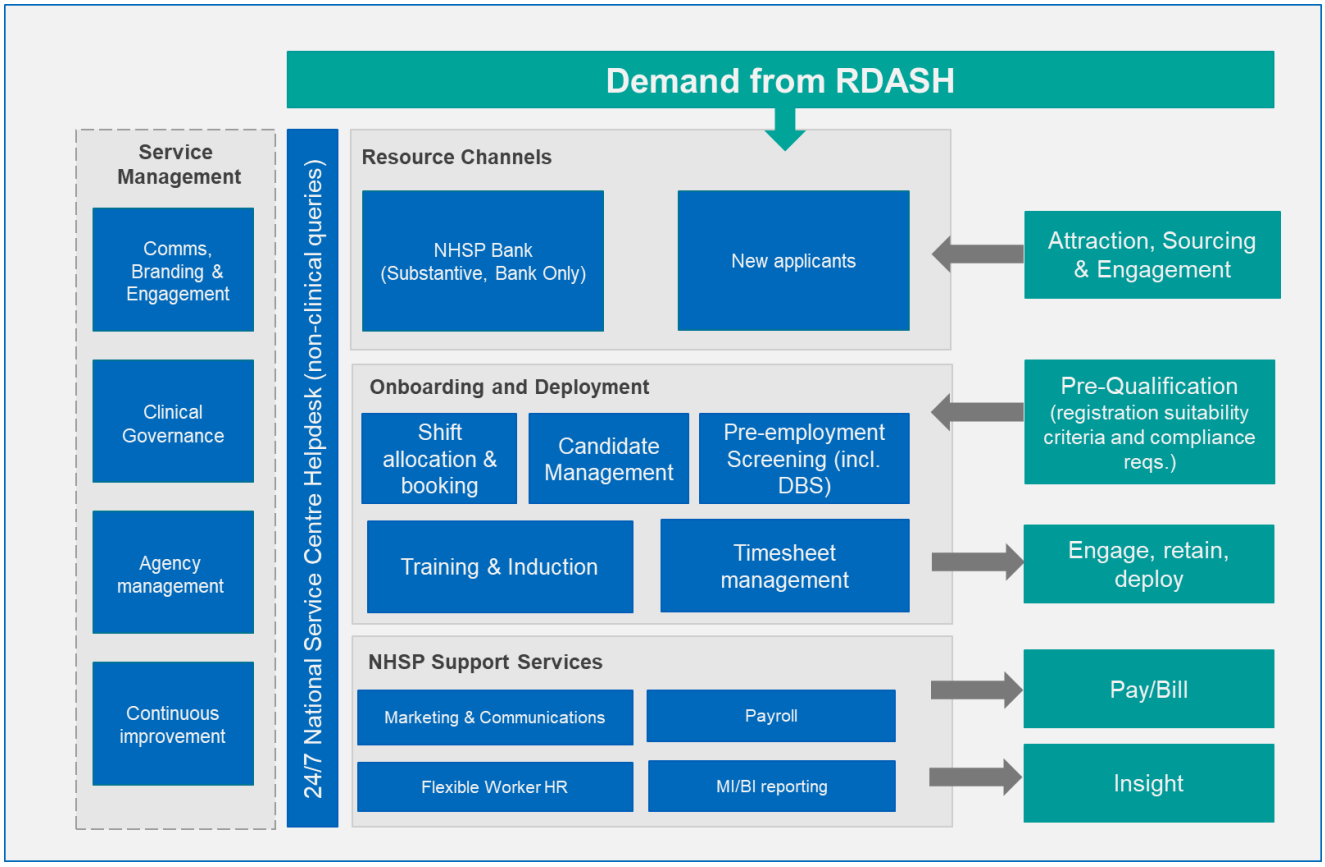
The NHS is an extraordinary, world-class service. Together we have achieved, and continue to achieve, the extraordinary. We should all feel proud of this.

We want our culture to be positive, compassionate, and inclusive – and we all have our part to play.

- We are a team
- We work flexibly
- We are always learning
- We are safe and healthy
- We each have a voice that counts
- We are recognised and rewarded
- We are compassionate and inclusive

3. Scope

Solution Overview



The scope of the Managed Bank solution will be as follows:

Management of Bank provision across all staff groups

The solution will transition the current in-house bank to the enhanced NHSP provision supported by an onsite client relations team. This will include all elements of flexible worker engagement, screening and compliance, training and booking management etc.

Increased recruitment to the Bank

A core focus of this solution will be the building and enhancing the bank to better meet our required shift fill, thereby reducing our reliance on agencies. The onsite team will co-ordinate campaigns which will focus on challenging skillsets and roles with the support of the NHSP specialist marketing and recruitment teams.

Reduction in agency spend

The Managed Bank solution will reduce agency spend in several different ways:

- By increasing the engagement with and capacity of the RDASH bank, roles will more easily be filled via bank workers.
- The agency cascade process will be improved and more rigorously monitored by the onsite team to identify areas of high usage. These areas will then be supported with targeted management and recruitment strategies to ensure that the bank can fulfil shifts that are typically always filled by agencies.

- Where possible the client relations team will work to transition key agency workers to work through the bank for the benefit of the Trust.

Support of Direct Engagement for relevant staff groups

NHSP acknowledge our wish to engage directly with some staff groups – specifically doctors. Therefore, NHSP will perform the search and selection of appropriate candidates and manage all compliance checks. NHSP will then pass us all the appropriate data and RDASH will engage the worker directly on a fixed term contract for services.

The NHSP solution also offers additional support for our directly engaged doctors as they can support with appraisals and revalidations via their Medical Director and Responsible Officer - Dr Helen McGill. This isn't currently included in the scope of the project.

Clinical Governance

All elements of the NHSP solution are underpinned by their highly developed clinical governance structure. They have robust internal processes for screening and engagement which meet all NHS Employer Check requirements and uniquely they have their own internal team of registered nursing professionals who would manage any escalations or complaints in relation to Bank members.

Solution and process design will be overseen and approved by NHSP's clinical governance team to ensure that they effectively meet all regulations and legislation and adequately reflect best practice.

Process and Systems Integration

Technology is a fundamental part of NHSP solutions and they have close relationships with all key suppliers including a relationship spanning 20 years with Allocate. All process and systems integration would be managed hand in hand with the NHSP IT Function and their experienced Implementation Team.

Innovations and solution evolution

A key deliverable within this solution will be the continuous improvement workstream. A benefit to RDASH will be the potential to build service evolution and improvement into the reporting and service delivery plan from day one. This could include development across any element of the solution in line with our need and any potential future regional solution integrations.

4. Projected Outcomes

Savings

This solution will deliver savings via:

- Building a broader and more efficient staff bank
- A reduction in agency usage
- Structural savings e.g. reduction in employment “on costs” for example National Insurance and Pension Contributions for substantive workers working through the bank, non-pay elements of employing the bank like uniforms, DBS, and occupational health etc.
- Partnership savings achieved via a range of strategies and initiatives for example demand reduction realised through focussed business intelligence and associated strategies that can identify and improve booking behaviours

An effective and sustainable staffing strategy

Partnering with NHSP will allow us to benefit from their expertise in building a sustainable and improvement focussed approach to the engagement of flexible workers. They offer a significantly enhanced service to bank staff that will incentivise and motivate them to work through the bank thereby improving bank fill and reducing agency spend.

Integration to the required outcomes of the NHS People Plan

Ensuring that we engage with our flexible workforce in line with the NHS People Plan is of paramount importance. This, combined with the increased focus on the welfare and treatment of flexible workers following the recent outcomes of high-profile lawsuits means that we need to ensure that we have the best possible engagement platform. NHSP have dedicated flexible worker engagement programmes that deliver training and development, staff discounts, communication tools and support forums which will offer a more holistic employment experience for our bank, in turn, helping us more effectively meet our own commitments per the NHS People Plan.

5. Potential Risks

Risks of taking no action

Obviously, a transition of this kind is not to be entered into without proper assessment of risks/benefits but the risks of taking no action at all must be considered:

- Increasing costs of temporary staffing via agencies.
- Potential for failure to meet NHS Improvement targets.
- Potential for increased compliance/clinical governance incidents.
- Potential for increased migration of substantive staff to more flexible ways of working, including agencies and other employers.

Potential risks of making this change

- Perceived loss of control – using a third party to interface with agencies and flexible workers could distance us from our relationships with these key populations.
- Potential additional costs – if we do not establish a clear solution specification.

Whilst there are risks of outsourcing – NHSP as a potential partner are proven and experienced and are themselves part of the NHS so share the same goals and ethos as RDASH. Additionally, provided we select the right stakeholder(s) for the implementation and ongoing management of the solution we will be able to manage all aspects of delivery closely enough to mitigate against these risks and build a productive partnership for both parties.

Implementation Risks

The key risks in this case are all those typically associated with the rollout of a new solution. Any service or system implementation involving many people will necessarily appear complex and of higher risk than standard day-to-day operations. The implementation will require full RDASH sponsorship, particularly given the potential for workforce TUPE which will need to be handled in a sensitive manner and in accordance with employment legislation.

RDASH Mitigations

For the purposes of the implementation the Trust will need to assign appropriate resources to ensure a smooth roll out. To facilitate this NHSP recommends the formation of a Project Board to steer the project effectively and ensure the best possible start for the partnership. More detail in respect to the make-up of the Project Board is provided later within this document.

Once the solution is in place the Trust will need to allocate a Trust Lead who will be the single point of contact for the NHSP Lead who can provide operational feedback and strategic direction to guide the solution. This is not a full-time role but one suited to a senior stakeholder with a strategic role or insight into staffing or recruitment. This Lead will need to be identified if the implementation progresses.

NHSP Mitigation

NHSP are experienced in delivering projects of this kind and their approach reduces risks through the following:

Application of an implementation methodology proven to successfully deliver go-lives on schedule, a methodology which has undergone refinement incorporating lessons learned from numerous implementation projects in the past few years.

Projects mainly fail or take longer due to insufficient detailed planning. Each key element of the plan is reviewed to ensure that appropriate resources are available, and timescales are achievable, considering the risks and hence the contingency that should be incorporated.

Care is also taken to understand if there are any other initiatives within the Trust that could impact the project but which are outside the control of the project itself, e.g., revision of a clinical system, re-organisation of how a particular service is being delivered, or transfer of services from one provider to another.

In accordance with PRINCE2, risks and issues logs are maintained, reviewed and updated on a weekly basis by the project team. One result of having undertaken many such implementations is that most significant risks are common to all implementations contingency effectively incorporated into the plan. Risks specific to a given Trust and severity of “standard risks” are assessed per local conditions. All risks have action plans to mitigate (i.e., reduce the likelihood) and contingency (i.e., what to do if the risk materialises).

In unlikely event that something occurs within or outside of the project which could cause slippage, then an extraordinary meeting of the Project Board would be convened.

The NHSP project management approach has proved successful in monitoring and controlling progress. This is based upon:

- Weekly project team meetings reviewing progress against plan, identifying and resolving issues, managing risks, and resulting in documented actions.
- Checkpoint reviews towards the end of each phase of the project. For each checkpoint there is a list of tasks/deliverables associated with each work-stream that need to be on schedule to assure that the target go-live can be met.
- Project board meetings arranged to take place just ahead of critical points in the plan. Provision is also made for extraordinary meetings of the project board, e.g., by conference call, in the unlikely event that a major deviation from plan has become evident.
- Weekly highlight progress reports distributed to project team and project board members noting progress this week, expected next week, and any high priority risks or issues. The highlight report also contains dashboard-like data monitoring the progress of data load and training.

6. Dependencies and Assumptions

The key dependency from the Trust's perspective will be the identification of the project manager and the allocation of the Trust's workstream leads. Other key activities include:

- *Framework selection for best possible engagement for the Trust.*
- *Contract approval and signature.*
- *Allocation of appropriate Trust resource.*
- *Availability for kick off meeting and identification of all of the right stakeholders.*
- *Agreement of communication plan to so that all audiences understand the objectives of the programme and that it is sponsored by the Trust at the highest level.*
- *Commitment and allocation of time to the project.*
- *Joint ownership of the risk register.*
- *Provision of access to all relevant systems and processes.*

7. Programme Plans

7.1. Programme Plan – Delivery Stage

This is an organisational change requiring effective engagement with all Trust management and staff. NHSP will provide a dedicated project team who will work with the Trust project team using their expertise gained from over 100 such projects.

NHSP have assured us that they will fully support the change process at each stage, with a partnership approach needed to ensure minimal disruption.

Engagement will be key through all levels of the Trust. Managers will need to be given information around the change, and to cascade to their teams in conjunction with Trust-wide communications, supported by workshops to answer questions, which will be run by our staff in partnership with NHSP.

To fully make use of the benefits of the NHSP platform, booking systems interactions will change for some managers and for all temporary workers. System training will be given to Trust users, initially during implementation, and fully supported with continual training by the local Trust Services team following the go live date of the service.

Full consultation will be run in association with the change and the potential TUPE of any staff. Those staff currently working on Bank contracts will be transferred with the same terms and conditions as per TUPE, fully supported by NHSP.

Any corporate staff whose roles are identified as being in scope of TUPE due to the appointment of an outsourced service provider will be subject to a consultation process and role matching exercise. If no matching roles are identified, Trust redeployment may be required. Communication throughout the implementation will be managed by our communication and HR teams, supported by NHSP who will generate a plan agreed with the Trust, mapped from initial messaging to completion of TUPE and go live. A small number of colleagues within the Procurement Team have been identified as being in scope should the implementation progress.

The above plan is indicative and will be tailored our needs, it doesn't feature the detail associated with the delivery of direct engagement, which would fall within the above timeframes.

7.2. Resource Plan – Delivery Stage

At the point of the project go-ahead, a project management structure consisting of both RDASH and NHSP representatives will be established to ensure the timely and effective implementation of the contract. The primary focus of the team is to ensure an efficient implementation process that facilitates the launch of the service in alignment with agreed timescales whilst minimising all risk and disruption to RDASH BAU staffing activities.

Key RDASH Implementation Roles (6 month timeframe total) Based on NHS P Recommendations

Roles	Responsibilities	Time Allocation
Executive Sponsor	The Executive Sponsor will provide senior leadership and input to the Project Board and will keep the project aligned with the organisational goals and strategy.	½ day per month
Project Manager – Band 7	The Project Manager will be required for the duration of the implementation; they will be the designated Trust representative acting as a primary contact for NHSP during the implementation of the partnership. The Project Manager will have the responsibility for the detailed planning and execution of a project.	2 ½ days per week
Medical staffing lead – Band 5	A member of the existing medical staffing team to provide details of the existing processes and procedures. (To facilitate transition to Direct Engagement).	1 day a month.
Finance/Payroll Lead – Band 8a	The Finance/Payroll Lead will provide detail to the NHSP Implementation Team around the existing/desired finance process and all required interactions and data feeds.	1 day a month
HR Lead – Band 7	The HR Lead will work with the NHSP Implementation Team to manage the TUPE process and deliver all the required data and information to manage a compliant and effective consultation and transfer.	2 ½ days per week
Marketing/Comms Lead – Band 5	The Marketing/Comms Lead will work with the NHSP Implementation Team to create RDASH comms and approve NHSP comms to ensure effective on brand messaging.	1 day a month
Roster Administrator – Band 5	The Roster Administrator will provide the NHSP Implementation team with all of the information necessary to set up the rostering interfacing Bank staff.	1 day a month
Clinical Lead – Band 7	The Clinical Lead will work the NHSP Clinical Governance Team to establish and approve the solution requirements for screening and compliance.	½ day a month

L&D Lead – Band 5	The L&D Lead will work the NHSP Clinical Governance Team to define the training and validation requirements for the solution.	½ day a month

The above roles are likely to involve backfill for current colleagues or additional fixed term roles to support the implementation.

7.3. High Level Programme and Resource Plan – Whole Programme

On implementation we will need to appoint a Trust Lead who will be the main point of contact for the NHSP BAU Lead. They will provide operational feedback and strategic direction to guide the solution. This is not a full-time position but a supplemental role suited to a senior stakeholder with insight into staffing/recruitment.

8. Considerations

8.1. Workforce

The three major workforce populations that need considering are the current in-house Bank Team, the Trust managers who commonly use bank or agency staff, and the flexible worker population who will be transitioning to the new solution.

Current bank team

The current bank team will be in scope for TUPE to the NHSP solution. This is obviously an incredibly sensitive process and requires careful and compliant management.

Trust Managers

The implementation of this solution will require them to change their behaviours and learn how to operate using new processes and procedures. Clear communications will be required in the first instance explaining the reasons for the change and the objectives we hope to achieve via the NHSP solution. Following this they all of the support and training they will have available will need to be clearly signposted.

The onside client relations team will be key to this whole process and they will be tasked early on during the rollout with meeting as many of the key users as possible and building a partnership with them.

Existing flexible worker population

Existing Bank Members will need to be transferred over to the new NHSP solution. The TUPE process is one that needs careful and proper management in line with legislation.

NHSP has extensive experience in transferring staff, both employees and flexible workers.

In the 2019 to 2020 calendar year, prior to the COVID-19 pandemic, NHSP TUPE transferred in approximately 6,000 workers across 12 implementation projects.

The Trusts' aim will be to ensure a seamless transfer of the service to NHSP which ensures staff terms and conditions are protected and continuity of service is guaranteed, which in return guarantees continuity of client safety. NHSP has assured us that they would manage TUPE transfers very proactively in the context of it being both an employee relations issue, in that we want to ensure that staffs terms and conditions are protected, and in that the statutory process also provides a legal framework which enables a smooth business transfer in and out.

The transfer process would be overseen by the dedicated Implementation Team and supported by stakeholder from each of the key workstreams (finance, payroll, IT, legal, marketing and PR, HR, existing bank team, clinical governance, learning and development). Each project is sponsored by a NHSP Director.

The Team will lead the end-to-end HR TUPE process, ensuring that all TUPE issues are handled professionally, within regulations and with commercial astuteness. The team will provide expert advice to the Trust on any areas of risk during a project and are able to make commercial recommendations for mitigation where required.

Ongoing engagement with the workforce and recruitment stakeholders

Engagement with service users and the flexible worker population will be a key deliverable of this solution and will be measured and monitored along with all of the other key KPIs. At a minimum we would expect NHSP to:

- Create and deploy a flexible worker communication plan.
- Create and deploy a service user communication plan.
- Enhance the RDASH flexible worker employer proposition.
- Engage productively with agencies to ensure best possible delivery and supplier management.
- Engage proactively with agency workers to encourage migration to the bank

8.2. Training

There are several clearly defined areas where training needs to be considered as part of this process.

RDASH Manager Training

As part of the implementation, all managers who interface with the recruitment solution will be provided with NHSP training sessions and content to support their transition onto new systems and processes. This training will be further supported by access to the client relations team and 24/7 service centre who will be able to support with any issues.

Existing Flexible Worker Training

Similarly, all existing flexible workers will be provided with NHSP training sessions and content to support the move onto new system. They will also have full access to the client relations team and 24/7 service centre who will be able to support with any challenges.

New Flexible Worker Mandatory Training and Compliance

In order to deliver the highest levels of patient safety RDASH need a solution that provides competent and compliant workers with the right skills and training.

The NHSP solution delivers:

- All flexible workers trained upon induction to statutory and mandatory requirements, as relevant to their role. Professional Regulator alerts outlining conditions of practice from NMC, GMC and HCPC are managed in real time to ensure any competence issues are managed effectively.
- Total compliance with automatic validation against the training records of all flexible workers, to ensure that they can only be booked into a shift if they have completed the training required for the role.
- A dedicated Learning and Development function which supports the on-site team and operationally manages the end-to-end training process and are responsive to flexible worker queries, to deliver a seamless experience for flexible workers.
- Management of the full end to end booking process for the practical training sessions including venue booking and sending any pre-course information to attendees.
- In-person training is also an option via the NHSP solution utilising their in-house Learning and Development function.

Skills development for Flexible Workers

As part of the NHSP's engagement programme, they offer flexible workers access to a wide variety of training and development content. This ranges from career development programmes where flexible workers can develop and enhance their existing skills to webinars on specific topics, including an in-depth lecture series for doctors on topics as diverse as Leadership, Resilience and Appraisal and Revalidation.

8.3. Contractual

As per our request and the nature of the services we are looking to procure NHSP has supplied pricing under HealthTrust Europe's Total Workforce Solutions 2 framework agreement.

We are able to procure these services under the associated HTE call-off contracts, based on a standard specification, with agreed pricing and can be made use of with immediate effect, without the need to run a full competitive tendering process, and are fully compliant with the Public Contract Regulations.

9. Projected Investment Requirements

NHSP have worked with the Trust to review a baseline spend for temporary staffing that has been verified by the finance team which showing spend of £12,142,747 for the full year 2019, assumptions have been agreed giving a high degree of confidence in the modelling, this shows a forecasting net of fees cost reduction of £871,180 per year.

NHSP pricing is provided in line with Health Trust Europe's TWS 2 frameworks lots 2a and 2 b as per discussions:

Charge	Unit value
Bank transaction charge	£1.44 per hour
Agency transaction charge non-medical	£0.00 per hour
Agency transaction charge medical	£0.45 per hour
Annual management charge	£40,000 pa
Direct engagement	£2.00 per hour

The cost reduction forecast is shown in the table below, it is formatted to show the cumulative savings over the four years of a partnership with NHSP, where most savings are seen. It separates out the key staff groups of medical and nursing plus showing the total financial picture. Further detailed modelling has been completed and available for review.

	All staff groups net financial position
Release of in-house bank	**117,100**
Change to NHSP employment	**161,760**
Overtime premium removal	**413,485**
VAT	**(336,111)**
NHSP Charges	**(611,667)**
Demand Reduction	**140,783**
Agency Cascade	**65,403**
Agency Migration Year 1	**543,593**
Agency Migration Year 2	**222,124**
Agency Migration Year 3	**77,355**
Agency Migration Year 4	**73,355**
Total	**871,180**

The forecast cost reductions are made of two broad types, structural savings which are fixed variations in costs between the NHSP service and the current Trust costs, and partnership savings which are core service activities delivered by NHSP but requiring the Trusts active engagement to fully realise potential.

Structural savings are realised in several ways:

- **Change to NHSP employment** As NHSP will employ all Bank members (still classed as bank in NHSI reporting) during their assignments, this generates a differential between the rates NHSP charges at 15.25%, and the Trust rate of 20.77%. NHSP's ability to charge this lower harmonised rate comes from:
    - National Insurance: Trust substantive post holders working through NHSP do not attract employer's National Insurance contributions for the first £162.00 of their earnings.
    - NHS Pension Contributions: whilst NHS staff can usually transfer to NHSP and retain their pension contributions, newly recruited bank workers are entitled to join

an NHSP' defined contribution pension scheme. NHSP contributes a matched 6% rather than 14%, saving the Trust an 8% contribution. This will be greater after the planned increase to 20.6% which is currently being centrally funded.

- **Release of in-house bank costs** comes from the release of pay costs for the current in-house bank team.

- **Agency Cascade** comes from a 2% saving against agency spend through increased visibility and control. The automation of the cascade is specific to assignment code and location. Bumping is a system functionality developed to allow one agency worker to bump another out of a shift if from a less expensive supplier, this generates an automated best value supply. NHSP also rationalises the number of agencies applying national buying power on the Trust behalf to deliver the best rates. This was not factored into medical locum staffing as the bookings are done on a very specific basis.

- **Direct engagement** generates cost reduction from the widely applied VAT mitigation mechanism. The mechanism means NHSP or agency locum supply will not attract VAT when utilising direct engagement, as they will be deemed as employed by the Trust during their assignment. The Trust will benefit from an outsourced payroll with SBS delivering full integration with ESR and the NHS pension. This is a valuable tool in migrating locums to the bank as it give visibility of the agency charging structure. Direct engagement ha a limited timeframe as it is expected that HMRC will change their stance on the VAT position in 2022.

Partnership savings are realised through:

- **Demand Reduction** is based on a conservative 1.5% overall reduction in demand based on NHSP observed reductions of between 5 and 20% in new partner Trusts.
  The efficiency savings are generated from locally applied processes, which identify future staffing requirements based on business intelligence and experience:
  - Identify root causes of demand enabling active management.
  - Identify potential 'lines of work' or 'fixed term' opportunities.
  - Booking behaviour improvement.
  - Understanding demand patterns.

- **Agency migration and Bank development** realised over the four years of partnership from agency and overtime migration to bank. Migrating all overtime to bank delivers reduced and consistent costs, but also increases a culture of equality in temporary staffing. This policy ensures transparency through NHSP's Power BI technology recognised by NHSI as market leading. The migration from agency to bank is carried out in a tried and tested manner in partnership with service areas and application of intelligence from direct engagement and other business intelligence sources. The assumed migration levels are conservative and below those observed at other NHSP Trusts.

Associated evidence from NHSP

Due to NHSP's widespread engagement in the region two case studies from neighbouring Trusts are available with peer reference support which demonstrate cost reductions in access for forecast levels:

1. Mid York's – saving £1million in a year with bank fill doubling and agency fill down from 27% to 19%.
2. Barnsley – controlling agency spend in the year following implementation of NHSP with bank hours increasing month on month by 50% and bank recruitment increasing by 70%.

10. Project Communication and Engagement Plan

Project Communications

A comprehensive and detailed communications plan would be agreed with the support of NHSP but at a minimum would include:

- RDASH Communications
    - Programme overview and high-level objectives to workers, Trust and agencies with associated timeline.
    - TUPE consultation communications to flexible workers and any Trust employees affected by the change.
    - Any intranet, newsletter content that can be used to communicate the objectives of the programme and build buy in across the Trust.
    - Introduction to NHSP and high-level overview of service and support available.
    - Trust HR open day sessions, supported by NHSP for workers to drop in and ask questions and access information about the changes.

- NHSP Communications
    - NHSP communications to workers after TUPE is completed to make a detailed introduction and outline next steps.
    - NHSP flexible worker communications around logins and systems access.
    - NHSP agency communications around process and next steps.
    - Senior User Group workshops – to be held jointly with the Trust – for key managers to go through the different stages of the project.
    - NHSP post go-live workshops where required to help support workers and Trust Managers.
    - Ongoing drop-in sessions and clinics to support the BAU provision of the service.

NHSP are able to support across all elements of communications in consultation with our Marketing and Communications teams with templates and any other supporting information necessary.

Ongoing Engagement

A key benefit of this solution will be the increased levels of flexible worker engagement provided through the dedicated NHSP client relations team. They provide and high touch service across all flexible workers for example they will provide flexible workers with an induction to a new teams or areas helping them to integrate quickly and provide the highest possible standards of client care.

NHSP also provide all workers with access to a dedicated NHSP bank worker online hub where they can access information, guidance, training, book shifts, timesheets, and payslips. Flexible workers also have access to 24/7 support, training videos, clinical resources and receive regular newsletters and communications to keep them appraised of wellbeing initiatives, any changes to payroll deadlines, etc.

11. Key Performance Indicators

Dependant on the framework agreement we elect to use there will be standard KPIs that we will be able to utilise to support the management of this solution but key measures would include:

- Compliance to framework pricing
- Fill rates
- Consistency of fill rates
- Accuracy of invoicing
- Success of compliance audits
- IR35 Compliance
- Timely provision of Management Information
- Number of Workers failing to report for a booked shift (DNAs)
- Number of name changes for booked shifts (Ghost Bookings)

Given the criticality of this solution in the effective operation of RDASH we would expect to manage this solution very closely with a reporting schedule resembling the following at the very minimum:

- Weekly Account Management Meetings: to communicate current progress on shift fulfilment and information around forthcoming recruitment requirements.
- Monthly or Quarterly Face to Face Review Meetings: for a detailed analysis of performance against SLAs, provide feedback from flexible workers and line managers and to assess recruitment trends and the strategic direction and continuous improvement of the solution.

Over and above formalised meetings and reporting we would ask that the NHSP Lead will remain in regular contact with the relevant RDASH stakeholders to ensure any potential issues or challenges are managed in a quick and responsive manner.

The key expectation of NHSP as a partner will be to provide management information and reporting that can inform continuous improvement through insight and analysis. The solution will be expected to establish improvement initiatives with clear milestones in line with the RDASH workforce strategy and the NHS People Plan.

13. Impact Assessments

11.1. Quality and Safety Impact Assessment

Will require completing if the recommendation is supported

11.2. Equality Impact Assessment

Will require completing if the recommendation is supported

11.3. Data Protection Impact Assessment

Will require completing if the recommendation is supported.

12. Conclusion and Recommendation

In summary the recommendation is to transfer all of the Trust banks, both those which are centrally managed and those managed locally within operational services to NHSP to deliver the financial savings identified in section 9 and the wider benefits as highlighted in this document.

There is recognition of additional short term funding which will be required to support the implementation and transfer but the projected financial savings as highlighted in Section 9 should be viewed a realistic savings as the saving projections have been significantly reduced by our internal Finance team, based on our scrutiny of the data and proposals.