NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – IN PUBLIC

Thursday 28 March 2024 at 10.00am
CAST Theatre, Civic Quarter, College Rd, Doncaster DN1 3JH

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Sheila Lloyd, Jo McDonough	Note		
3	Quoracy (One third of the Board; inc. one NED and one ED)	Information		
4	Declarations of Interest • NED Independence	Decision		A
	Staff Story			
5	Staff Story	Information	NMcI	Verb
	Standing items			
6	Minutes of the meeting held in public on the 25 January 2024	Decision	KL	B
7	Matters Arising and Follow up Action List: • Risk Management Framework	Decision		C
8	Chair's Matters	Information		Verb
9	Fit and Proper Person Framework Declaration	Assurance		D
	Board Assurance Committees			
10	Report from the Audit Committee	Assurance	KG	E
11	Report from the Mental Health Act Committee	Assurance	SFT	F
12	Report from the Public Health Patient Involvement & Partnerships Committee	Assurance	DV	G
13	Report from the People & Organisational Development Committee	Assurance	DV	H
14	Report from the Finance, Digital & Estates Committee	Assurance	PV	I
15	Report from the Quality Committee	Assurance	DL	J
16	Report from the Commissioning Committee	Assurance	DL	K
17	Chief Executive's Report	Information	TL	L
	Break at 11.30am			

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18	NHS Professionals	Decision	NMcI	M
19	Draft Finance, Savings and Capital Plan 24/25	Decision	IC	N
20	CQC Preparedness Briefing – Effective Domain	Assurance	JG	O
21	Suicide Prevention Update	Information	GT	P
22	Clinical and Operational Strategy: • Strategic Objective One *'Nurture partnerships with patients and citizens to support good health'*	Information	TL	Q
Break – approximately 1.15pm				
Operating Performance / Risk Management				
23	Board Assurance Framework	Decision	PG	R
24	Integrated Quality Performance Report (IQPR) inc Finance Report M11	Assurance	TL / IC	S Si
25	Operational Risk Report	Assurance	PG	T
26	South Yorkshire Mental health, Learning Disabilities and Autism Provider Collaborative – Joint Working Agreement and Terms of Reference	Information	PG	U
Supporting Papers (previously presented at Committee)				
27	Safe Staffing Annual Declaration and Six-Monthly Assurance (Inpatient Areas)		KL	V
	Mortality Quarterly Report (Nov. and Dec. 2023 Data)			
	Eliminating Mixed Sex Accommodation Annual Declaration			
	Guardian of Safe Working Hours Quarterly Report (1 Oct 2023 to 31 Jan 2024)			
Closing items				
28	Any Other Urgent Business (to be notified in advance to the Chair)		KL	Verbal
29	Chair's Summary (Actions, Decisions, and new risks)			
30	Public Questions *			
31	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 remainder of the meeting, which will conclude in private.'*		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 30 May 2024 10.00-13.30
Unity Centre, St Leonard's Rd, Eastwood, Rotherham S65 1PD

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**	28 March 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 Banks and Kathryn Lavery.
- Additionally, ahead of the production of the Annual Report and Accounts 2023/24 and in line with the requirements of the NHS Code of Governance, the Board is asked to consider for each individual acting as a Non-Executive Director, that they meet the requirements of being independent.

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

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.
x	**AGREE** that all Non-Executive Directors are considered to be independent in line with the requirements of the NHS Code of Governance.

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)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

PART A: 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**~~ • **Wife works in administration at Sheffield Children's NHS Foundation Trust.**
Richard Chillery, Chief Operating Officer	• 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 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*	• 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.

PART B – Non-Executive Director Independence

Within the Code of Governance, provision B.1.1 requires the Board of Directors to identify each NED it considers to be independent.

As set out in this paper (Part A) the Board of Directors maintains its Register of Declared Interests and presents this each month in its meetings. In considering the 'independence' of each NED, the Board should consider the register of interests and the guidance below.

The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement.

The board of directors should state its reasons if it determines that a director is independent notwithstanding the existence of relationships or circumstances which may appear relevant to its determination, including if the Director:

- has been an employee of the NHS foundation trust within the last five years;
- has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;
- has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance related pay scheme, or is a member of the NHS foundation trust's pension scheme;
- has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or
- is an appointed representative of the NHS foundation trust's university medical or dental school.

<u>RDASH Position 2023/24</u>

With reference to the declarations made by the Non-Executive Directors and presented in Board of Director meetings each month – see Part A).

The Annual Report will state that all Non-Executive Directors are considered to be independent. This statement is made conscious of and with due regard for the following:

- the declarations made by each NED with respect to their other interests; and
- after considering the guidance stated above (whilst acknowledging that Dawn Leese and Justin Shannahan have served on the Board for 7 years and 4 months, in excess of the 6 years stated in the guidance, but within the maximum period of 8 years previously agreed by the Council of Governors*)

The Board of Directors is asked to agree the inclusion of the statement that "all Non-Executive Directors are considered to be independent." Within the Annual Report and Accounts 2023/24.

* Justin Shannahan leaves the Trust on 31 March 2024; Dawn Leese's final term will conclude on 30 November 2024.

Item 5: Staff Story

Rotherham Doncaster and South Humber NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING – HELD IN PUBLIC ON THURSDAY 25 JANUARY 2024 AT 10.00AM– 1.30PM BATHS HALL, DONCASTER RD, SCUNTHORPE DN15 7RG

PRESENT

Kathryn Lavery	Chair
Richard Chillery	Chief Operating Officer
Ian Currell	Executive Finance Director
Sarah Fulton Tindall	Non-Executive Director
Kathryn Gillatt	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
Dr Graeme Tosh	Medical Director
Dave Vallance	Non-Executive 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

5 members of staff and 3 Governors joined to observe.

Ref		Action
Bpu 24/01/01 & Bpu 24/01/02	**Welcome and Apologies** Mrs Lavery welcomed the attendees to the meeting. Apologies for absence were received and noted from Mr Shannahan and Dr Jankowski	
Bpu 24/01/03	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 24/01/04	**Declarations of Interest** Mrs Lavery presented the Declarations of Interest report which outlined the changes to the register since the last meeting relating to Mr Chillery, Dr Jankowski and Ms Fulton-Tindall. **The Board received and noted the changes to the Declarations of Interest Report.**	

PATIENT / STAFF STORY		
Bpu 24/01/05	**Staff Story – Integrated Neighbourhood Teams** Mrs Lavery welcomed Ms Treen, Ms Jubber and Mr Bennett to present the staff story on Integrated Neighbourhood Teams (INT). The presentation provided an overview of their contribution to joined up working and the community offer as part of South Scunthorpe INT. The presenters highlighted their role and remit within the INT covering the wider strategic framework at ground level, the experience of working at the community service level and what this could look like in terms of transformation. The current status of community mental health transformation and integrated working / collaboration was outlined in both primary care at Place and across the wider system. The next steps for integrated working directly aligned with the promises was to progress a pilot on population serious mental illness (SMI) diagnosis, to break down historical barriers in engaging with services. Professionals from across the social care system regularly meet to provide support the entering referral pathway and prevent delays to treatment. The Board reflected on the benefits of this hyper local working. Mr Lewis highlighted the need to focus on practical care changes for the 500+ residents with SMI. He expressed a desire to make sure the Trust delivered on this specific change, if necessary at the expense of 'system working' on a broader more policy orientated sense.	
STANDING ITEMS		
Bpu 24/01/06	**Minutes of the previous Board of Directors meeting held on 23 November 2023** The Board approved the minutes of the meeting held on 23 November 2023 as an accurate record subject to minor amendments from Ms Fulton Tindall (minute ref Bpu 23/11/17): 'Ms Fulton Tindall asked members to also note an endemic issue within some Trusts of older age defining patients, which can impact on expectations for their treatment, and queried whether attitudes to older people also needed identifying to raise awareness and recognition in this regard.'	
Bpu 24/01/07	**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 apart from action Bpu 24/01/2022 regarding NHS Professionals which was to remain an open action.	**NMc**

	Gender Pay Gap The Board revisited the prior paper on the gender pay gap. There was not support to progress affirmative action steps to close the gap. **There was agreement to take all other relevant steps, and to provide three monthly monitoring data to the People and OD committee of the Board.** A significant debate took place over the significance of responsibilities to narrow the gap on employment benefits, which was the largest single driver for our residual GPG. Dr Graham stressed the gendered nature of these benefits and resisted suggestions that it should be set aside.	
Bpu 24/01/08	**Chair's Matters** Mrs Lavery provided a verbal update of activities and engagements since the last meeting. She highlighted the success of the Annual Awards ceremony that took place in November. Mrs Lavery referred to the visits to services in December undertaken with Mr Lewis to express Christmas wishes and deliver small tokens of appreciation, and to her visit to St John's Hospice. The peer review on Magnolia Ward had gone well and Board members were encouraged to take part in these. A meeting was held with the lead Governor Jo Cox with work ongoing with Mr Gowland on constituency changes and meeting arrangements, pending the upcoming Council of Governors. As the non-executive lead for Equality and Diversity she had participated in the South Yorkshire Equality, Diversity and Inclusion (EDI) Group and Mrs Lavery also noted her attendance at the Trust's anti-racism alliance group. She noted that there remained a significant amount of work to be done to achieve the promise of becoming an anti-racist organisation, but she and many others were determined that this promise would be met. On behalf of the Board, Mrs Lavery expressed her thanks for Mrs Lloyd's contributions at the Trust and in the wider NHS, on the occasion of her imminent retirement.	
BOARD ASSURANCE COMMITTEES		
Bpu 24/01/09	**Report from the Audit Committee** Mrs Leese presented the report in Mr Shannahan's absence. She highlighted: • the number of deferments to the Internal Audit plan; • the limited assurance opinion in the procurement audit; • the Board Assurance Framework (BAF) refresh expected by March 2024 (separate agenda item today) and • the resultant potential of a limited or moderate assurance in the Head of Internal Audit Opinion (HOIAO).	

	Mr Lewis responded to the concerns over deferment, which he had separately discussed with Mr Shannahan and the Trust chair. These related to specific patient experience/safety audits where Q1 activity would provide a more useful prompt to action, given bandwidth issues in the department. He highlighted that nothing in the procurement audit was an immediate or pressing priority, notably when compared to other work that function needed to undertake in respect of our promises. Mrs Gillat noted this item would come to the next Audit Committee. He asked that the report from the committee was reworded as it could be taken to imply that the Board had not current BAF, which is not true. This amendment was agreed. **The Board received and noted the report from the Audit Committee.**	
Bpu 24/01/10	**Report from the People and Organisational Development Committee** Mr Vallance presented the report and highlighted a decrease in turnover rate, that Mandatory and Statutory Training (MAST) compliance was at 90%, and there were no extreme risks reported. The Guardian of Safe Working Hours (GoSWH) report had been highlighted in respect of elevated reporting levels from trainees. Dr Tosh confirmed the concerns raised had been addressed through medical staffing and the provision of admin support. Mr Vallance contrasted the Learning and Education Plan seen by the committee, which was fully developed, with the more outline People and Teams Plan. It was acknowledged by executive members that significant focus on the P&T plan was needed by May. **The Board received and noted the report from the People and Organisational Development Committee.**	
Bpu 24/01/11	**Report from Finance, Performance and Informatics Committee** Mrs Vickers presented the report, which was the final one from the committee in its current form. Mrs Vickers advised that the committee had increased confidence in the forecast year end position (the current deficit of £4.3m against a planned deficit of £6.15m.) There was significant progress with the delivery of the savings target with £7.42m achieved at month 9 (£9.4m planned by 31 March 2024). This success was acknowledged, albeit there remained ongoing challenges and having reviewed the programme of work, whilst assured about the process, the Committee had asked for additional information in respect of three key areas.	

	She highlighted that there remains a failure to deliver the planned reduction in agency staffing. This is a significant opportunity for the year ahead but lessons need to be learned from the failure to deliver in 23/24. Mrs Vickers highlighted a minor amendment required on the paper with reference to the expenditure controls issued by the ICB. The Trust would *respond to* not *comply with*, as currently stated, as two deviations from the proposal had been agreed by the CLE and noted in FPIC. **The Board received and noted the report from the Finance Performance and Informatics Committee.**	
Bpu 24/01/12	**Report from the Public Health Patient Involvement & Partnerships Committee** Mr Vallance presented the report from the first Public Health Patient Involvement and Partnerships (PHPIP) Committee in Mr Shannahan's absence and gave focus to two areas. • The Doncaster Fairness and Wellbeing Commission report had been discussed, enabled by the acting director of public health. The committee had discussed how to align our work the recommendations of the commission, and Mr Lewis had agreed to outline in May how this would be done. • Work on Promise 6 "Poverty proofing" had been procured to identify and address barriers for those in poverty accessing our services. Committee members reminded the Board that the Research and Innovation Plan was a key part of the work of the PHPIP Committee. **The Board received and noted the report from the Public Health Patient Involvement & Partnerships Committee.**	
Bpu 24/01/13	**Report from Quality Committee** Mrs Leese presented the report from the Quality Committee and gave focus to three areas. Compliance with Resuscitation standards were still not in place. This longstanding issue was a concern in itself, and a symptom of wider non-compliance. Mr Lewis acknowledged the persistent failure of the management to grip this issue and resolve it. He would offer an oral update at the next Board meeting. The Malnutrition Universal Screening Tool (MUST) assessment data indicated non-compliance. A deep dive review was ongoing, and an initial snapshot audit had identified improvement opportunities. Dr Graham was leading work with the Care Groups to address data and delivery issues. Racist incidents had increased. There had been discussion at the Board previously around compliance and organisational tolerance levels. Mr	**TL**

	Lewis drew attention to his recent vlog, and noted work he would take forward to identify with local police forces what steps they would in practice take when hate crime reports were made from mental health inpatient wards. Ms Fulton Tindall asked about serious incident reporting and the learning that arises. Mrs Lloyd suggested that although the immediate work to improve had already taken place, further changes were planned which also included the pre-empting and addressing of any potential questions from the coroner and family. **The Board received and noted the report from the Quality Committee**	**TL**
Bpu 24/01/14	**Chief Executive's Report** Mr Lewis drew attention to four items within his report, which included his usual annex on governors' priorities as well as a strike impact analysis. • He was concerned that, notwithstanding work on eating disorders in community and specialist settings, the existing liaison arrangements with district general hospitals, fell short of safe standards. He had agreed with the Board of the collaborative that the Trust would take forward discussions with TRH/DBTH. He had also highlighted his concerns to the Chief Nurse and Medical Director of the South Yorkshire ICB. • As noted by FPIC, agency spend reduction had fallen short of intention. Upcoming internal guidance would change the Trust's authorisation model for 2024/25, to sharply reduce non-medical agency staffing and eliminate use of long-term agency employees. He acknowledged this would lead to some unhappiness at the disruption of established working relationships. • 2024/25 ICB financial planning discussions were ongoing with Chairs and CEOs. The national position was extremely challenging; however, the Board's leadership role was not to expose frontline teams or leaders to unwarranted pressure, but to manage demands and expectations choicefully. • During Q3 the Trust had continued to invest in local communities, for example with S62, and had also provided continued support to PFG to establish a community of practice among local VCSE/peer led groups across RDASH. He invited Mrs Lloyd to provide a summary of the 2-day Health Services Safety Investigations Body (HSSIB). She drew attention to positive feedback on the Trust's patient flow methodology and the openness of staff on risk and safety. Staff quotes would be included in the final report. HSSIB had requested an opportunity to revisit the Trust at a future date.	

	The Board received and noted the Chief Executive's report and the forward actions it contained.	
Bpu 24/01/15	**Emergency Preparedness, Resilience and Response (EPRR) update report.** Mr Chillery presented the EPRR update report and highlighted the key issues arising. In line with a prior report from September 2023, there were increased requirements and a resultant reduction in compliance against the Core standards: a 'hard reset' had been applied nationally and benchmarking results showed the Trust's compliance of 21% (as against 17% on average for Trusts in South Yorkshire). He was satisfied that a clear plan of improvement action was in place and drew attention to the priorities outlined in the report. Members discussed the immediate risk, as well as the organisational effort required. There was a consensus that business continuity planning and evacuation arrangements were a priority. Mr Lewis sought, and received, confirmation that the focus would be on actual changes to improve risk management as distinct from policy updating to improve the rating. Mr Chillery noted that an ICB check and challenge collaboration meeting has been scheduled for 1 March 2024. Mrs Lavery summarised the discussion and asked for a report in July, rather than the proposed September. **The Board received the EPRR update report and agreed as amended the recommendations contained in the report.**	
Bpu 24/01/16	**Operational Risk Report (operational & strategic) as at January 2024 including Risk Management Framework** Mr Gowland presented the Operational Risk Report (operational & strategic) as at January 2024 and highlighted there were no extreme operational risks. The BAF was still in place and included within today's report, however a refresh was underway. Mr Gowland presented the revised Risk Management Framework which outlined the process for the management of risk in the organisation. He drew attention to the significant change in approach and commented on the upswing in risk focus visible across the Trust. Mr Vallance referred to the section in the framework around the chief executive's responsibility for communicating and embedded the necessary values and behaviours to support the appropriate risk culture. Mr Gowland noted the training regime intended from June with key leaders. Mrs Leese challenged the framework's lack of clear measures of effectiveness and suggested that the document needed material amendment. Mr Gowland was asked to review the monitoring	**PG**

	arrangements and ensure that they were comprehensive and clearly articulated how the Trust and its Board would be sure that the framework was being followed and was effective. Mr Lewis queried whether high impact/low likelihood risks were specifically referred to in the framework and it was agreed that this would be checked. He asked that during 24/25 a specific analysis of this framing was brought to the Board. **Post meeting note** – reference to these risks was included as an area to be reviewed by the Risk Management Group. **The Board received and noted the Operational Risk Report (operational and strategic).** **The Board approved the Risk Management Framework subject to receiving and agreeing a revised monitoring section at the March 2024 Board.**	
Bpu 24/01/17	**CQC Preparedness Briefing – Caring** Mrs Lloyd presented the CQC Preparedness briefing on Caring. She highlighted the Trust's ambition to be 'outstanding' on Caring. This had been agreed with the Board and members recognised the stretch required. The current informal assessment might suggest that the Trust was at 'Good' based on previous audits, peer reviews, 15-step work, and feedback from CQC and Mental Health Act (MHA) investigators. The recommendations in the report provided some potential further improvements that could be taken forward. Members held a discussion on how the organisation could demonstrate caring and collective accountability against a background of tired staff, racist incidents and the level of current vacancies. It was recognised that the challenge was to support exceptional behaviours as outstanding caring actions, whilst needing to try to systematise good practice. Mrs Lavery questioned how the Board would know how we were going and wondered whether KPIs might help. A detailed discussion took place, which included considering the current data available highlighted in the report. Mr Lewis disagreed that for this ambition a dataset was the key step, recognising that the interventions were cultural. He agreed to discuss further how the desire for visibility of progress could best be achieved, drawing attention to timeout visit times planned six times a year over the coming months. **The Board agreed the recommendations in the CQC Preparedness Briefing – Caring**	**KL/TL**
Bpu 24/01/18	**Operating Model and new ways of working including Board Committee Terms of Reference & Standing Financial Instructions**	

	The Chair informed members the report on the Operating Model and new ways of working would be discussed in the private Board session in the interests of time and other agenda items.	
	OPERATING PERFORMANCE	
Bpu 24/01/19	**Integrated Quality Performance Report (IQPR) December 2023 including Finance Report M9** Mr Lewis noted that the current format would continue, recognising that Mr Banks would review the data items included at the start of the coming year. He felt that operationally the use of the IQPR was maturing with informed discussions taking place regularly at the Clinical Leadership Executive (CLE) and the Delivery Reviews. He introduced Mr Chillery to discuss the key data items. He highlighted progress with the virtual ward; he confirmed the perinatal CYP target achievement was on track and that there was a significant amount of work underway regarding data validation and quality for CMHT. Mr Lewis requested work to ensure Children & Young People (CYP) and Community Mental Health Teams (CMHT) hit their markers as both were timebound (31 March 2024). He stressed the significance of delivery, which Mr Chillery acknowledged. Mr Currell advised that from May the Finance data would be reported to the Board via the IQPR only, with a revised and detailed report through FDE. This would bring finance into parity with other data items at the Board. This was welcomed by members. The year end forecast position ranged from a deficit of £4.3m to £3.5m and included a £3.5m system support income reduction from South Yorkshire ICB to help reduce the system planning gap. All corporate and care groups were forecast to achieve their budgets. This is a transformation from twelve months previously where central 'top ups' had been used to balance local positions. Mr Currell noted that he had been asked at the prior meeting about liquidity and a review carried out since had confirmed that the reported cash position was accurate. However, it was being compared to a cash plan set regionally which was no longer accurate. He proposed to consider this further within the Finance, Digital and Estates Committee. **The Board receive and noted the Integrated Quality Performance Report (IQPR) December 2023 including Finance Report M9.**	**RC**
Bpu 24/01/20	**Eliminating Out of Area Placements (OAP) target and Health Based Place of Safety (S136 suites) usage review.** Mr Chillery presented the related reports on out of area placement and health-based place of safety (S136). He highlighted reducing numbers of	

	OOAP and the pressure created by s136 suites which were closed on average 25% of the time. The issues and reasons for the medium-term increase in the out of area placements were due to two broad reasons. The lack of specialist provision for learning disability and secure rehab within the region; and the spread of flow through community resource to support people in community and manage risk and system anxiety requiring an extension of the community work. Members discussed the geographical factors impacting service provision and considered other related matters including the potential increase in the use of s140. Dr Tosh noted that that practice was not uniform across South Yorkshire. Mrs Lloyd added that clinical pathways would give a solution to achieve a safe and therapeutic bed base however where special beds were not used appropriately this required the provider collaborative to ensure all providers improved their systems to help the overall position. Flow needed to be clinically led with resulting care pathways, gatekeeping and rules of the collaborative looking at engagement of the system. Mr Chillery informed members of initial actions that are to be completed, with ambitions on more complex issues to be brought back to Board in the future. Mrs Leese welcomed the report, the detail and discussion. She highlighted the refreshing candour of the position. Mr Vallance wondered what specific actions might be taken to improve matters. Mr Chillery noted the work being done in Rotherham to reduce OOAP. He highlighted discussions with place leaders in North Lincolnshire on S136 availability. But he drew attention to our reliance on the behaviour of others. Members agreed to the recommended strategic oversight through Mr Lewis as lead Chief Executive of the collaborative to galvanise the whole system, mindful of promise 19 in which the Trust Board has committed to eliminating OOAP by the end of 2024. **The Board noted the recommendations from the Eliminating Out of Area Placements (OAP) target and Health Based Place of Safety (S136 suites) usage review reports.**	
13.30 Break for Lunch		
Bpu 24/01/21	**Strategic Objective 5** Mrs McDonough introduced a new routine report, this time focusing on the fifth objective. The aim of the paper was to stimulate discussion on the 'hardest parts' of the objective. Within this report she noted the wider infrastructure challenges of the green promise on climate adaptation and the challenges posed by anti-racism. Mrs Gillatt questioned whether action plans for each promise existed and felt that the Board should discuss this further. Mr Lewis noted that this	

	work was part of the operating model agreed by the Board in September, but highlighted, as an example that approval of the strategy was to his mind agreement that the Real Living Wage would be adopted. Work would take place through 2024 to that end and the paper helpfully set out the dilemmas arising from that. **The Board received and noted the report on Strategic Objective 5.**	
Bpu 24/01/22	**NHS Professionals update and proposal** Ms McIntosh presented the proposal to move the Trust's bank to NHS Professional (NHSP). She acknowledged that this discussion, whilst it had been ongoing over two years, may require more than one conversation. She highlighted the potential benefits to a mental health and community Trust, recognising that NHSP was dominant in the acute sector. Mrs Lloyd supported the proposal, highlighting the benefits to safe staffing and reduced agency. She felt that the proposal should now move forward. Mrs Lavery voiced concerns about experiences in other Trusts. She enquired what assurance we had about our own and NHSP's implementation capability. Ms McIntosh reflected on positive reports from peers. Mrs Lavery raised a view that the Trust might provide its own, and queried how surpluses from NHSP were spent. There was an extensive discussion about the merits of the case, the clarity or otherwise of the dissent, and how the Board might move forward. Mr Vallance drew attention to prior assent and suggested that the Chief Executive should indicate a decision. Mr Lewis noted both his queries and support, but disagreed that this was a management decision, highlighted the significance of TUPE transfer of so many colleagues. Ms McIntosh expressed some frustration about the ask, and the further delay implied. Mr Lewis asked whether the transfer was an exclusive arrangement or whether risk could be reduced if NHSP did not deliver in a given domain. It was agreed to explore this further. Mrs Leese voiced concerns about the risk of implementation, and members agreed that this was a key issue: if the proposal proceeded, we need to have the bandwidth to do it well. Mrs Lavery summarised the discussion and agreed to a proposal to revisit the item at the next meeting. Ms McIntosh questioned what was needed next time. On invitation, Mr Lewis suggested that the new paper needed to consider: • A brief appraisal of alternatives to NHSP. • Confirmation of support from MHLDA CEO partners. • Agreed terms of trade with NHSP, jointly accepted by the CEO and Director of Finance • A risk and risk mitigation plan for the first six months of transfer	**NM / TL / IC**

	The Board agreed to consider a further proposal subject to the completion of the criteria noted above	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 24/01/23	Mrs Lavery informed the Board of the following additional reports for information which were presented as supporting papers that had previously been presented at committee level for scrutiny and challenge: • Mortality Quarterly Report (Sept & Oct 2023 Data) • Guardian of Safe Working Hours Report (June to Sep 2023 Data) **The Board received and noted the additional reports for information.**	
CLOSING ITEMS		
Bpu 24/01/24	**Any Other Urgent Business** There was no further urgent business raised today.	
Bpu 24/01/25	**Chair's Summary (Actions, Decisions, and new risks)** Mrs Lavery gave a brief overview of discussions from the meeting in particular the staff story on the work of Integrated Neighbourhood Teams, Gender Pay Gap, risk reporting, CQC report on Caring, and places of safety which linked to the CQC Caring item. She noted that the NHSP item and proposed risk management framework would return to the next meeting for further scrutiny.	
Bpu 24/01/26	**Public Questions** There were no questions raised by members of the public.	
Bpu 24/01/27	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 remainder of the meeting, which would conclude in private.'	
	Next Meeting Thursday 28 March 2024 at 10.00am - CAST Theatre, Civic Quarter, College Rd, Doncaster DN1 3JH.	

Rotherham Doncaster and South Humber NHS Foundation Trust

PAPER C – ACTION LOG – BOARD OF DIRECTORS:

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
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	**March 2024:** It was agreed that the action would be taken forward through the Quality and Safety Plan, but that the action would remain open until that Plan was active.	Open
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	**March 2024:** 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 In response to Mrs Fulton Tindall, Mr Lewis indicated that Quarter 1, 2024/25 would see a structured focus on 'productivity'.	TL	**March 2024:** As previously discussed and agreed, an update on this matter will be provided at the end of Q1 2024/25.	Open
28/09/2023 **CEO Report**	Suicide prevention strategy 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	**March 2024:** Board of Directors meeting - *See Agenda item 22 (Paper Q).*	Propose to Close
23/11/2023 CEO Report	Audit of Practice 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	**March 2024:** The audit has been concluded and is deeply disappointing. Remedial action in Q1 will be overseen by TL and GT, reporting direct to the Board.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
23/11/2023 CEO Report & Bpu 24/01/22	<u>NHS Professionals</u> Mrs Lavery summarised the discussion, and agreed to a proposal to revisit the item at the next meeting. Ms McIntosh questioned what was needed next time. On invitation, Mr Lewis suggested that the new paper needed to consider: • A brief appraisal of alternatives to NHSP. • Confirmation of support from MHLDA CEO partners. • Agreed terms of trade with NHSP, jointly accepted by the CEO and Director of Finance • A risk and risk mitigation plan for the first six months of transfer	NMc / TL / IC	**March 2024:** Board of Directors meeting - *See Agenda item 18 (Paper M).*	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 the EPR final business case. Accordingly, the Trust commenced negotiation with a preferred supplier, and the outcome of that work will return to the Board during Q4.	RB	**March 2024:** Item deferred to May 2024.	Open
Bpu 24/01/09 Report of the Audit Committee	<u>BAF</u> The BAF was currently being refreshed and the report required rewording as it implied the Trust did not have BAF available at present.		**March 2024:** The record of the Audit Committee meeting has been amended and the position clarified with Internal Audit. The Board is today presented with the next iteration of the BAF – See Agenda item 26 (Paper Q).	Propose to Close
Bpu 24/01/13a	<u>Resuscitation Equipment</u> Mr Lewis was keen to revisit this topic at the next Board for further discussion to understand the challenge and issues on resuscitation equipment.	TL	**March 2024:** Oral update to be provided at the meeting.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/01/3b	<u>Racist Incidents</u> Mr Lewis would take steps to agree a definition of what the police deemed was a hate crime/ racist incident to achieve clarity on what the police would respond to in relation to interventions.	TL	**March 2024:** Update to be provided to May 2024 meeting	Open
Bpu 24/01/15	<u>EPRR</u> Mrs Lavery summarised the discussion and asked for a report in July, rather than the proposed September. The Board received the EPRR update report and agreed as amended the recommendations contained in the report.	RC	**March 2024:** Update due July 2024	Open
Bpu 24/01/16	<u>Risk Management Framework</u> The framework was agreed, save for Board sight and approval of an evaluation model for issued policies, consistent with (but not limited to) the intent to deploy a tracking mechanism into the Trust during 24/25.	PG	**March 2024:** See updated Monitoring Section attached.	Open
Bpu 24/01/17 **CQC Preparedness Briefing**	<u>CQC Preparedness - Caring</u> Discuss further how the desire for visibility of progress could best be achieved, drawing attention to timeout visit times planned six times a year over the coming months.	KL/TL	**March 2024:** An update will be provided in May 2024, benefitting from Steve Forsyth's input.	Open

Bpu 24/01/16 **Risk Management Framework**

The framework was agreed, save for Board sight and approval of an evaluation model for issued policies, consistent with (but not limited to) the intent to deploy a tracking mechanism into the Trust during 24/25 – this is referred to below where changes (highlighted) have been made in response to the comments at the previous Board meeting. The changes ensure internal evaluation and reporting on the use of the Framework, with a third party view also formed by the internal auditors.

Appendix 2 – Monitoring and Evaluation 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 strategic 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 strategic 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.
- An annual evaluation of the implementation and impact of the Risk Management Framework, confirming that all aspects of the Framework have been completed. This includes the receipt and acceptance of the Framework (and its requirements) by designated staff, in line with the Trust's Policy tracking mechanism.
- Risk management as undertaken by the Trust's Internal Auditors on a cyclical basis. Risk management and governance are standing items within their plan and their work to deliver the Head of Internal Audit Opinion.

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 (for example the frequency of reviews undertaken by risk owners) – 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.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Fit and Proper Person Test (FPPT)	**Agenda Item**	Paper D
Sponsoring Executive	Kath Lavery, Chair		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	28 March 2024

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

Fit and Proper Person Test (FPPT) guidance issued in August 2023, outlined an expected implementation date from 1 April 2024. This paper provides confirmation of implementation readiness and of the checks undertaken in the period since August that allow for the Chair to confirm that all members of the Board of Directors are 'Fit and Proper' with no exceptions.

Alignment to strategic objectives (indicate with an 'x' which ambitions this paper supports)	
Business as usual	x

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

The Board of Directors last received a report on FPPT in September 2023, when the guidance was issued. There was an expectation that Trust's would be in a position to fully implement the guidance from 1 April 2024.

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

The Board of Directors is asked to:

x	The Board of Directors is asked to **RECEIVE** and **NOTE** the update that confirms the progress and state of readiness for implementing the requirements of the FPPT.
x	The Board of Directors to **RECEIVE** and **NOTE** the statement from the Chair that, following the receipt and review of self-attestation statements, she has deemed all members of the Board to be fit and proper.

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

Trust Risk Register		n/a					
Board Assurance Framework		n/a					
System / Place impact		n/a					
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)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

NHS England Guidance for board members

Background and Guidance

A number of recommendations were made by Sir Tom Kark in his 2019 review of the fit and proper person test (FPPT) and in accepting them, NHS England published revised guidance in August 2023 with the expectation that Trusts fully implemented the guidance by 31 March 2024.

The FPPT is one of a number of related guidance documents issued by NHS England relating to board members.

Fit and proper person test framework for board members

Key requirements

NHS England published updated guidance, *NHS England Fit and Proper Person Test Framework for board members.* The revised framework introduced new and more comprehensive requirements around board appointments, annual reviews, and provision of references, which had widespread implications from a HR, legal and governance perspective. It is considered to be a key element of patient safety and good leadership in organisations – recognised by all board members, and with an intent that poorly performing managers and directors are prevented from moving between health organisations.

The new elements included:

- The introduction of an NHS Leadership Competency Framework (LCF) (published in February 2024)
- Fields within the NHS Electronic Staff Record (ESR) to record relevant information.
- A Board Member reference
- An extended scope to also include Integrated Care Boards (ICB) and some Arms Length Bodies (ALB)
- Re-emphasis of the accountability of chairs in implementing the Framework

Progress with implementation

Since the publication of the related guidance in August 2023, there has been work undertaken by the Chair and others to respond to the requirements. The Trust has progressed implementation to ensure that the following four requirements have been met:

- For all new appointments to the board, their respective Electronic Staff Record (ESR) contains the required information and confirmation of checks to satisfy the requirements of the FPPT. This is specifically relating to Richard Chillery and preparatory work in respect of the next appointment, Steve Forsyth on 1 April 2024, is underway.

- All current members of the Board of Directors have completed and submitted self-attestation statements. There are no issues of concern and all members have been assessed as achieving the requirements of being ‘Fit and Proper’.

- Where board members are leaving the Trust, the required Board References will be completed (this is in respect of the two members due to depart the Trust on 31 March 2024, Sheila Lloyd and Justin Shannahan.

- The annual declaration by the Chair is being prepared in readiness for submission to the NHS England Regional team.

The Board of Directors is asked to RECEIVE and NOTE the update that confirms the progress and state of readiness for implementing the requirements of the FPPT.

The Board of Directors to RECEIVE and NOTE the statement from the Chair that, following the receipt of self-attestation statements, she has deemed all members of the Board to be fit and proper.

Philip Gowland
Director of Corporate Assurance
22 March 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	7 February 2024		
Attendees:	Kathryn Gillatt (Chair), Dawn Leese, Pauline Vickers, Ian Currell, Dr Jude Graham, Phil Gowland.		
Apologies:	No apologies for absence received.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Annual Accounts Preparations 2023/24 –** • The deadline for the submission of the accounts is June 2024 in line with the Trusts Annual General Meeting scheduled for July 2024. • Initial planning work underway in terms of the annual external audit cycle for 2023/24. • Comprehensive update received regarding the action plan ongoing to address the ISA260 report recommendations and other items flagged during the year. • The committee requested to receive the management judgements & estimates in due course. **Clinical Audit –** • Work is underway to develop the Clinical Audit Plan 2024/25 and to include the reporting lines, governance and oversight arrangements – to be presented to the committee in April 2024. • Mapping exercise to be undertaken to identify the audits from other services which contributed to clinical delivery. **Risk Management Update –** • Reduced reporting against current Board Assurance Framework to 'by exception', however the risks continued to be reviewed and remained live - the refreshed strategic risks will be received by the Board of Directors in March 2024. • Positive position in respect of risk review compliance. **Audit Recommendations Progress –** • There were 4 overdue internal audit actions, all of which had revised timescales for completion, it is anticipated that the position would be improved going forward due to the focus on internal audit recommendations as part of the care group and corporate delivery reviews. • The Committee recognised that the overall Head of Internal Audit Opinion will not be as positive as the previous year. **Standing Financial Instructions –** • Downward trend in respect of the value of single quote / tender waivers - this would be a focus area as part of the procurement action plan / savings review.		
Positive highlights of note:	Standards had been exceeded in respect of the Data Security & Protection Toolkit - Clinical Coding Audit.		
Matters presented for information or noting:	• Audit Committee Terms of Reference and Draft Workplan. • Annual Governance Statement in-year update		
Decisions made:	None		
Actions agreed:	None		

Kathryn Gillatt, Non-Executive Director, Chair of the Audit Committee.

Report to the Board of Directors meeting scheduled for 28 March 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	21 February 2024		
Attendees:	Sarah Fulton Tindall (Chair), Justin Shannahan, Dr Janusz Jankowski, Dr Graeme Tosh, Dr Jude Graham.		
Apologies:	Toby Lewis.		
Key points of discussion relevant to the Board:	**CQC MHA Inspections -** One inspection took place during Q3, which was of the Sandpiper Ward. The Committee discussed the need for more evidence of closed loop learning.		
Positive highlights of note:	None		
Matters of concern or key risks to escalate to the Board:	**Trust Associate Hospital Managers** One of the Trust Associate Hospital Managers (TAMs) was in attendance for the Hospital Manager Q3 Report. Serious concerns were raised with regards to the operational infrastructure in place to carry out the role effectively, and thereby achieve compliance with the Mental Health Act. This is being explored further to ensure there was a fit for purpose and sustainable process in place. **Legislation Compliance Performance Report Q3** Concerns were raised regarding Reducing Restrictive Interventions (RRI) staff training compliance. The committee understands that work is ongoing to review all mandatory training and to ensure it was streamlined across the Trust. An increase in Category D MHA incidents was reported. The Committee will receive further understanding around this at the next meeting. **Board of Directors being sighted on all areas of overarching governance** The committee noted the potential benefit of the Board of Directors/Audit Committee being sighted on all areas of overarching governance, such as the MHA, to determine if the committee had appropriately discharged its duties as outlined in the Terms of Reference and/or where responsibilities are spread across one or more committees.		
Matters for information:	None.		
Decisions made:	None.		
Actions agreed:	None.		

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Legislation Committee Report to the Board of Directors meeting scheduled for 28 March 2023.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper G
Date of meeting:	20 March 2024		
Attendees:	Dave Vallance (Chair), Dawn Leese, Toby Lewis, Graeme Tosh, Nicola McIntosh, Jo McDonough, Phil Gowland, Dianne Lee – North Lincs Public Health, Rosie Atack – GGI (Observing)		
Apologies:	Justin Shannahan		
Matters of concern or key risks to escalate to the Board:	• IQPR (and other datasets): We need a step-change in our data and insights to ensure we understand if our services are provided equitably to all in our communities (ie IQPR data sets split out by protected characteristics; wider datasets to be developed to track Equity and Inclusion progress)		
Key points of discussion relevant to the Board:	• Draft Equity & Inclusion (E&I) Plan – a progress update, illustrating we have some Promises where we have key actions the Trust can start, and for others they will need further work. Final Plan expected in May. • Flourish Enterprises – the Committee received its first report of the Shareholder Representative with regards to People, Director Oversight of Operational Performance, Strategy and the future. Regular reporting to be included in the Committee workplan.		
Positive highlights of note:	• "Poverty proofing" – programme of work scheduled. The initial pilot will focus on three services to be "Poverty Proofed" which cover all 3 Places, an adult and a children's service; a mental health and physical health service. Evaluation of the pilot and next steps for roll-out to be presented at the next Committee. • Partnering and Relationship Management – the Committee supported the emerging approach for improving relationship management with partners. It will require a significant change in capability. • North Lincs Public Health – we heard from the Director of Public Health and committed to improve partnership, including support for the delivery of the Trust Promises and us being an active contributor to the Health & Wellbeing Board in North Lincs.		
Matters presented for information or noting:	• Risk Register – Further work to do, as the Committee acknowledged that the risks as presented need to be refined to be focused on the strategic objectives under the Committee's remit, the 2 Plans and the Promises within them.		
Decisions made:	None.		
Actions agreed:	• Strategic Plan Promises have been mapped to all 28 Promises and align against the Trust Committee governance structure (previously presented to BoD in January). Agreed Promise 5 needs to be realigned to the Committee. • Draft Committee Workplan continues to be developed including IQPR data metrics and partnership reporting (to include Flourish, Adult Eating Disorders amongst others) • Committee Effectiveness Discussion – patient involvement. Council of Governors representative to be identified and supported for future Committee meetings.		

Dave Vallance, Non-Executive Director and Chair of the Public Health, Patient Involvement and Partnerships Committee

Report to the Board of Directors meeting scheduled for 28 March 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper H
Date of meeting:	21 February 2024		
Attendees:	Dave Vallance (Chair), Richard Chillery, Sarah Fulton Tindall, Philip Gowland Nicola McIntosh, Pauline Vickers, Dr Judith Graham.		
Apologies:	Sheila Lloyd, Lea Fountain		
Matters for escalation:	• **Racist Incidents** – Whilst recognising this is a complex issue to tackle, the Committee felt the Board should have greater clarity on, and visible commitment to, actions to reduce the unacceptable levels (eg including the Trust's stance on zero-tolerance and what that really means in practice).		
Key points of discussion relevant to the Board:	• **Promises**: 1, 9, 11, 24, 25 and 26 are under PODC remit, covered by the People & Teams and Learning & Education Plans, with oversight by relevant leadership groups. The Committee received draft plans showing progress in development. The five-year KPIs/targets in the People Plan required greater clarity, to help drive and ensure that subsequent actions were appropriate. • **POD Dashboard and IQPR**: Further work is required to ensure the Committee is sighted on the right measures (ie those linked to delivery of the People and Teams and Learning and Education Plans, plus any other key operational People measures) and to ensure ownership/responsibility for reporting and actions are in the right place. • **Staff Absence:** Remains high at 5.7% in month.		
Positive highlights of note:	• **Staff Turnover and Vacancies:** Rolling Turnover continues to reduce (to 10.2%) and Registered Nurse Vacancies dropped to 7.6%. A call was due with the NHS Director for Staff Experience in response to the Trust excelling within the region and nationally.		
Matters for information/noting:	• **Guardian of Safe Working Hours**: Some improvement in the number of fines raised for breaches. Positive to see issues highlighted by the Guardian (Dr Yusufi) have now been addressed, including: the need for admin support; resolving the fines collection process; support for the Junior Doctors' Forum. • **Audit Recommendations**: No overdue actions. • **RIDDORs**: Zero reported.		
Decisions made:	• **GoSWH report:** The Committee agreed the GoSWH and FTSU would be invited to present their papers in future, as they both have independent roles.		
Actions agreed:	• **Workforce Dashboard**: This will continue to be presented in the current format until an improved version was available. • **Partnerships:** Identification of the key partners under P&T and L&E Groups to be pulled together using the three lines of sight (internal processes, internal audit, external audit) in the context of delivery with PODC oversight. This would be on the April P&T agenda with an update to April PODC.		

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

Report to the Board of Directors meeting scheduled for 28 March 2024.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper I
Date of meeting:	21 February 2024		
Attendees:	Pauline Vickers (Chair), Richard Banks, Richard Chillery, Ian Currell, Justin Shannahan, Sarah Fulton Tindall, Nicola McIntosh, Nikola Idle (Shared Agenda representative)		
Apologies:	None.		
Key points of discussion relevant to the Board:	• Performance against the finance domain of the IQPR – Month 10. At month 10 the position has improved to a forecast £3.3m year end deficit (better than plan). • Cash Plan – The committee noted the planned cash of £46.5m for March 24 was incorrectly assessed in the final submitted plan in May 23. A reforecast of cash for the final quarter of 2023/24 to be £40m. Robust assessments are put in place to determine planned cash more accurately in future planning.		
Positive highlights of note:	• DPA18/GDPR, IG Incident & DSPT Update Report – robust plans and processes in place to support IG compliance. • Cyber Security – latest position and assurance of effective cyber controls in place. • Clinical Coding Audit Report – robust processes are in place to facilitate the accurate application of clinical coding.		
Matters of concern or key risks to escalate to the Board:	• Procurement Audit – update provided on outstanding Audit recommendation from the Procurement 360 Audit Report dated November 2023, and new Procurement actions identified. Mr Currell and Mr Shannahan subsequently met to discuss future. • Vacancy and Workforce Reporting – update received on work being undertaken to rebase Trustwide vacancy factors as part of 2024-25 planning to ensure a consistent approach is taken across all areas. • Savings Programme 2024-25 & Savings Dashboard Month. At month 10 the delivery of recurrent savings of £7.8m FYE and forecasting the achieve £9.4m by the end of the year (of £10m savings target). Areas of concern continue to be Doncaster Mental Health Care Group and Estates & Facilities as previously reported. The Committee will receive further updates at the next meeting in relation to Agency Reduction Plans.		
Matters presented for information or noting:	• Terms of Reference – approved by the Board of Directors. • Draft Finance Plan 2024-2025 to 2029-2030 - an introduction to the 5 year financial plan continues to be developed and will be presented for ratification to the Board of Directors in March 2024. • Draft Digital Enabling Plan 2023 – 2028 sets out the Trust's digital priorities 2023-28 and continues to be developed. To be presented for ratification to the Board of Directors in May 2024. • Estates Plan – progress update provided by Shared Agenda		
Decisions made:	• The Committee will continue to monitor and have oversight of the Finance Team Action Plan, developed to address the recommendations contained in the 2023-24 ISA260 report.		
Actions agreed:	• Areas of good and best practice explored with reference to wider application - DPA18/GDPR, IG Incident & DSPT. To consider digitalising data and creating a dashboard for future reporting.		

Pauline Vickers, Non-Executive Director and Chair of the Finance, Digital & Estates Committee

Report to the Board of Directors meeting scheduled for 28 March 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper J
Date of meeting:	20 March 2024		
Attendees:	Dawn Leese (Chair), Dave Vallance, Dr Graeme Tosh, Dr Jude Graham, Richard Chillery, Richard Banks, Ian Currell & Mark Swift (for item 17), Rosie Atack (GGI).		
Apologies:	Dr Janusz Jankowski		
Matters of concern or key risks to escalate to the Board:	**Annual Safe Staffing Declaration (ward-based nurse staffing) 2023/24 -** • The Trust demonstrates compliance with the monitoring and operational management of the current planned and actual ward-based nurse staffing. QC remains assured around compliance with the day- to-day operational management and mitigation of risk. • There remains a gap in compliance with required best practice, due to a delay in the organisations ability to demonstrate a robust approach to the assessment of both the number and skill mix required across all wards to inform planned staffing levels. • Previous reports to the Board (September 2023) identified further work required and planned to address this gap in mental health wards initially. This was via the Mental Health Optimal Staffing Tool (MHOST). The implementation of this approach has not progressed as planned and is currently paused. Recent discussions held with NHSE and has agreed a full re-launch planned for Q1 2024/25. • QC noted the focused work plan required to understand and provide assurance regarding safe staffing requirements. This includes a safe staffing plan for in- patient wards and community settings, Ensuring a full MDT perspective, and to articulate the associated risks / financial implications going forward. **Resuscitation Update** – QC discussed the continued safety concerns associated with non-compliance with resuscitation equipment audits (via Tendable) and Level 3 training compliance. Action requested for executive leads to intervene and ensure action is progressed at pace.		
Key points of discussion relevant to the Board:	**Quality Peer Reviews 2023/24** – Evaluation report received which included the findings, areas of good practice and learning from peer reviews throughout 2023/24. Discussion around variation identified in required standards and follow up. Plan in place for further roll out and repeat reviews in 2024/25. **Estates & Facilities Quality Report** – the response to the Patient Led Assessments of the Care Environment (PLACE) 2023 audit results highlighted a slight improvement overall, however below the national average in some areas. Areas of focus are food, dementia and disability. Facilities portfolio under the lead of the DoN and to be followed up via the Quality and Safety Group. Follow up at QC in 6 months. **Top 5 patient safety themes** - Continued reduction reported in self-harm by ligature incidents. QC noted the progress made and actions taken to date. New CQC best practice guidance – ligature risk assessment has been published. A review, gap analysis and implementation plan to QC in May 2024 to ensure compliance. **Racist incidents** - QC noted the opportunity to triangulate the data around Freedom to Speak Up, staff survey results and reported racist incidents as part of the Patient Safety Incident Response Framework (PSIRF). To be included within future reporting to QC. **Mandatory Patient Safety Checklist** - currently in development as part of the		

	Quality & Safety Plan – the Q&S plan to be reviewed at QC in May 2024. **Integrated Quality Performance Report (February 2024 data) –** • Perinatal Mental Health services and adults access mental health services are above the YTD target. • Virtual Ward - good progress made - within Northeast and Yorkshire (25 providers) 18 providers have lower capacity than Doncaster. • Improvement noted in the reporting and recording of MUST, increased to 64.08% (not yet at satisfactory level), Continued monitoring of progress and sustainability via IQPR at QC. • Out of Area Placements remain high at 28. Remedial action and recovery plan discussed. A comprehensive work programme is planned to focus on the complete pathway and including admission avoidance, reducing LOS and timely discharges. Summary report to be provided in May 2024 to enable. **Quality Safety Impact assessment (QSIA)** - The committee received information that 100% of saving programmes and service improvement programmes have been formally reviewed. Further work to do to ensure that ongoing monitoring and the cumulative impact of changes is monitored across the trust.
Positive highlights of note:	**Mortality Report** - QC remain assured by the systems and processes in place associated with learning from deaths. **Medicines Management** – QC was assured that appropriate governance arrangements are in place to ensure there is robust systems and processes to safely manage medicines within the Trust. **Eliminating Mixed Sex Accommodation Annual Declaration** - Assured that there is a robust process in place to report, monitor and achieve compliance with the National definition of EMSA.
Matters for information:	**Measles briefing** – QC noted the plan following the NHS England published guidance for risk assessment and the key IPC measures required to prevent transmission of measles.
Decisions made:	QC workplan for 2024/25 agreed.
Actions agreed:	• Recovery plan OAP • Executive follow up to ensure compliance with resuscitation standards • Action to address findings of PLACE audit (2023)

Dawn Leese, Non-Executive Director and Chair of the Quality Committee
Report to the Board of Directors meeting scheduled for 28 March 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Commissioning Committee	**Agenda Item:**	Paper K
Date of meeting:	28 March 2024		
Attendees:	Dawn Leese (Chair), Jo McDonough Ian Currell, Phil Gowland, Dr Janusz Jankowski, Pauline Vickers.		
Apologies:	Sheila Lloyd		
Matters of concern or key risks to escalate to the Board:	After a recent visit by the CQC to Ellern Mede, Specialist Eating Disorder Service in Rotherham concerns had been found in patient quality and safety, resulting in a Section 31 being issued under the Health and Care Act. The service is currently closed to admissions and remains on enhanced monitoring. As commissioners we are working with the provider and partners to mitigate immediate risks. Financial concerns around providing the Adult Eating Disorder service for 2024/25 has resulted in the level of risk being increased. Work is ongoing to agree approach for 24/25.		
Key points of discussion relevant to the Board:	The quality / safety and financial risks for the Adult Eating Disorder Service were agreed to be increased (as per key risks above). Associated mitigation plan to be provided.		
Positive highlights of note:			
Matters presented for information or noting:	The work of the hub and the future commissioning intentions were presented. The draft evaluation of the Stepping Stones service for 2023/24 was discussed with the draft report being presented to the meeting in April 2024. Work is underway to better understand length of stay and update on this to be provided in April 2024.		
Decisions made:	The meeting held on 7 February 2024 was scheduled to be the final meeting of this group, however, due to the increased risks around the quality, safety, the financial position of the Adult Eating Disorder Service and with the future governance arrangements still in discussion within the collaborative, a further meeting has been planned for April 2024.		
Actions agreed:	Meetings are to be scheduled with NHS England, Toby Lewis, CEO and the Adult Eating Disorder Provider Collaborative to explore future funding and governance of AED commissioning.		

Dawn Leese, Non-Executive Director and Chair of the Commissioning Committee.
Report to the Board of Directors meeting scheduled for 28 March 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper L
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	28 March 2024

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

The report highlights significant work to address patient safety and quality of care issues. We have made good progress ensuring we have sufficient Talking Therapies capacity and have a clear plan in place to address unacceptable ADHD waiting times. The Trust has met the perinatal and CMHT long term plan targets for the first time.

Year-end inevitably means financial focus, and whilst we have over-achieved to plan in 23/24, we have work to do to secure in full our plans for 24/25. However, we need to recognise the improvements in behaviour, focus, and capability to make change as we balance expanding clinical services with making savings elsewhere. It is important momentum is not lost, with each Care Group having reached balance, and, initial data, would suggest with 22 of 23 directorates planning balance for the year ahead.

Not all of the Governing Bodies' priorities have been delivered and revised governance to support persistent focus on those priorities will be put in place before the next Council of Governor's meeting.

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** work being done to sustain and improve against the staff survey results

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		N	x	If 'Y' date completed	

Appendix

Annex 1: Update on Governing Body priorities for 2023/24
Annex 2: Guidance summary, incl. full NHS Providers' briefing on WRES
Annex 3: Report summary on RDASH 2023 national staff survey
Annex 4: Summary report arising from CLE
Annex 5: Board summary of South Yorkshire MHLDA Collaborative Board (Jan 24)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Chief Executive's Report

Introduction

I would hope that we can see through our Board's papers increasingly joined-up work across the Trust to deliver the very ambitious agenda we have, but also to put in place basic disciplines of practice that improve reliability and reduce strain.

The papers before the Board this month bring a conclusion to some important work done during 2023/24. We can confirm **delivery of our work to secure the Trust's underlying finances** by making a substantial savings programme happen – itself supporting necessary expenditure in the coming year which will enhance quality of care and move towards delivery of some of our promises. Elsewhere in the Board's papers is work on safe staffing, and the revised proposal to transform our flexible staffing arrangements via contracting bank workers through NHS Professionals. Improving fill rates through growing our bank numbers and shifts is an important step towards greater team consistency on our wards, as is work to reduce sickness, and to improve the rigour and equity of rota management. Implementing this latter discipline in Q1 will prepare us better to make a success of NHSP in Q3 (if the Board supports the case before it this month). Our finance plans see us continuing to make use of bank staff but **dramatically scaling back agency staffing**, not least through significantly more centralised and senior models of approval from May. These were outlined for CLE in our February internal operating guidance and are being reinforced through directorate reviews.

As we consider the 23/24 annual report work for the Trust, I would suggest we should especially note a handful of key improvements teams have led locally over the last twelve months:

- The closure of Goldcrest ward in Rotherham has allowed us to **expand the acute outreach team's hours and seven-day service**. This has led directly to a 50% growth in care volumes offered through the team, and the weekend service has improved crisis management.
- The completion of long-term work to create a **24/7 CAMHS on-call service** has introduced improved resilience in our response to crisis for children and young people, and improved equity between the places we serve.
- The major **expansion of our volunteering effort** (with a further big growth needed in Q2 and Q3 of 25/26) responds both to our strategy and to the priorities set by our Governing Body
- Our virtual ward service is gathering pace and scale, and its connection with teams within Doncaster Royal Infirmary has been widely acknowledged. Our **IV pathway pilot** has now been supported on an ongoing basis to improve care outside hospital.
- Our **employee incident response team** continues to support colleagues effected by trauma and difficulty at work, and a modest expansion of that team is now planned.

This is not intended to overlook the very positive educational attainment cited below, nor the research esteem indicated by our new role as a coordinating hub within local NIHR arrangements.

Our patients

Both our physical health teams and our older adult mental health services continue to **support patients with dementia**. At CLE in February, we agreed diagnostic pathway changes to tackle waiting time delays in Rotherham, and half of the backlog of confirmed cases has now been addressed. Risk management group is retaining oversight of the further work to improve. Meanwhile, changes including funding new roles, to create equity and sustainability in our older people's services have been prioritised. The new Doncaster joint services with Alzheimer's' UK has launched – alongside a strategy for the city.

In bringing together **learning disability services** across the Trust, within one management structure, it has become startingly clear that there are imbalances of service offer and service safety, including staff safety between our sites. We are therefore progressing at pace emergency work to stabilise the service in North Lincolnshire, and to ensure that it has the bare minimum multi professional staffing that the client group requires. This step is within the 'bids' and cost pressure process that the Board is sighted on: we would expect by the summer to have a position of equity – meanwhile through delivery reviews we are moving forward with our STOMP compliance analysis including standardising data practices and pathways RDaSH-wide.

The Board is aware that in two respects service **waits in Rotherham Children's Services are outwith our Trust-wide position**. ICB investment in 22/23 to address neurodiversity waits has shown some benefit but concludes in March 2025. CAMHS waits were also an outlier, and the latest plans being presented through delivery reviews suggest that we can achieve our promise 19 4-week standard in this service from July. The number of children waiting too long has halved since January, which is encouraging work. There remains a focus on ensuring that our pathways across Children's services are consistent, but that the results of those changes improves rather than deteriorates patient experience, including waiting times.

Extensive work, led by Claire Klein, has taken place to re-examine **our Talking Therapy services**, with a new service manager in post, and clinical lead joining us next month. Even though the national access (volume) 'target' for the service has been abolished from April, we continue to measure against this standard, and are now clear that we have the capacity in 24/25 needed to meet it: for the first time. Revisiting our low banding of counsellors will help us to improve turnover, and this may aid recovery rates, which are now the nationally tracked data point for the service. It is very difficult to see that expanding Talking Therapies services is not the right step, in view of economic growth and benefits reduction plans in the wider public policy realm.

As reported last time, work was undertaken in Q3 to assess the **therapeutic quality of our inpatient mental health services**, mindful of CQC standards, and of our own promises within strategic objective 4. Richard Chillery has developed a proposed implementation model to take this work forward, alongside and integrated with, work

to tackle long stay inpatient care, out of area placements, and the various parameters of the national Inpatient Mental Health Quality programme.

Graeme, Jude and Steve, will all take on specific workstreams. This integrated approach to ward improvement is exceptionally important as we seek to avoid myriad initiatives, monitoring regimes, and other suggestions, given national focus on these settings. I will work as executive sponsor for this safety work given its centrality to the agenda, we have for the Trust over the coming nine months. We have sought support from NHS England to peer review/inspect our wards in November, as a timely test of impact over the coming months. Laura Wiltshire joins us in June to take on the leadership role with the flow team, and Laura's experience in driving meaningful trauma informed improvement will help greatly in the work ahead.

Whilst our quality and safety plan remain in finalisation, I wanted to draw the Board's attention to **the Outcome Measures** that teams are proposing for initial work; they speak to the diversity of the Trust's portfolio but also the mindset shift being observed in our 'reach'. Our children's services teams are seeking to focus their attention on school readiness – and within that on *toilet training* among our clients. Readiness is the ICB's number one health inequalities priority. Across adult community services we will be looking to achieve a substantial improvement in the timeliness of *wound healing*, building perhaps on the notable success of the Wound Care Alliance over recent years. Within adult mental health services, the primary initial focus will be on exceeding national norms for patients within *Early Intervention Psychosis services*, albeit to do this will require us to invest in a missing pathway within our North Lincolnshire team.

Our people

Health Education England now sits within NHSE. In early February, their visit to inspect our educational work has produced a glowing and positive endorsement of the Trust's improvement. This review covered all disciplines except social work, and especially praised the greater profile and reach of our AHP/psychological professionals mentoring and educational support work. We discussed the role of PAs going forward, as well as the needs of peer support workers. It is helpful to have an outside-in view of the quality of support we are providing on placement, as expansion in numbers can sometimes come at the expense of this. We have agreed that in July we will spend some time as a Board exploring all of the educational roles and approaches taken across the Trust as we aim to more clearly lead and govern a tripartite mission of service, research and education.

Joining up our vacancies with our safety and finance has been a thread of these reports for several Board meetings. We are working to **establish vacancy numbers**, reconcile those to a vacancy factor of no more than 2.5%, and fill residual posts. Our workforce returns for 24/25 show a net decrease in establishment but a rise in staff in post. From May, as part of our move towards being, 'fully staffed' I will be providing a vacancy summary to the Board as an annex to this report.

Annex 3 includes a summary report provided by Nicola McIntosh on the September 2023 national staff survey, with data published in March 2024. More responses than ever before were submitted by RDaSH colleagues, and whilst our results remain

comparatively good, both within our 'sector' and locally, the results show three significant falls from the prior year. More troublingly **our WRES data** contains a large jump in the proportion of staff suggesting discriminatory behaviours by their line manager. The jump is substantial enough that I consider we need a targeted response during Q1 to hear from colleagues about which behaviours they experience and what needs to change. There is no concurrent rise in formal claims or grievances. NHS Providers' wider WRES report is included with the guidance annex (2) to provide some balance and context for Board members.

The prioritised **investment to support peer support workers**, as part of securing promise 1, creates an opportunity for us to test how such roles are best created and employed. We will look to compare our own employment model (used currently in CYP) with hosted arrangements through VCSE structures. In either model we need to ensure that we have the right support in place, and the executive need to review that infrastructure, as we employ more people with lived experience. Our historic wellbeing and support offer, whilst notable (for example in our staff survey) may not be sufficient or elegantly structured for a different clientele.

Overseas recruitment remains an important part of our work, and I reported on our accreditation last time. Up to **nine doctors from India** will join the Trust at below consultant grade this autumn, as part of their work towards CESR status. This significant change will help us to tackle longstanding vacancies and also contribute further medical time to our research work. Diarmid Sinclair is supporting the transition of these new colleagues into each of our Care Groups. The Board is aware of wider work to support our internationally educated colleagues, and I have asked Steve Forsyth to review the effectiveness of that support before the end of the summer.

The Trust's **staff app** has now reached over 2,000 people. I would hope all Board members have downloaded it. During 24/25 it will become our dominant electronic communication model, as we look to scale back email channels, and introduce greater face to face communication linked to Learning Half Days. The need for messaging/translation work to be a much greater part of the management role is acknowledged in discussions being held within CLE about how we liberate leader's time from meetings and formal obligations – both inside the Trust and especially arising from "system working".

Our population and partners

When the Board meets in May, we will bring work from the South Yorkshire Collaborative on **future use of section 136 suites**. This work tests the scale of current provision in Barnsley, Sheffield, Doncaster, Scunthorpe, and Rotherham. It is likely to suggest that the key improvement steps rely on suites being staffed (we have standardised our staffing model within RDaSH from Q1), but on length of stay being at 24 hours. This is a *huge* step from current state, albeit it is a timescale which accords with the expectation of the legislation. This work directly speaks to whether, as a South Yorkshire system, we have scaled our in-area beds and sub-specialist capacity, to what is needed.

We have agreed with Doncaster's Strategic Homelessness Executive, that it would be helpful for the Trust and primary care partners **to develop homeless health**

services at scale in the city. These would compliment and sit within the Complex Lives structure led through the local authority. NICE guidance, and other related publications, will be followed to develop a final proposal during Q1. There is considerable energy and excitement about this possibility and it will be important to capitalise on this collective commitment, not only in itself but because of the relationships it nurtures of relevance to our wider pathways of care.

We have succeeded, with our partners, in retaining **the drug and alcohol service's Aspire contract.** This marks a 100% tender success rate during 23/24: a pleasing indicator albeit the time taken by procurement processes remains notable. We will look to operate constructively to compare dual diagnosis arrangements in Doncaster (where we run services) and Rotherham (where we do not). The latter remains an identified improvement priority for local primary care colleagues and is being added to the health and wellbeing board's mental health improvement plan.

The Ministry of Justice have confirmed their intent to contract with the Trust to develop and **expand our Rotherham based Trauma and Resilience service**, which developed initially to respond to operation stovewood. We are clear that this will offer not only South Yorkshire but also North Lincolnshire access.

ICB colleagues are currently leading **a "refresh" of last year's Joint Forward Plan**. The current expectation is of minimal change. Meanwhile, Place Plans are being tested for, among other things, their ability to contribute to financial balance. The structural financial imbalance in Doncaster is of note and considerable joint work continues to seek to find a route to balance working across primary and secondary care.

Concluding comments

I recognise that the sheer scale of change across many facets of the Trust's work can feel overwhelming. Whilst our ambition, through the promises, is an energising one, it remains **important to check-in and adjust as we go**. The fundamentals of good care planning and accurate waiting list management, the basics of good sickness support and effective appraisal, will underpin our ability to flex and change in different spaces implied by our strategic objectives. At the next Board when we consider our Well-Led position we need to examine how we are supporting our leaders to both lead and change. This will be timely as our procurement of leadership development support will have reached a decision point.

It has been helpful to begin to mobilise our work on health inequalities, and the Board's new committee for that purpose will help to ensure we keep pace and focus. There is pressing work to be done to ensure that during 24/25 **our IQPR and other key datasets routinely assess all our key indicators for protected characteristics and consider spatial and deprivation indices too**: a 'reasonable unreasonableness is needed now' to make a rapid step-change in expectations.

Nicola McIntosh steps down from the Board in late April, with our *thanks*, and mine. This meeting is her last with us. Successor arrangements are in place designed to maintain momentum in our work to improve people management across RDaSH. The 2023 staff survey annex illustrates some elements of the task ahead, but the key step is our journey to being Fully Staffed, and work to reduce vacancies and improve

retention. The wider NHS desire for ‘flat staffing’ should not be confused with the need to address gaps and risk.

Annexes provide detail of our work on the (1) governors’ key priorities, show the (2) latest guidance documents, including in detail a WRES summary, then set out the (3) key issues in our latest Staff Survey, and (4) precis the work of the CLE since the Board last met.

Toby Lewis, Chief Executive
22 March 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	March 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	Expected to be met Our employee survey is ongoing and among responses awareness is high: renewed efforts are taking place to expand survey take up (n 58). A targeted survey for TLC will now take place.
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	Expected to be missed This ambition will be exceeded in 24/25 given the expansion agreed by the clinical leadership executive, it was not met in 23/24.
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 March	Expected to be partly met.

From prior paper to COG	Current framing	Success by March 2024	March 2024 status
			The Board will consider progress in May, as we review the work being done to deliver promise 9 of our strategy.
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	Expected to be partly met This ask rolls over into 24/25 as part of promise 7. The new national ask is 75% and the Trust is aiming to go far beyond this. We have been re-contracted as the area's SMI healthcheck provider. This has been funded and has now started work!
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	This can still be met Discussions are continuing within Chief Officer's Group in Rotherham over both the Boots site, the market development and opportunities within Riverside: as at time of writing the Trust is committed to the Boots site which would open in 2026. We have created an asset map and are exploring how it can be visualised to support presentation to the named groups.
Health promotion and prevention	GB6 We are working with three local public health departments and others, to assess the calibre of promoted/certified mental	Six clear access routes to certified information are 'endorsed' by RDASH 3xCYP and 3xadult and their	This has not been met

From prior paper to COG	Current framing	Success by March 2024	March 2024 status
	wellbeing advice available to both children and young people (CYP) and adults in our three Places. Our new website goes live in December 2023.	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 promoting evidence-based wellbeing interventions. AND Funding route for current time-limited support in schools service is established (funding expires 2025).	A review with the CEO and relevant teams is taking place before the next COG and BOD This work has started, with place leadership and will need to form part of 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.	This can still be met 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 This has been met but there is more work to do to secure volume and diversity.

Annex 2

National publications/guidance summary – February/March 2024

Building the right home: NHS housing capital guidance
(NHS England, published 01/02/2024)

This guidance will help integrated care boards, local authorities and support, care and housing providers to access capital grant funding to develop housing that will play a key role in reducing the number of autistic people and people with a learning disability in a mental health hospital setting, as set out in the NHS Long Term Plan.
https://www.england.nhs.uk/long-read/building-the-right-home-nhs-housing-capital-guidance/

Commissioning framework for mental health inpatient services
(NHS England, published 12/02/2024)

This framework summarises the commissioning guidance relating to mental health inpatient provision. It aims to, provide guidance for those responsible for the commissioning of mental health inpatient services and within this, advance the system-wide requirement to ensure that services are local, inclusive and deliver safe, personalised, and therapeutic care and support systems to develop local plans for change, so that inpatient provision better fits the needs of the population, makes more effective use of the funds available, and protects and improves the lives of citizens in the locality.
https://www.england.nhs.uk/long-read/commissioning-framework-for-mental-health-inpatient-services/

Arrangements for delegation and joint exercise of statutory functions
(NHS England, published 20/02/2024)

This guidance is for integrated care boards, NHS trusts and foundation trusts and provides an overview of the new collaborative working arrangements that are possible between NHS organisations and local government following commencement of the Health and Care Act 2022.
https://www.england.nhs.uk/long-read/arrangements-for-delegation-and-joint-exercise-of-statutory-functions/

NHS leadership competency framework for board members
(NHS England, published 28/02/2024)

This framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs.

https://www.england.nhs.uk/publication/nhs-leadership-competency-framework/

National flexible working people policy framework
(NHS England, published 13/03/2024)

The NHS People Promise is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone. It says:

“We can work flexibly, doing whatever work pattern fits our needs, regardless of the type of role we’re in. As a modern and model employer, flexible and less than full-time working isn’t a barrier to progress in the NHS – it is commonplace.”

This policy brings this part of the People Promise to life. It will provide you with the information you need, support you to have conversations and take steps towards working in a way that suits you best.

https://www.england.nhs.uk/publication/national-flexible-working-people-policy-framework/

NHS Workforce race equality standard 2023 data analysis report for NHS trusts
(NHS England, published 18/03/2024)

https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/

Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts
(NHS England, published 18/03/2024)

https://www.england.nhs.uk/publication/workforce-disability-equality-standard-2023-data-analysis-report-for-nhs-trusts/

NHS Workforce Race Equality Standard report 2023

On 18 March 2024, NHS England published the annual Workforce Race Equality Standard (WRES) data report. This year's report includes new analysis on the experience of internationally recruited nursing and midwifery staff, a welcome addition, that will help further support trusts' work to achieve the goals of NHSE's equality, diversity and inclusion improvement plan.

NHSE recently published the results of the NHS Staff Survey 2023, however, the 2023 results have not been included in this most recent WRES report. Where possible, we have included 2023 staff survey data in this briefing.

The WRES report uses the term "Black and minority ethnic" to describe ethnic minority staff. However, this briefing will not use this term, the acronym "BME", or the alternative acronym "BAME". Instead, NHS Providers uses the full description "Black, Asian and minority ethnic" or "ethnic minority" as preferred descriptions to denote the same aggregation where disaggregation into more appropriate, distinct categorisations of ethnicity is not possible.

This briefing outlines the WRES report's key findings and NHS Providers' view. If you have any questions about this briefing, please contact Olli Potter, senior policy officer (workforce), oliver.potter@nhsproviders.org.

Key findings

- The overall percentage of ethnic minority staff across the NHS workforce has increased year-on-year and now stands at 26.4% in 2023, compared to 24.2% in 2022 and up from 17.7% in 2016.
- At very senior manager (VSM) level, the percentage of ethnic minority staff has also increased year-on-year, with 11.2% of staff from an ethnic minority, compared to 10.3% in 2022 and 5.4% in 2016.
- However, while there has been an increase in the diversity of board members, the report again notes that increasing diversity in the overall workforce has resulted in the mean gap between overall workforce and board diversity increasing, particularly among executives (15.7% compared to 13.5% in 2021).
- It is concerning that white applicants remain much more likely than ethnic minority applicants to be appointed from shortlisting at 76% of trusts.

- There have been improvements in the relative likelihood of ethnic minority staff entering the formal disciplinary process compared to white staff, falling from 1.14 in 2022 to 1.03 in 2023. At 46% of trusts, however, ethnic minority staff are over than 1.25 times more likely to enter the disciplinary process compared to white staff.
- It is concerning to see that abuse, bullying and harassment from patients remains high, alongside the gap in experience of these behaviours between ethnic minority and white staff. Using NHS Staff Survey data from 2023, ethnic minority staff remain more likely to experience these behaviours from patients, their families and the public (28.6%), compared to their white colleagues (24.7%).
- This year's report includes data on the experience of internationally recruited nurses, midwives and nursing assistants and healthcare assistants (HCAs) across a number of metrics:
    - Ethnic minority nurses and midwives recruited internationally were the least likely to agree that their organisation offers equitable access to career progression and promotion as were ethnic minority nursing and HCAs recruited from within the UK
    - White nurses and midwives recruited from outside the UK were more likely than all other groups to experience harassment, bullying or abuse from patients, their families or the public (49.0% in 2022), followed by ethnic minority nurses and midwives recruited from within the UK (40.4% in 2022).

2023 data

The below briefing summarises the nine WRES indicators under the themes of representation, equal opportunity, discrimination and harassment, and internationally recruited nursing staff. Data for the WRES is collected via the Data Collection Framework (DCF), with a return rate of 100% of trusts, and via the NHS Staff Survey. For indicators that utilise NHS staff survey data, this data is from 2022, published in 2023. NHSE has since published 2023 data and our briefing on these results is available here.

Representation

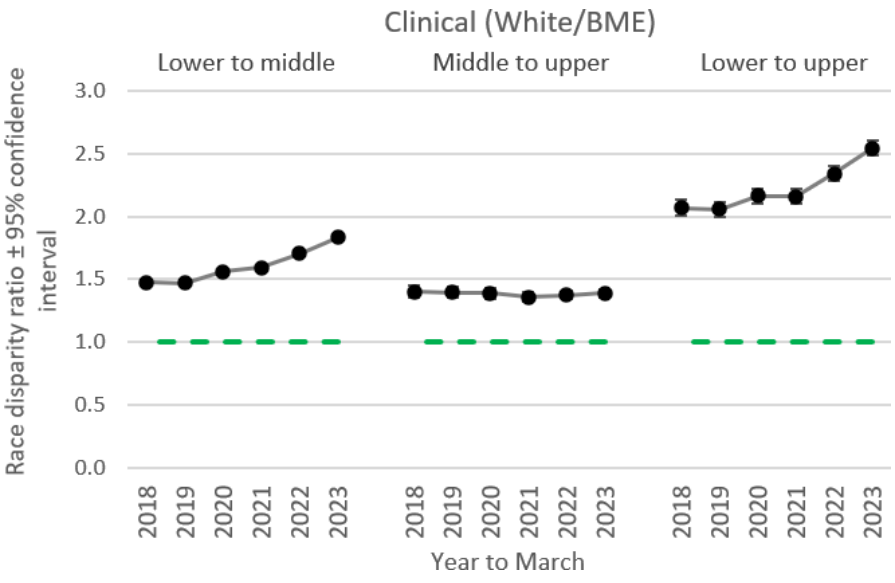
The overall percentage of ethnic minority staff across the NHS workforce has increased year-on-year and now stands at 26.4% in 2023, compared to 24.2% in 2022 and up from 17.7% in 2016. At VSM level, the percentage of ethnic minority staff has also increased year-on-year, with 11.2% of staff from an ethnic minority, compared to 10.3% in 2022 and 5.4% in 2016.

By region, London is the most diverse with 52.1% of the workforce from an ethnic minority (49.9% in 2022) compared to the South West, where 15.0% of staff are from an ethnic minority (12.8% in 2022).

When considered by Agenda for Change (AfC) band, band 5 sees the highest percentage of staff from an ethnic minority (38.5%, compared to 34.3% in 2022), while bands 8d (11.5%) and 9 (11.2%) again see the lowest. Ethnic minority staff at VSM level represent 11.2% of the workforce (10.3% in 2022).

Band 6 remains the most diverse AfC band for non-clinical staff, with 19.8% of staff from an ethnic minority, followed by 18.7% at band 5. However, in clinical roles, band 5 remains the most diverse band, with 41.6% of staff from an ethnic minority background (36.8% in 2022). The next highest band for clinical staff is band 2 and under, at 27.0%, up from 24.0% in 2022. For doctors, 61.0% of non-consultant specialists are from an ethnic minority, followed by 48.8% of trainee doctors. Overall ethnic minority representation among doctors is 46.8%. Race disparity ratios included in the report show that disparity is increasing in clinical (non-medical) roles, particularly in the lower to middle and lower to upper levels (see Figure 1). On this graph, a ratio of one (1) shows equity, and a ratio higher than one (1) shows inequity, with disadvantage to ethnic minority staff. It is also important to note higher non-disclosure rates among clinical staff at VSM level (9.7%) compared to other bands, as well as a non-disclosure rate of 28.4% among 'other' medical staff and 10.8% among trainees.

Figure 1 – Disparity ratios for clinical roles



Indicator 9 looks at representation at board level and shows an increase in overall board diversity at a national level (15.6% up from 12.6% in 2021 and 7.1% in 2016). Executive board member diversity has also increased to 10.8% compared to 9.7% in 2022. While there has been an increase in the diversity of board members, the report again notes that increasing diversity in the overall workforce has resulted in the mean gap between overall workforce and board diversity increasing, particularly among executives (15.7% compared to 13.5% in 2021).

NHSE EDI Improvement Plan
High Impact Action (HIA) 2 calls for trusts and NHS organisations to embed fair and inclusive recruitment processes and talent management strategies, targeted at under-represented groups. A success metric for this HIA is year-on-year improvement on WRES indicators 1 and 9, which has been achieved since 2016.

Equal opportunity

Indicator 2 considers the relative likelihood of white applicants being appointed from shortlisting compared to ethnic minority applicants. It shows that white staff continue to be more likely to be appointed than ethnic minority candidates in all regions, although relative likelihood has fallen nationally to 1.59, compared to 1.61 in 2021. However, regional trends have varied, with the East of England seeing improvement (from 1.96 in 2022 to 1.46 in 2023) and the North East showing deterioration (1.70 in 2021, 2.01 in 2023). It is important to note that white applicants remain much more likely than ethnic minority applicants to be appointed from shortlisting at 76% of trusts.

NHSE EDI Improvement Plan
High Impact Action (HIA) 2 calls for trusts and NHS organisations to embed fair and inclusive recruitment processes and talent management strategies, targeted at under-represented groups. A success metric for this HIA is year-on-year improvement on WRES indicator 2. Between 2022 and 2023 this gap has widened from 1.53 to 1.59.

Indicator 3 examines the relative likelihood of ethnic minority staff entering the formal disciplinary process compared to white staff, which fell from 1.14 in 2022 to 1.03 in 2023. While all regions saw sustained improvement since 2021, London remains an outlier against wider regional performance, performing more poorly than the rest of the country.

Access to non-mandatory training and continued professional development (CPD) by white staff compared to ethnic minority staff is measured in Indicator 4, which shows improvement to 1.12 compared to 1.14 in 2021. The South East saw its performance worsen slightly, compared to flat or improving trends elsewhere.

Indicator 7 considers the percentage of staff who believe their organisation provides access to equal opportunities for career progression or promotion. Using 2023 NHS Staff Survey data, 48.9% of ethnic minority staff agreed, compared to 59.4% of white staff. This compares to 44.0% of ethnic minority

staff and 59.6% of white staff in 2020. Staff identifying as Caribbean or selecting 'Other – Black/African/Caribbean background' are the least likely to report their organisation acts fairly regarding promotion and progression (35.9% and 34.1% respectively). Staff from Gypsy or Irish Traveller communities also report low scores on this measure (36.7%).

Discrimination and harassment

Indicators 5, 6 and 8 utilise data from the 2022 NHS staff survey data published in 2023. NHSE recently published 2023 data on 7 March 2024. Our briefing on these results is available here and we have utilised 2023 data where possible.

Experiences of harassment, bullying or abuse from patients, their relatives or the public are measured in Indicator 5. In 2023, ethnic minority staff remain more likely to experience harassment, bullying or abuse from patients, their families and the public (28.6%), compared to their white colleagues (24.7%), however rates of abuse have reduced for both ethnic minority (30.4%) and white staff (26.8%) compared to 2022. The WRES report includes breakdowns by gender and role, and data from 2022 shows that women (27.9%) are more likely to experience these behaviours than men (26.3%). Women from white Gypsy or Irish Traveller communities and staff who identity as Asian 'other' are the most likely to experience these behaviours from the public and patients. Women are the most likely to experience bullying, harassment or abuse (30.8%), but when considered by role, men working as registered nurses and as nursing assistants and HCAs experience high levels of these behaviours. Ambulance (operational) staff continue to experience the highest rates of bullying, harassment and abuse from patients and their families, compared to other staff in the NHS.

Indicator 6 shows the percentage of ethnic minority staff experiencing harassment, bullying or abuse from staff has increased to 27.7% in 2022 from 27.6% in 2021. White Gypsy and Irish Traveller staff experienced the highest levels of abuse, bullying and harassment from staff (39.0% for women and 45.7% for men), followed by staff who identify as Arab (33.7% for women and 32.7% for men) and women identifying as Black 'other' (33.6%). Ethnic minority women continue to experience the highest levels of these behaviours from other staff, particularly women working in general management (30.5%), medical and dental staff (32.6%) and registered nurses and midwives (30.7%).

Using 2023 NHS Staff Survey data, the percentage of staff experiencing discrimination from a manager, team leader or other colleague (Indicator 8) has decreased for all staff between 2022 and 2023, but the gap between the experience of this behaviour by ethnic minority staff (15.5%) compared to their white peers (6.7%) remains large at 8.75 percentage points in 2023. The 2022 data

included in the WRES report shows that men (9.3%) are more likely to have experienced this behaviour compared to women (8.3%) and that men from Gypsy or Irish Traveller communities are the most likely to have experienced this behaviour (25.5%). Ethnic minority women working in general management are the most likely to have experienced this discrimination from a manager (19.8%).

Internationally recruited nursing and midwifery staff

This year's report included data on internationally recruited staff working as nurses, midwives and nursing assistants and HCAs in the NHS for the first time. This is particularly important to ensure targeted work to achieve high impact action 5 of the EDI improvement plan can be completed, and because data from WRES indicator 1 shows that clinical staff in band 5 are the most ethnically diverse group working in the NHS. One factor is that international recruitment to nursing roles at band 5 has been significant in recent years.

These metrics use data from the NHS Staff Survey published in 2023 and collected in 2022. The results show:

- White registered nurses and midwives recruited from outside the UK were more likely to experience harassment, bullying or abuse from patients, their families or the public (49.0% in 2022), followed by ethnic minority nurses and midwives recruited from within the UK (40.4% in 2022). Among nursing assistants and HCAs, the trend is similar with 46.0% of white staff recruited from outside the UK reporting these behaviours and 41.0% of ethnic minority staff from within the UK reporting the same.
- When asked about harassment, bullying or abuse from staff, among registered nurses and midwives, 31.0% of ethnic minority staff recruited from within the UK reported these behaviours, followed by 30.1% of ethnic minority staff recruited from outside the UK. White nursing assistants and HCAs recruited from outside the UK were the most likely to experience these behaviours in 2022 (34.0%), while 29.8% of internationally recruited nursing assistants and HCAs reported experiencing the same.
- White registered nurses and midwives (62.0%) as well as white nursing assistants and HCAs (61.1%) were the most likely to report their organisation provides equal opportunities for career progression or promotion in 2022. Ethnic minority registered nurses and midwives recruited internationally were the least likely to agree (44.2%) as were ethnic minority nursing assistants and HCAs recruited from within the UK (51.5%).
- Ethnic minority staff recruited internationally or from within the UK were the most likely to report experiences of discrimination from other staff in 2022, with white staff recruited from inside the UK the least likely to report experiences of this behaviour.

NHS Providers resources

Our race equality programme has published a wide range of resources to help trusts tackle racial disparity and inequality, aligned with the ambitions of the EDI improvement plan. Most recent examples include:

- A guide to evidence based effective recruitment and talent management interventions for race equality
- Closing the gap: a guide to addressing racial discrimination in disciplinaries
- A guide to supporting your internationally educated workforce

Details of our upcoming events are also available here.

NHS Providers view

As with previous national WRES reports, it is positive to see improvements on some metrics, but it remains clear that there is much to be done to improve the experience of ethnic minority staff in the NHS, particularly with regard to experiences of bullying, abuse and harassment. Progress has been made in addressing disciplinary gaps between ethnic minority and white staff, but it is concerning that this divide remains at almost half of trusts in England. Furthermore, the findings show a specific focus is needed on providing equal opportunities for career progression and promotion for staff from a Black background.

It is welcome, however, to see a continued increased in the overall diversity of the NHS workforce, as well as at board level. This is tempered by the fact that increasing diversity in the overall workforce has resulted in the mean gap between overall workforce and board diversity increasing, particularly among executives.

It is particularly useful to see this year's data broken down to allow for greater analysis of the experiences of internationally recruited nurses, midwives, nursing assistants and HCAs. This will allow trusts to further develop and adapt targeted interventions to support internationally recruited staff, who make up a significant proportion of staff in these roles.

Using the data from this report, there have been year-on-year improvements across WRES Indicators 1 and 9, two of the success metrics linked to high impact action two of NHSE's EDI improvement plan. While these year-on-year improvements have been sustained since 2016, it is important to note that increasing board diversity must, at least, keep pace with increased overall workforce diversity.

WRES Indicator 2 is also linked to high impact action two, so it is concerning to see a worsening of this measure between 2022 and 2023.

We have been working closely with NHSE as part of the initial development and implementation of the EDI improvement plan. As part of this, we have spoken to 12 trusts, integrated care boards and NHS organisations, including a community interest company, to understand the successes, barriers and challenges they have experienced implementing the six high impact actions to date. We will be publishing a final report as part of this piece of work in spring 2024.

Finally, it would be useful for national WRES reports to be published closer to the period of data collection to allow alignment with the latest NHS Staff Survey results and to maximise the breadth of data available to trusts and other stakeholders as they work to tackle inequities experienced by their staff.

Annex 3: Trust Board update Staff Survey update March 2024

Introduction

The NHS staff survey is carried out on an annual basis between September and November, and we chose to survey all applicable employees. Our comparator group is Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts. A total of 53% of the Trust's staff surveyed completed their 2023 questionnaire, which is an increase of 2% in comparison to the 2022 response rate. The CQC median response rate for our comparator group (51 Trusts) was 52%, therefore we were 1% higher.

In 2022 an additional survey was introduced specifically for Bank Staff. When the survey was introduced in 2022 all 596 pure bank staff recorded on the ESR system were sent a questionnaire and a response rate of 19.3% was achieved. In 2023 only those colleagues that had worked in the 6 months prior to the survey going live were sent a questionnaire, which resulted in 282 questionnaires being sent out and a 32.3% response rate. The actual number of people responding to both surveys was 115 in 2022 and 101 in 2023.

Areas of focus

There are three areas that the Trust has scored significantly lower than that it did in 2022, these areas are "we are compassionate and inclusive", "we each have a voice that counts" and "Staff Engagement". In order to deliver the best standard of care to our patients it is important that our colleagues feel valued and respected in their roles and feel engaged with the organisation. It is for this reason that these areas have been identified as our areas of focus for this year.

1. We are Compassionate and Inclusive

Colleagues recommending RDaSH as a place to work has reduced by 2.6% since the 2022 survey. When looking at this in more detail several reasons for this are evident. There has been a decline in colleagues feeling that their immediate manager is interested in listening to them or will work with them to understand problems. In addition, we have seen a decline in people feeling that those they work with are kind to one another and respect one another.

There has also been an increase in people reporting that they have experienced discrimination from their manager/team leader or work colleagues and when examined in more depth this shows that of the 134 respondents from ethnic groups (other than white) 25.3% had experienced harassment bullying or abuse and 20.9% had experienced discrimination. This figure in isolation is concerning, but is an increase from last year of 11.47%. **Appendix One** also provides a break down of these questions by Care Group.

Promise 26 is our commitment to becoming an anti-racist organisation by 2025 and fighting discrimination and positively promoting inclusion. Further work needs to be undertaken to understand the stories behind these results and this can be done through linking in with the Staff Network Groups and freedom to speak up champions. Each area manager has to understand their own results and by utilising an appreciative enquiry approach seek to listen and change what has been happening. Concerns raised about bullying, harassment and discrimination must not be taken lightly and should be reported and investigated appropriately as the HR data relating to concerns raised doesn't correspond with this level. Colleagues need to be encouraged to raise concerns

and feel psychologically safe in doing so and this directly links with our second areas of focus, we each have a voice that counts.

In addition further work needs to be undertaken to promote the Trust's fully trained mediators who can help colleagues talk to each other in a facilitated way, hopefully preventing situations from escalating. As part of the leadership offer, managers will enhance their skills in handling difficult conversations, which should address concerns in a more timely manner and prevent escalation.

In order to understand how people are feeling across the organisation participation and promotion of the quarterly NHS Pulse Check will provide more regular feedback to the organisation on how colleagues are feeling and whether steps are being taken to improve the employee experience across the organisation. This pulse check will feed directly into delivery reviews for all groups and directorates.

In addition colleagues are asked on what grounds they have experienced discrimination and the highest response with 31.2% is "other" with the second highest (30.6%) being on the grounds of ethnicity. As an organisation we need to understand what colleagues are indicating when they state they have experienced discrimination on the grounds of "other". Work has already begun to explore this with our staff network groups and the initial response is that people are concerned that the survey isn't anonymous and therefore they are ticking "other" so they cannot be identified.

2. We Each Have a Voice that Counts

This people promise has two elements: autonomy & control and raising concerns. Whilst there has been a decline in people feeling that they have autonomy in their role the decline is greater in colleagues' responses to the raising concerns questions. Focus needs to be placed on ensuring people feel safe to raise their concern and if they do that something will be done about it. **Appendix Two** shows a break down of these questions by Care Group and show that the area of focus needs to be on reassuring people that they are safe to raise their concerns and that the organisation will address their concern as a high number of people are unsure about how there concerns will be treated.

Information from the Staff Survey has been shared with both the patient safety group and the Freedom to Speak up Guardian so that they can consider whether there are any areas within which the results are lower than expected as previously the Trust scored highly in this area. They can also work with care groups and directorates to promote the work they are doing and celebrate the changes that are being made due to colleagues raising concerns.

We also need to consider how outcomes are feedback to the concern raiser, how we thank colleagues for raising their concern and share the learning across the Trust to prevent similar situations

3. Staff Engagement

The staff engagement score has decreased from 7.31 in 2022 to 7.19 in 2023. This score is devised from looking at the responses to questions focusing on, motivation, involvement and advocacy. This score is a good gauge of how people in the organisation are feeling and includes the responses to the questions, I look forward to going to work and I would recommend my organisation as a please to work.

There is more work to do, but initial work **appendix two** indicates that we have a high proportion of colleagues choosing the middle option ie "sometimes" or "neither agree

nor disagree” therefore work needs to focus on understanding what would improve their work experience so that they enjoy work and would definitely recommended RDaSH to friends and family as a good place to work.

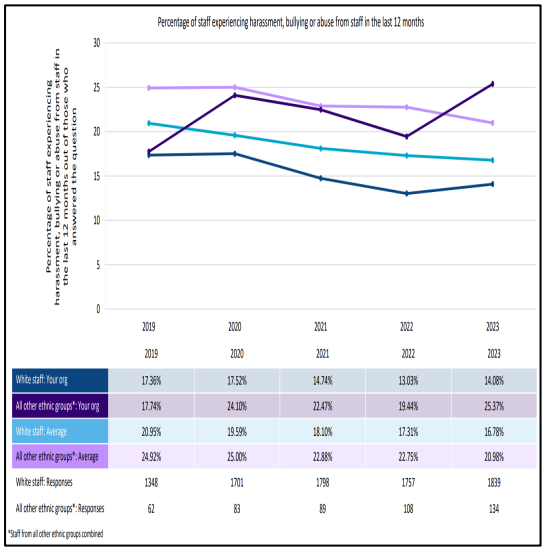
We can improve the retention of our staff if they enjoy coming to work and feel that their work is valued, this will be further explored as part of the People Promise Exemplar work**.**

Having seen a decline in responses in “we are compassionate & inclusive” and “we each have a voice that counts” it is not surprising that the overall staff engagement score has declined. It appears that the culture within the organisation is changing, people are reporting that colleagues aren’t kind to each other, they don’t feel supported by their manager and departments don’t work well together. A new governance structure was launched in January 2024 and it is hoped that this will have a direct positive impact on the 2024 results

Through leadership training that is due to commence in 2024/25 we can upskill managers and work with them to look at how they can support their staff in the workplace. Through the network groups we can share stories and take forward pieces of work that promote colleagues working together . The Organisational Development team have developed a Civility and Respect Workshop which has been delivered to 21 teams across the organisation, 316 colleagues, and a further 11 workshops are scheduled to take place.

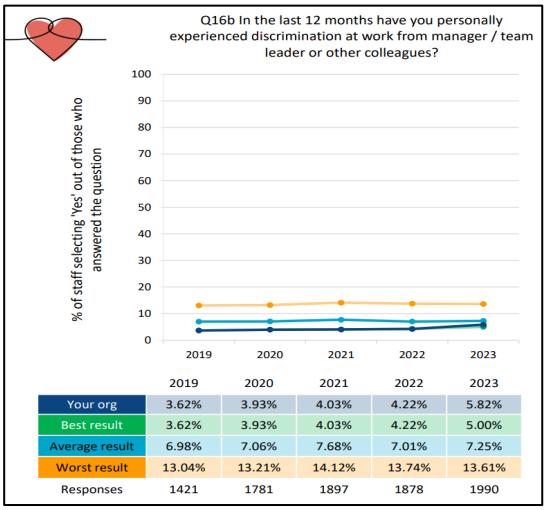
Jeanette Marvin, Head of Human Resources (Employee Relations and E-Rostering)

Appendix One

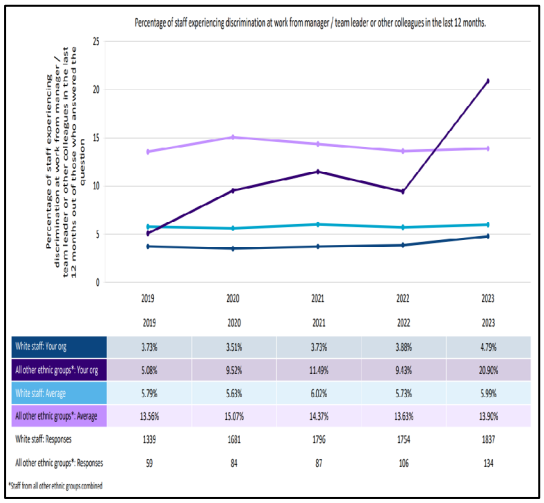


	2019	2020	2021	2022	2023
White staff: Your org	17.36%	17.52%	14.74%	13.03%	14.08%
All other ethnic groups*: Your org	17.74%	24.10%	22.47%	19.44%	25.37%
White staff: Average	20.95%	19.59%	18.10%	17.31%	16.78%
All other ethnic groups*: Average	24.92%	25.00%	22.88%	22.75%	20.98%
White staff: Responses	1348	1701	1798	1757	1839
All other ethnic groups*: Responses	62	83	89	108	134

*Staff from all other ethnic groups combined



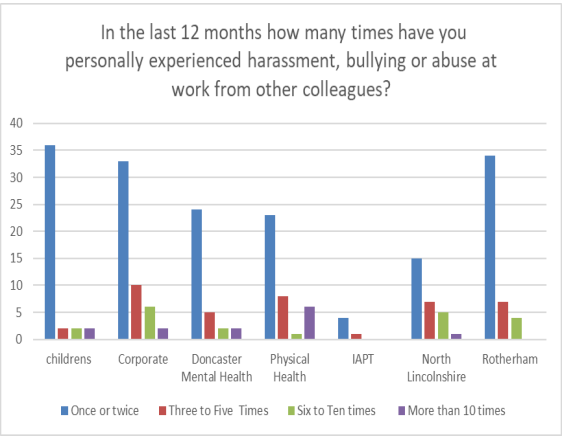
	2019	2020	2021	2022	2023
Your org	3.62%	3.93%	4.03%	4.22%	5.82%
Best result	3.62%	3.93%	4.03%	4.22%	5.00%
Average result	6.98%	7.06%	7.68%	7.01%	7.25%
Worst result	13.04%	13.21%	14.12%	13.74%	13.61%
Responses	1421	1781	1897	1878	1990



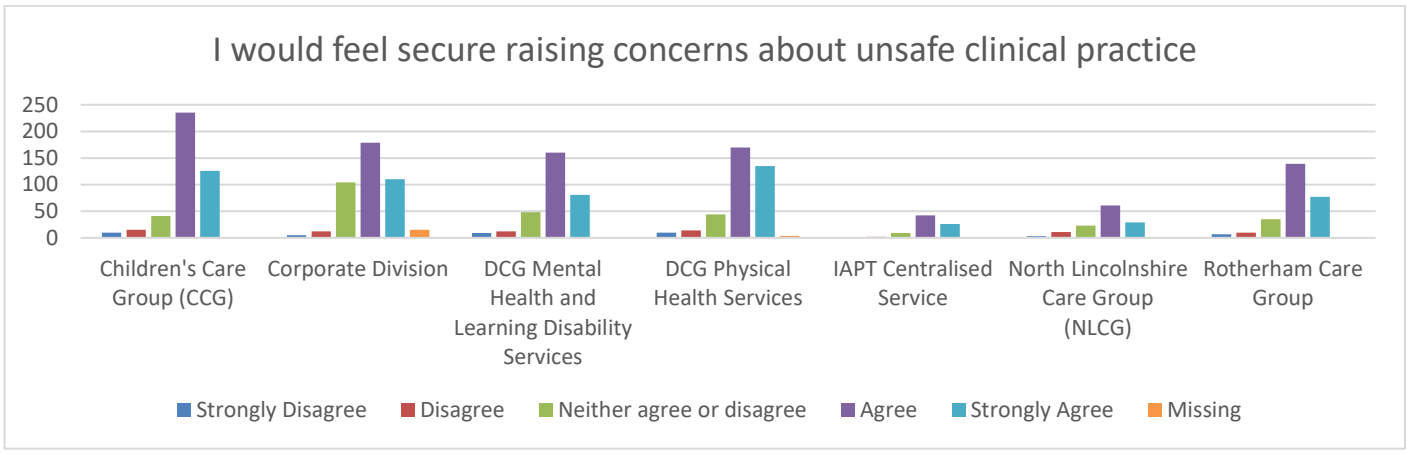
	2019	2020	2021	2022	2023
White staff: Your org	3.73%	3.51%	3.73%	3.88%	4.79%
All other ethnic groups*: Your org	5.08%	9.52%	11.49%	9.43%	20.90%
White staff: Average	5.79%	5.63%	6.02%	5.73%	5.99%
All other ethnic groups*: Average	13.56%	15.07%	14.37%	13.63%	13.90%
White staff: Responses	1339	1681	1796	1754	1837
All other ethnic groups*: Responses	59	84	87	106	134

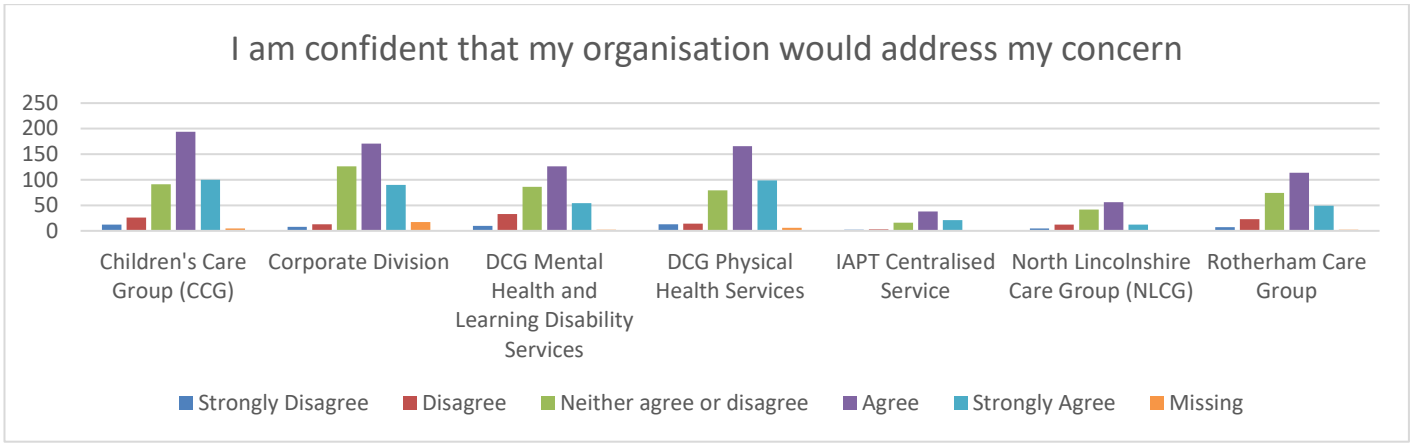
*Staff from all other ethnic groups combined

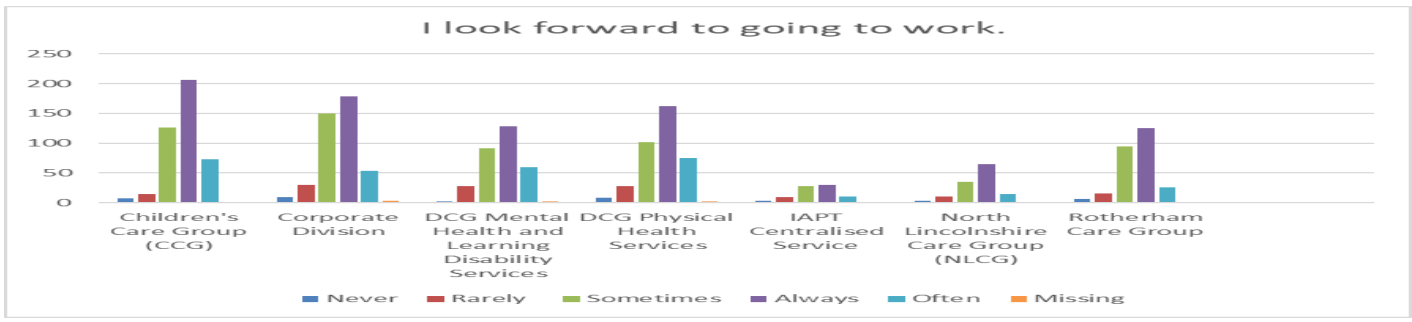
(Taxonomy reflects the organisation on 1 September 2023)

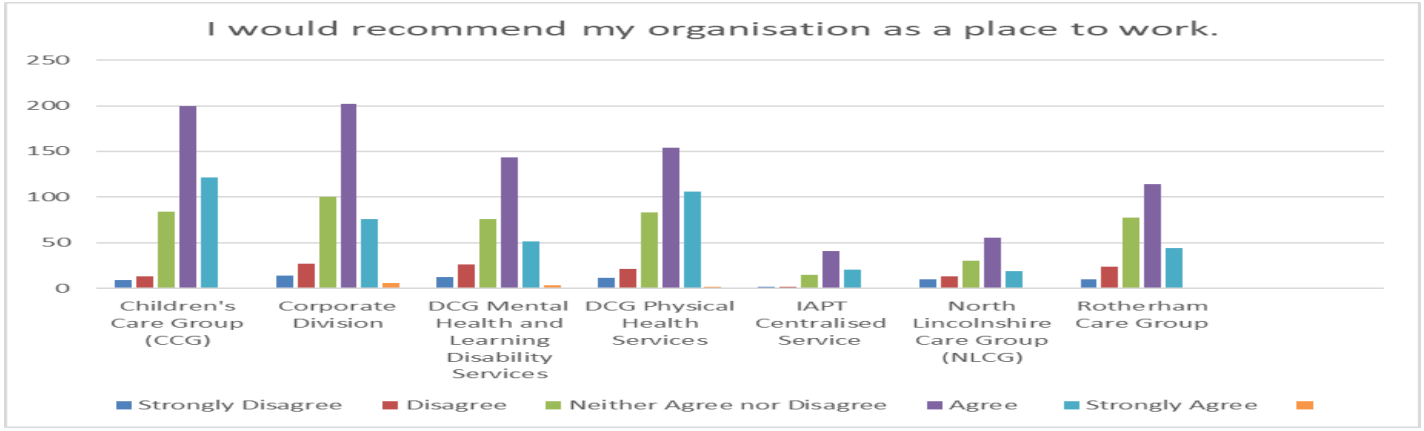


Appendix Two









(Taxonomy reflects the organisation on 1 September 2023)

Annex 4

Clinical leadership executive – February 2024 & March 2024

There have been two meetings of this body since the Board last met; these meetings focused on our own RDASH Operating Guidance for 24/25, as well as important work on expenditure plans, cost improvement work, and our future change function.

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.

February	March
DIALOG+ implementation	IQPR year-end delivery of the Big Six
Investment/cost pressures proposals	Care Groups' research priorities
Mandatory training – time reductions	Promises' prioritization and our change function
	Draft financial plan, savings, cost pressures and capital plan

In terms of decisions made, February's meeting approved changed arrangements for dementia diagnosis, escalated from delivery review. In March we agreed complaint responsibilities including changed arrangements for those submitted via MPs.

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 (April/May) we will consider in particular:

- Each of the 8 plans – notably finance, estate, P&T, and R&I which are not yet visible to members…
- How we best manage time, as part of concerted work to ensure we balance formal meetings/time with staff and teams/development work/change leadership
- Our approach to partnering at place, and the balance of leadership between parts of the Trust..
- How we support our work to meet core CQC standards
- Learning Half Days: a big deal in Q3

Toby Lewis, Chief Executive – 21 March 2024

Annex 5

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note –5 December 2023

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 5 December 2023. The main areas of discussion and subsequent action are outlined below.

Managing Director Report

This report highlighted issues at a national, regional and local level that might have implications for the Collaborative members. This was discussed and the key actions are as follows.

National Inpatient Quality Programme Launch – An overview of the programme was provided noting that shared learning was already in place across the providers in addition to work within organisations. Areas to note included national funding for the appointment of temporary project management post to work on behalf of the whole system, hosted by the ICB with a start date of January 2024. The post holder will support a self-assessment process which will be undertaken to inform the system plan and report through the System Strategic Delivery Group and link into work ongoing in provider organisations.

Specialised Perinatal Mental Health Commissioning – The Board and system will need to strengthen mechanisms for oversight of potential impact on South Yorkshire families, ensuring access to the services in Leeds, especially in light of the commissioning of additional beds. The Collaborative will support a review of the existing Maternal Mental Health and Perinatal Mental Health Steering Group led by the ICB. Decisions about the role and funding of case management are still underway.

Clinical and professional assembly – The Board reviewed plans for delivery of clinical and professional leadership to the Collaborative. The model proposed is a Clinical and Professional Assembly (the assembly); which will comprise a clinical reference group that reflects the MHLDA workforce and specialism rather than being represented by a single profession or place. The aim is to share innovation and learning at greater pace, support the development of the collaboration and help to build consensus to achieve our objectives. Representatives will be of a senior level and link in with existing forums, to further enable distributed leadership and referral to appropriate subject matter expert. The Managing Director will endeavour to ensure this is in place by the end of March 2024, and will seek support from the Board if necessary

Branding **–** Options were discussed to improve the branding of the Collaborative. It was agreed that this would be taken forward by Chief Executives.

Deliverables for the Four Objectives

A paper and presentation were shared regarding the four Collaborative programme objectives. Considerable progress has been made including agreement of the objectives and related outcomes. Areas of improvement work underpinned by coproduction were highlighted.

Actions included an emphasis on appropriate data sharing, development of integrated reports and communication of objectives and progress.

Future Commissioning Role for the South Yorkshire Provider Collaborative

Part One - A paper was provided to update the Board on progress to develop a proposal in respect of eating disorders, which had previously identified as an area where providing/commissioning responsibility might be shared in common across our Collaborative to achieve population benefits.

It was agreed that discussions among the Chief Executive's Group would continue, and no proposal will come to the Board until that consultation and co-production is completed. The aim will be to bring that proposal to the January Board en route to individual Trust Boards.

Part Two
The Board received a paper describing potential relationships between the Board and the specialised commissioning arrangements and requested that the Board consider the paper and suggest any additional matters for Chief Executives to consider. An update will be brought to the meeting in January 2024.

Parity of Esteem
Achieving parity of esteem as a South Yorkshire Integrated System was discussed with reference to a potential model that could be utilised. The framework will be developed further, with a view to working with system colleagues to identify a small number of focussed areas where the biggest difference to parity of esteem might be made.

Collaborative Contribution to the System Efficiency Programme
The Board discussed general principles around the approach to the system efficiency programme which were essential to ensuring parity of esteem in this area. The Board was asked to consider two areas of work that the Collaborative could effectively focus on at system level to generate benefits – both in term of quality and efficiency

- out of area placements with a specific focus on services where there is no in district provision,
- fragile services, with a different approach to workforce – shared between some or all partners. This approach has been taken to the ICB Senior Leadership Executive (SLE) and will be considered further at the next SLE.

Specialised Commissioning Update
The Board received a paper highlighting key agenda items from the SYB Specialised Commissioning Provider Collaborative Partnership Board meeting on 20 November 2023, represented by all partners from the Adult Secure, CAMHS Tier 4 and Adult Eating Disorders Provider Collaboratives and in addition, brought to the attention of the Board items for escalation or risk to the system.

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	NHS Professionals	**Agenda Item**	Paper M
Sponsoring Executive	Nicola McIntosh, Executive Director of People & OD		
Report Author	Nicola McIntosh, Executive Director of People & OD Carlene Holden, Deputy Director of People and Learning Izaaz Mohammed, Deputy Director of Finance		
Meeting	Board of Directors	**Date**	28 March 2024

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

1. The Board is asked to consider the benefits for agreeing to contract with NHS Professionals, recognising the TUPE transfer that such a contract requires.
2. Consider the rationale provided about new ways of working (bank workers really being part of RDaSH) after implementation and why this transfer will facilitate this.

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?)

January 2024 Board – adapted paper

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

The Board is asked to:

x	**AGREE** to contract during 2024/25 with NHS Professionals, recognising the TUPE transfer that such a contract requires, as well as the new ways of working about allowing bank workers being part of RDaSH teams.
x	**REQUIRE** the executive group, executive sponsor and Chief Executive to establish implementation arrangements as outlined – escalating any elevated concerns to the Board through routine management reporting.

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

Trust Risk Register	x						
Board Assurance Framework	x						
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)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

NHS Professionals

1.0 Introduction

1.1 This paper covers a topic of considerable and twofold importance: the wellbeing and employment of more than 5% of our current employees; and the best way to secure flexible workers for the Trust now and in the future.

1.2 The prior Board meeting accepted that the status quo arrangement could not be retained. The Board is being invited to agree on a preferred course of action and to direct any additional mitigations to risk beyond those identified in the paper.

2.0 Situation

2.1 We want to find a long-term solution for managing the teams of people who we use to manage our flexible and sometimes temporary workforce planning arrangements (known as our bank workers). Currently they are not being managed consistently and we all acknowledge that we wish to find a sustainable option for them and us.

2.2 There are a number of things we could choose to do: -

1. Nothing, which we do not think is the right answer, as there is inconsistency in how we manage bank workers, how we communicate with them, how we ensure that they are MAST compliant and our ability to forward plan their work schedules.

2. Appoint NHSP as the preferred supplier to manage these bank workers, since they are part of the Department for Health & Social Care, so profits go back into the NHS. NHS England and ICB trusts advocate them, high standards exist to ensure bank workers are MAST compliant and they utilise health roster so forward planning is possible. Managers have informed us that they feel more confident with more support from an onsite management team.

3. Create a procurement process to find a third party outsourced supplier. Soft market engagement suggests that a single alternate supplier will not have the reach across professionals that we require, and as such we will need a network of providers. This is inherently complex and involves sensitivities about non-NHS provision and maintenance of terms and conditions.

4. Manage our own bank workers with an internal team, which would require us to appoint dedicated colleagues on each site to manage the bank across the 24 hours a day. Sheffield Health and Social Care do this and they have a AFC band B8a 0.5 wte clinical lead, AFC band 7 1 wte manager, 4 wte AFC band 4, 7 days a week. This costs approximately £220,000 per annum. We might expect that our resource need is slightly higher, perhaps closer to £300,000 given our larger scale than our neighbour.

5. Seek to create a collaborative bank arrangement with neighbouring NHS providers. During February, mindful of concerns voiced within the Board, we have explored the feasibility of this arrangement. Within South Yorkshire there is no appetite to take up this option. SCH use NHSP, as do acute providers locally. SHSC are committed to their in house model outlined above. SWFT are part of the West Yorkshire Collaborative. A collaborative bank is mooted across the whole of HNY ICB, but it seems unlikely that enrolled staff will be available to cover the geography we require. It is not considered that this is a realisable near term option.

2.3 This paper is drafted on the basis that only an in-house or NHSP option is truly feasible. The expertise and reach of NHSP are the key distinguishing features which suggest to the author, and in peer challenge to the Director of Finance and Chief Executive, that the Board should take this option.

2.4 Subsequent to February's Board, we have met with NHSP at Chief Executive and senior director level. This paper is informed by their advice about past successful and less successful transitions.

2.5 It is recognised that both the idea of transfer, and the protracted nature of our discussions, have occasioned some staff concern. Briefings to Trade Union colleagues have taken place, focusing on reconfirming the maintenance of terms and conditions for those colleagues currently employed by the Trust who would be subject to TUPE under this option.

2.6 The temporary staffing solution offered by NHSP covers the following key components:-

- A blended on-site and off-site fully managed service 24 hours a day 7 days a week.
- 100% compliant flexible workforce across all skill sets (Nursing, Medical, Admin & Clerical, AHPs, Research Professionals, Estates & Ancillaries).
- Strong governance and compliance.
- Interface with our current Rostering solutions.
- Work schedules so bank workers have more predictability and visibility of their shifts.

2.7 In considering the way forward, we would suggest we explore how the options best deliver 3 key benefits:

- A decrease in total agency expenditure, already emerging for medics.
- Improved fill rates and a reduction in unfilled shifts
- Recruitment programmes to attract more high quality staff

3.0 Current state

3.1 In late 2022 RDASH had over 800 registered bank workers. During 2023 we have transitioned many of these bank workers to become RDaSH employees. There remain 500 workers on the bank, of which 249 have been active in the last 12 weeks.

3.2 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 Trusts offer a premium payment.

3.3 Following the Trust restructure and the move to the 23 Directorates in late 2023 we continue to have a mixed economy with the management of our bank workers. Centrally, the very small office-based procurement team support the management of the following banks:-

- Administrative & Clerical
- Nursing – Inpatient Only

3.4 Individual directorates maintain the responsibility for the following banks:-

- Estates & Facilities
- Childrens – Vaccination & Immunisation
- Community Nursing Adults
- Community Nursing Childrens
- AHP

3.5 This distributed model leads to inconsistencies in the management of bank workers, including 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 as out of hours the central service managed by the Procurement Team offers a Monday-Friday, 9am-5pm service. This 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.

4.0 Assessing our options

4.1 If the Board accepts that the status quo is not an option, and that either a public sector collaborative bank, or an outsourced network of supplier, is undesirable and/or unachievable, we need to appraise two options:

- An in house option
- Using NHSP for all professions (we currently use them for medical bank)

4.2 It is important to be clear that NHSP do not require an exclusivity arrangement with the Trust, but in order to secure the benefits outlined, it is unlikely to be efficient to offer multiple options.

4.3 It is apparent that using NHSP will be more expensive than an in-house option. Accordingly, other benefits – either in terms of deliverability or reach - need to outweigh this additional cost. This additionality is achieved by anticipating a greater fill rate arising from NHSP's reach and by expecting greater reliability and resilience in using an established supplier able to maintain standards and oversight.

4.4 The cost equation for NHSP is set out below.

NHSP have provided the Trust with projected savings information based on current levels of demand and spend. The current in house bank is administered

with a combination of bank and agency workers, migrating to NHSP would mean that these costs cease. NHSP charges consist of a charge per bank hour worked of £1.44 per hour, and an annual managed service charge of £48k. The migration would also result in an increase in VAT charges. The total net annual saving is estimated to be £149k, a breakdown is provided below:

	£k
Annual saving per NHSP assumptions	750
In house bank administration savings	79
NHSP charges	- 401
VAT charges	- 279
Net Annual Saving	**149**

4.5 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 VAT related to the Estates and Ancillaries staffing group, which is not an exempt category.

4.6 It is recognised that the saving outlined above, contains both savings inherent to the transaction, and improvement from agency reduction. The latter is already assumed in our financial plan and cannot be duplicated here as cash released. The former can be and is £294k per anum.

4.7 NHSP are typically achieving a fill rate of above 93%. The current RDaSH fill rate for comparison is not calculated, because of the weaknesses of our data, but professional advice suggests that it is significantly lower. A key consideration for the Board, and management, is the improvement in resilience that such improvement in rate-fill suggests.

4.8 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 areas such as 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 our waiting lists and fluctuations in demand.

4.9 Concern has been raised that an NHSP option adversely impacts terms and conditions. The table summarises differences between:

- Substantive RDaSH employees
- RDaSH employees under TUPE to NHSP
- New employees joining NHSP

	RDaSH employee not NHSP	NHSP person who has tuped from RDASH Bank	New person who joins NHSP after 01/04/24
Sick pay	only SSP where earnings criteria applies	only SSP where earnings criteria applies	SSP
Mat pay /Pat pay	only SSP where earnings criteria applies	only SSP where earnings criteria applies	SMP/SPP
Unifrom costs	free	free	free
DBS	free	free	free
Payslip	access on esr	access on esr	Online SBS
Pension	AFC	AFC	Up to 6% contribution
Overtime pay	AFC OVER 37.5 HRS	AFC OVER 37.5 HRS	does not exist
Policies	legislation determines	legislation determines	legislation determines
Suspension	Average of the previous 3 mo	Average of the previous 3 months	no pay
Timesheets and pa	Monthly	weekly	Weekly
Training	paid by RDaSH	paid by RDaSH	paid by RDaSH

4.10 It can be seen that there are not obvious detriments to established colleagues, and indeed the move to weekly pay may be seen as a benefit by some. There are terms and conditions differences for new enrollees which we need to decide are consistent with our institutional values.

4.11 Bank workers generally will have the additional benefit of being paid for their ongoing training. They will be able to plan and schedule shifts into the future so they will achieve a better work life balance as well as plan their leave in advance.

4.12 They will have one account manager for all queries who will be based on each site 7 days a week. The intention is that this will still allow them to feel a valuable part of RDaSH whilst still enjoying the flexible working options that they enjoy.

4.13 A summary of the benefits sought via NHSP is tabulated below.

24 Hours / 365 Days a Year, Fully resourced 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 • DBS checked
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 • Interface with the Trust's e-rostering system for non-medical areas • Disaster recovery / business continuity • ISO 9001 accredited; Cyber-Essential Plus accreditation

4.14 After careful consideration, during Q4, the management advice remains that the slight cost delta of NHSP is worthwhile for the dual gains of resilience and the bank employee experience of a professional services partner. The Trust's workforce strategy must entail greater use fo flexible working, and we consider that a partner, in this case NHSP, offers us the greater likelihood of being able to deliver that gain.

5.0 Success measures

5.1 If the Board supports the transition, then we will work to achieve full deployment not later than October 1 2024. Transition in practice is three projects in parallel:

- Consultation and then TUPE transfer of all established bank workers within RDaSH, in all disciplines, to NHS Professionals
- Establishment of new working practices, both for those employees, and for RDaSH managers in working with the new bank regime
- Joint working to increase the take up of bank shifts, and remove use of agency staffing, both before, during, and after transfer

5.2 The first project is a defined one with established parameters. It will be led by the Director of People and OD and their team. It is a discreet and boundaried piece of work, which replicates what has been done across a number of NHS organisations. Both the Trust, bank employees, and their nominated representatives, will need to be available over a time period which includes the long summer holiday.

5.3 New working practices is a more distributed and nuanced project which involves both managers using bank workers currently, and those who rarely do. This may require some managers to better systematise their use of temporary staff and to predict and plan their use in advance. This work will be led by the Workforce Project Lead, who is based full time with the Nursing and Quality directorate.

5.4 The Trust and NHSP share a desire to reduce agency costs. Necessarily these benefits need to be secure in part before the transfer date. Authorisation and approval models at the Trust change in Q1, and this streamlining should support the new working practices required in Q3. This work is being project managed by Will Holroyd.

5.5 Post implementation is key to facilitate new ways of working as the care and ownership of our temporary workforce has to be just as important to us culturally as our own substantive colleagues do. They will feel part of the RDaSH teams and be highly respected and valued by all who work with them.

5.6 The Assistant Director of Nursing will be the operational and clinincal Trust lead for NHS professisonals and will therefore work with the Executive Director of People and OD through the implementation phase so that the new ways of working post impelemntation are sustained.

5.7 Service Level agreements will be established with NHS Professionals and signed off and reviewed monthly by the Chief Executive, Finance Director and POD Director, throughout 2024 and then quarterly into 2025 and beyond.

5.8 NHSP have recently had successful implementations and we have spoken with them about the learnings from these, which has resulted in us focusing particularly upon the importance of a robust project plan, clear ownership, exceptional commuication and partnership working throghout and detailed regualr delivery reviews. We will ensure that good working relationships between NHSP teams and RDaSH teams are established and continue throughout. .

6.0 Implementation Risks

6.1 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.

7.0 RDASH Mitigations

7.1 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 within this document.

8.0 NHSP Mitigations

8.1 NHSP are experienced in delivering projects of this kind and their approach reduces risks by utilising an implementation methodology proven to successfully deliver go-lives on schedule and one that refines incorporating lessons learned from numerous implementation projects.

8.2 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.

8.3 In accordance with PRINCE2, risks and issues logs are maintained, reviewed and updated on a weekly basis by the NHSP and the RDaSH project teams. One result of having undertaken many such implementations is that most significant risks are common to all implementations and we will work together to ensure that these are worked through on a weekly basis.

8.4 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.

9.0 Resource Plan – Delivery Stage and Post Implementation

9.1 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.

9.2 Post Implementation and smotth integration of the news ways of workign are fundamental to allow us to ensure that bank workers feel part of the whole worfkforce at RDaSH. Even with a commitment to reduce vacancies we still have to utilise a 9.3 flexible workforce in the future and the bank workers staff survey advsies us that we still have work to do inorder to allow them to feel part of the RDaSH teams. We are equally committed to ensure that they are part of the multidisciplinary teams that allow us to serve our populations with the care they need.

10.0 New Ways Of Working

10.1 The implementation of this solution will require managers of teams to change their behaviours and learn how to operate using new processes and procedures.The onsite client relations team from NHSP 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. Managers will feel confident that NHSP will deal with queries that they have historically had to deal with, thus freeing up more time for them.

10.2 Over and above formalised meetings and reporting 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. When we have spoken with other Trusts who have recently done this, we know that this close communication and ongoing dialogue has proved to be very effective.

10.3 The RDaSH project Team and NHSP project team will not walk away as soon as the implementation and TUPE transfers have been completed. This work is the start of a key partnership and stakeholder relationship that will last for many years between RDaSH and NHSP.The Assistant Director of Nursing will be involved in the Implementation Phase as well as lead on the new ways of working and post impelentation will be the Trust lead to work with NHS professionals ensuring that the benefits are enhanced and the bank workers all feel valued in the work that they do at RDaSH.

11.0 Recommendations

The Board of Directors are asked to:

1. **Agree to contract during 2024/25 with NHS Professionals, recognising the TUPE transfer that such a contract requires, as well as the new ways of working about allowing bank workers being part of RDaSH teams.**

2. **Require the executive group, executive sponsor and Chief Executive to establish implementation arrangements as outlined – escalating any elevated concerns to the Board through routine management reporting.**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Draft Finance, Savings and Capital Plan 24/25	**Agenda Item**	Paper N
Sponsoring Executive	Ian Currell, Executive Director of Finance & Performance		
Report Author	Izaaz Mohammed & Ian Currell		
Meeting	Board of Directors	**Date**	28 March 2024

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

In line with NHSE timescales draft plans were submitted to NHSE on the 21 March and final plans are due to be submitted on the 5 May. The draft plans show a deficit in 24/25 of £3.6m. It is suggested that Board discusses how we can develop these plans from being draft to being ready for approval by the 5 May. In particular, the current level of financial risk (slide 12) and the level of development of the savings plans (slides 14 to 18). The capital plan 24/25 has been split in to 2 phases. Phase 1 (slide 21) commits £1.7m of the total £6.6m available and is ready for approval at this meeting.

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

Business as usual	x

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

N / A

Recommendation

The Trust Board is asked to:

x	**RECEIVE** the 24/25 Draft Financial Plan and **AGREE** to set budgets based on the draft plan with an update in May based on the final approved plan.
x	**RECEIVE** the 24/25 Draft Savings Plan and **NOTE** the change of emphasis to Trust wide schemes and NOTE the remaining gap to target to be identified before the May Board.
x	**RECEIVE** the 24/25 Capital Plan, **NOTE** the split between Phase 1 and Phase 2, **APPROVE** Phase 1 of the Capital Plan, **NOTE** Phase 2 will be submitted to the Board for approval in May.

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 – Financial Stability						
System / Place impact	x							
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)

None

Draft Finance, Savings and Capital Plan 24/25

Ian Currell
Director of Finance
28 March 2024

Contents

Draft Financial Plan 2024

Recap of 23/24

- Plan - £6.2m deficit. Significant deterioration from previous years.
- Forecast outturn - £3.8m deficit, includes £3.5m system support.
- Why the improvement? Better budgetary control, achieving savings target, slippage and vacancies.
- Savings target - £10m, forecast FYE delivery - £9.1m. Fantastic achievement.
- Capital Plan - £6.6m, forecast spend c£7m (utilised available system slippage). Prior to 22/23 not managed to spend capital allocation in full.

Timescales

- Final planning guidance expected this week
- Draft plan submitted to NHSE 21 March
- Draft plan approval RDaSH Board 28 March
- Set budgets based on draft plan
- Final plan to NHSE estimated 5 May
- Update budgets based on final plan
- Internal directorate budget sign off with CEO and DoF in May.
- Final Board approval 30 May

Key assumptions - ICB

- The SY ICB has asked providers to use the 23-24 outturn, adjusted for any material non recurrent items.
- Inflation funding of 0.8% has been passed down to providers (1.9% inflation less 1.1% tariff efficiency)
- A reduction in funding of £2m has been applied to the starting point for convergence factor.
- Providers to assume an overall efficiency of 3%.
- Growth held centrally by ICB for draft plans. Further discussion for final plans.
- The above gave a planned £3.6m deficit we have been asked to work to

Key Assumptions - internal

- Directorate budgets in recurrent balance in 23/24
- Savings target of 3% (£6.7m)
- 0.5% CIP applied to all directorates, with 2.5% to be delivered via trust wide schemes.
- £4m cost pressure reserve.
- Additional non recurrent funding for ADHD (£1.75m).
- Assumes full cost funding of specialised services contract (estimated risk £1.6m) – assumption consistent ICB wide
- Vacancy factor of 2.5% applied to all directorates.
- All staff budgets actively recruited to.
- Draft planned deficit £3.6m. Further improvement may be required by ICB.
- Level of income from ICB still to be confirmed.

Draft Plan 24/25

Draft Plan	£m
Recurrent 23-24 position	-4.5
Additional AED income assumed	1.6
Inflation uplift	3.5
Inflation cost	-4.4
Tariff efficiency 1.1%	-2.0
CIP to match tariff deflator -1.1%	2.5
Additional CIP - 1.9%	4.2
Convergence adjustment	-2.0
Growth funding	0.0
Cost pressure reserve	-4.0
Slippage on cost pressure reserve	1.1
NR ADHD funding	1.8
NR spend on ADHD	-1.3
Contingency	0.0
Total	**-3.6**

The draft plan takes the 23-24 recurrent outturn of a £4.5m deficit and then applies the SY ICB planning principles referenced in the previous slide.

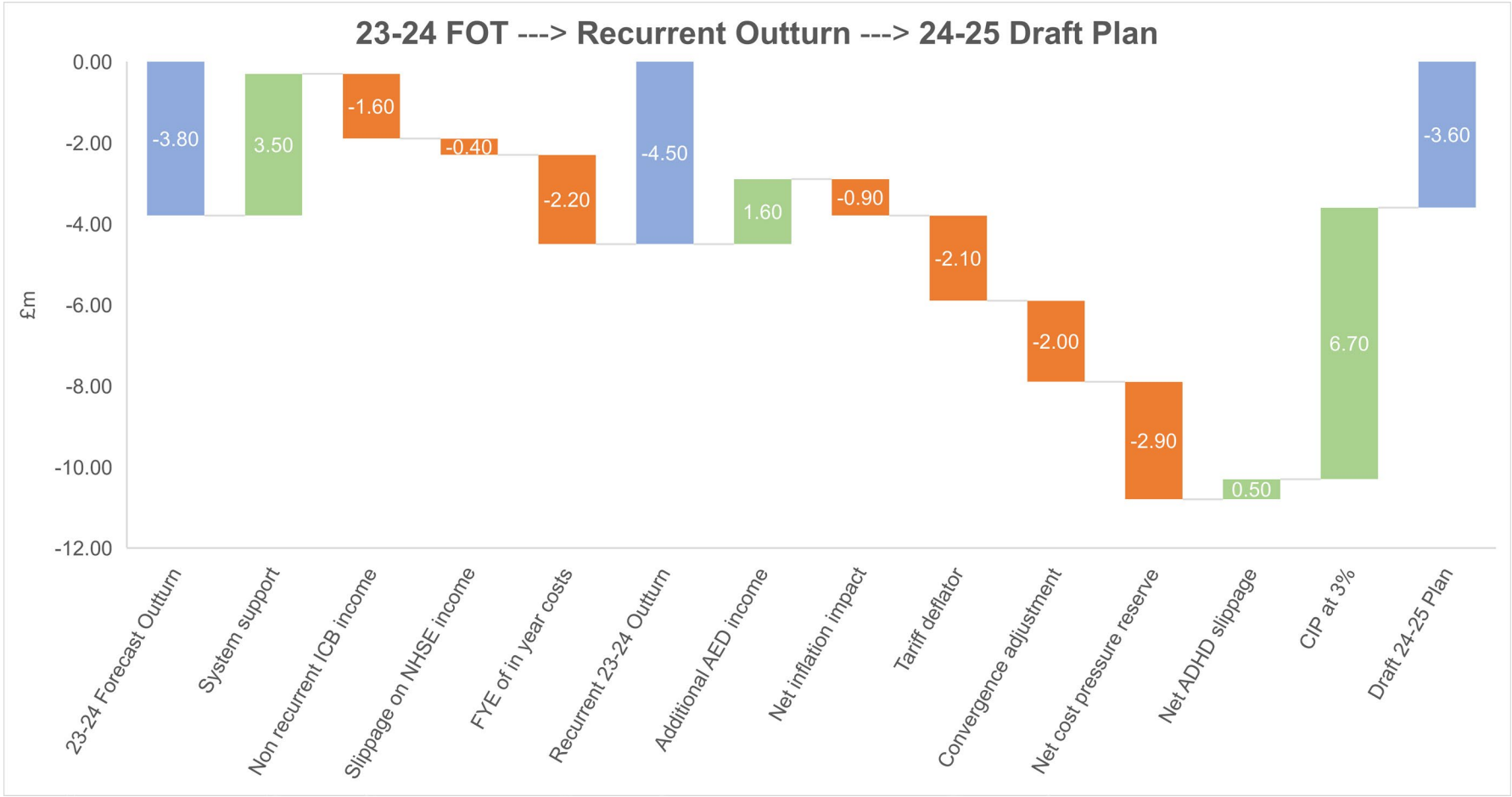
In addition to this, our draft plan includes the following items:

- Inflation pressure of £0.9m – known risk linked to the make up of our costs vs the national formula.
- A cost pressure reserve of £4m, with assumed slippage of £1.1m.
- Slippage on ADHD investment (£0.5m)
- Assumption that any spend above the contract on AED is offset with additional income.

Draft Plan 24/25

Draft Plan 2024-25	£'000
Operating income from patient care activities	205,644
Other operating income	10,248
Employee expenses	(172,980)
Operating expenses excluding employee expenses	(43,502)
Finance income	756
Finance expense	(1,426)
PDC dividends payable/refundable	(1,932)
Adjust PFI revenue costs to UK GAAP basis	(411)
Adjusted Financial Performance Surplus/(Deficit)	**(3,603)**

Waterfall from 23-24 FOT to 24-25 Draft Plan



Draft Plan 24/25 – Risks & Benefits

- CIP – CIP target of 3% (£6.7m) challenging to deliver.
- Inflation pressure – Although a pressure of £0.9m linked to current inflation assumptions is included in the draft plan, there will be a further pressure if pay and non pay inflation exceeds current planning assumptions.
- AED income and spend – The draft plan assumes any additional spend above the AED contract value is offset with additional income, this figure was £1.6m in 23/24, and is subject to NHSE agreement.
- Income risk – confirmed final allocations not received from ICBs.
- Contingency – The draft plan includes no central contingency to offset any shortfall in the delivery of the CIP programme or any of the other risks outlined above. This is a change from previous years.
- Growth funding – currently held at ICB, developments to be managed by growth conversations to come.

Draft Plan 24/25 – Risks & Benefits

	Draft Plan	Risks & Benefits	Total
Recurrent 23-24 position	-4.5	0.0	-4.5
Additional AED income assumed	1.6	-1.6	0.0
Inflation uplift	3.5	0.0	3.5
Inflation cost	-4.4	-1.0	-5.4
Tariff efficiency 1.1%	-2.0	0.0	-2.0
CIP to match tariff deflator -1.1%	2.5	-1.2	1.2
Additional CIP - 1.9%	4.2	-2.1	2.1
Convergence adjustment	-2.0	0.0	-2.0
Growth funding	0.0	1.5	1.5
Cost pressure reserve	-4.0	0.0	-4.0
Slippage on cost pressure reserve	1.1	0.9	2.0
NR ADHD funding	1.8	0.0	1.8
NR spend on ADHD	-1.3	0.0	-1.3
Contingency	0.0	0.0	0.0
Total	**-3.6**	**-3.5**	**-7.1**

Draft Plan 24/25 – Recommendations

- Receive the 24/25 draft plan.
- Agree to set budgets based on the draft plan, with an update to reflect the final plan in May.

Draft Savings Plan 24/25

Recap of 2023/24

- Set a target of £10m of recurrent savings.
- Predicting savings of c£9m in 2023/24.
- Excellent achievement and a real step change from previous years.

Draft Plan 2024/25

- Target of £6.7m (3%).
- Change the emphasis of delivery toward focused workstreams rather than blanket targets on budgets.
- Current assumption is 0.5% savings target to all and remaining savings will be delivered through specific Trust wide improvement projects.

Draft Savings Opportunities

Savings Project	Scope	Total Trust Spend	Potential Savings
Agency	Reduce	£8,400,000 full year forecast	£2,100,000 down to cap
Transport	Reduce secure transport & taxi use	£882,337 Secure month 11	£250,000 secure £100,000 taxi
Bed Base Review	Review of bed base across the Trust	-	£535,000 Estimate
Out of Area Placements	Explore how we share the benefit of improvements	-	-
Estates (Property & Energy)	Reduce energy consumption & maximise property management	*TBC*	£250,000 Estimate
Procurement	1% savings on non-pay	£24,000,000 Estimate non-pass through costs	£240,000 1% Savings
Telephony Review	Renew contracts and consider longer term comms requirements.	£130,000 Mitel £300,000 BT/EE	£50,000 Estimate
Pathology	Explore consolidating three locality contracts into a single provider.	*TBC*	£50,000 Estimate
Pharmacy	Consistent TTO policy, and other related savings to be explored	£1,441,150 Drugs £1,428,815 FP10s	£15,000 1% Savings
Income Streams	New income	-	-
0.5% Budget Reductions	All budgets to reduce costs by 0.5%	£205,661,144	£1,028,305
		Total savings	**£4,618,305**
		Gap to Target	**-£2,081,695**

Savings Plan 24/25 – Recommendations

- Receive the 24/25 savings plan
- Note the change of emphasis to Trust wide schemes.
- Note the remaining gap to target, to be identified before May Board.

Draft Capital Plan 24/25

Draft Plan 24/25

- 24/25 Capital allocation is £6.6m
- Clinical Leadership Executive has supported £1.7m of capital investment for 24/25 – these are phase 1 schemes which are either a continuation of existing schemes, or high priority.
- Phase 2 to be considered at May Board, linked to wider clinical risk assessment in April to ensure all schemes are considered. We have commissioned teams to undertake a top-to-bottom assessment of estate related patient and staff risk so that any future capex is determined against a backdrop of underlying risk profile.

Capital Plan 24/25 – Phase1

Capital Scheme	£k
Completion Of Sandpiper & Osprey Ward Refurbishments	650
Anti-Ligature Door Replacements To Mulberry	340
Great Oaks Phase 3 Design Costs	50
Amethyst Lodge Minor Upgrades	15
Opal Centre Reconfiguration Costs	20
ADHD/ASD Service Agile Hub	8
Reconfiguration Of 1 Bungalow At Emerald Lodge	30
Kingfisher Bedroom Door Replacement Programme	165
Acoustic Improvement Works At St. Nicholas House & Crystal	70
Reconfiguration Of 2 Bungalows At Emerald Lodge Phase 1	50
Reconfiguration Of 2 Bungalows At Emerald Lodge Phase 2	50
Building Management System	50
Wi-Fi Infrastructure Replacement	40
Integrated Risk Solution Software	187
Total Phase 1 Schemes	**1,725**

Capital Plan 24/25 – Recommendations

- Receive the 24/25 Capital Plan
- Note the split between phase 1 and phase 2
- Approve phase 1 of the capital plan
- Note Phase 2 will be submitted to Board for approval in May

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Preparedness Briefing Effective Domain	**Agenda Item**	Paper O
Sponsoring Executive	Jude Graham Director of Psychological Professionals and Therapies, Acting CNO		
Report Author	Kate McCandlish Deputy Director of Nursing Laura Powell Compliance Officer		
Meeting	Board of Directors	**Date**	28 March 2024

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

This paper is the fourth in a series. The focus is on the domain journey to good. The Board will wish to explore the calibre of evidence in place currently and the recommendations for improvement.

A review more generally of our work on CQC readiness will take place with the incoming CNO, MD, director of PPT, COO and CEO during early May.

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

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	**RECEIVE** the latest CQC preparedness paper in a series to Board
x	**CONSIDER** the eight recommendations identified in this SBAR

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

Appendix (please list)

None

Are we EFFECTIVE?

Situation

This paper presents the fourth 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 Requires Improvement for EFFECTIVE in 2019.

What does the CQC mean by effective?

*People and communities have the **best possible outcomes** because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring **best practice** is part of everyday work.*

Regulatory framework

The following regulations frame how CQC will assess the effectiveness of an organisation:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 14: Meeting nutritional and hydration needs
- Regulation 17: Good governance

Assessment

How do we know we are providing effective care?

The Trust has a range of methods which provide assurance against the essence of the CQC quality statements for Effective. Some of this assurance is internal within Care Groups and some is reported through the Trust governance mechanisms, including Quality Committee, People and OD committee, MHA Legislation Committee, and Trust Board.

The table below details examples of these, with examples of supporting data where relevant.

CQC EFFECTIVE domain: quality statements	Examples of assurance
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.	• Staff Survey • Complaints and compliments • Care plan audits and monitoring of care plan completion • CQC MHA reviews • Quality Peer Reviews • Trust Clinical Audits • Friends and Family Test • Discharge planning • Handover processes • Carers assessments
72 hour follow up post discharge from acute adult mental health wards is reported monthly via the IPQR to Board:	

Data as at 31/1/24						
IPQR indicator	**Metric**	**Actual**	**Value**	**QTD**	**TYD target**	**YTD**
OP12	People discharged from MH inpatients followed up in 72hrs	53/58	91.38%	91.00%	>=60%	87%

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.	• Consent • CQC MHA reviews • MHA audits • Quality Peer Reviews • Ensuring Protected characteristics information is gathered on admission to ward/acceptance to service • MDT meetings • Catering audits and feedback on food provision

Clinical Audit outcomes position as at 4/3/24 is shown in the table below:

Clinical Audit position as at 4/3/24		**Audit Outcome**				
	Work commenced 2023/24	**Top performing/ Outstanding**	**Good**	**Requires Improvement**	**Inadequate**	**Not fully completed therefore outcome not yet agreed**
Trustwide Audit 2021/22 2022/23 carried over	6	1	5	0	0	0
Local audit 2022/23 carried over	1	0	1	0	0	0
Key audits carry overs 2022/23	5	0	2	3	0	0
Key audit 2023/24	3	0	0	0	0	6
Local Audits 2023/24	7	0	2	0	1	4
National Audits	16	1	1	3	0	11

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.	• Audits • MHA audits • CQC MHA Reviews • Care plan audits and review • Consent • Discharge planning
We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support	• Health and well-being feedback • Quality Peer Reviews • Complaints and compliments • Staff Survey • Freedom to Speak Up information. • Healthy Hospitals programme

QUIT Performance target- *Increase % Inpatients who are identified as a smoker AND had a length of stay ≥ 1 day who were 'prescribed' Nicotine replacement therapy within 72 hrs of admission.*

- KPI target is 45%

The graph below shows the increase in compliance against the QUIT performance target between Q3 2022/2023 and Q3 2023/2024. Q3 2022/2023 achieved 41.9%. Q3 2023/2024 achieved 67.6%.

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.	• Care planning review • MDTs/PIPA • Discharge planning • Outcomes • Audits • Benchmarking • Service Accreditation Schemes
We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.	• MCA audits • MHA audits • Best interests' framework • Care plans • Inclusion of family and friends • Complaints and compliments • CQC MHA review • Quality Peer Reviews

How do we know this to be true? How do we correlate this?

- The main set of data, or one version of the truth has been summarized in the Integrated Quality Performance Report is reported monthly to Board. This includes indicators from the Nationally Mandated Long Term Plan targets and locally/internally agreed indicators. These include MDT following seclusion, suspected suicides, infection control, MUST and falls assessments, and waiting times.
  Breaches to targets are reviewed and actions taken to address these, for example a manual trawl of records was undertaken by Physical Health Care Group and ongoing work with Informatics/Clinical Systems to address why Malnutrition Universal Screening Took (MUST) is showing as being below the Trust's own target.

- Clinical audit activity and outcomes is reported quarterly to Quality Committee, and monthly in Care Groups and Medication Management Committee. This includes national and local audits. The establishment of a centralised meeting to mitigate against the risks of delays in progressing action plans and closing audits has enabled good progress since it commenced in October 2023. To provide a "look back" the Clinical Effectiveness Team and the Care Group Nurse Directors will discuss proposed Clinical Audit Activity for 2024/25 and finalize the Forward Programme by 30th March 2024.
- Mental Capacity Act audits are undertaken annually and the outcomes of the action plans are reported to Mental Health Operation Group and Mental Health Legislation Committee. Actions resulting from the audits are the responsibility of care groups to undertake.
- 360 Assurance undertook an audit at the end of 2023 around consent to invasive treatment for physical health; the action plan from this is currently in draft.
- To ensure learning from deaths and ascertain if safe and effective care was provided, the Trust has a mortality governance process in place. The Mortality Operational Group meets weekly to ensure that reported deaths are considered in a timely manner and to identify what appropriate process is required to investigate any deaths. This group reports to the Learning from Deaths and Prevention of Future Deaths Group which meets bi-monthly to maintain oversight of all expected and unexpected deaths and resuscitation events.
- To ensure learning from all Trust acquired Grade 3 and 4 pressure ulcers are reviewed by a multidisciplinary internal team of experts. The root cause and any lapses in care are established, themes and trends and learning are identified and are cascaded to the multi-professional Pressure Ulcer Harm Reduction Group. It is expected that this will further be reported for assurance to the Harm Reduction Group.
- One method of benchmarking against best practice is via the NICE Guidance Centralised Process meeting provides the care group NICE Leads the opportunity to meet monthly to discuss the recently published NICE Guidance, discuss applicability to services and supports consistency across the Trust. The group identify any guidance that requires a corporate review. All guidance is now reviewed, and a response recorded centrally within 28 days of publishing.
- Clinical Effectiveness dashboards are produced for each care group on a quarterly basis for discussion at care group assurance meetings. These dashboards include data on DOLS, blanket restrictions, NICE guidance, and clinical audit and provide a summary of data received by the Care Groups on these elements. The dashboards are discussed at Care Group Quality Senior Leadership Team meetings and are then provided to the relevant ICB for assurance.
- The Quality Peer Reviews of inpatient wards identified that:
    - Care planning is mostly undertaken in conjunction with patients and the patients spoken to confirmed this. However, patients were not always given a copy of care plans and electronic records did not consistently evidence the patient voice.
    - Purposeful Inpatient Admission (PIPA) was an effective way to review care and plan treatment and discharge, involving input from multi-disciplinary staff. Planning for discharge starting early in the admission was evident on all wards through observation and questioning teams
    - Staff were aware of how to meet individual patient needs which was evidenced around religion and dietary requirements, staff were observed making reasonable adjustments for disabilities (including ADHD, Asperger's and

Autism), and liaised with other appropriate services for additional support when required.
    - Provision of therapeutic activities for patients was exceptional on some wards and variable on others.
    - MHA rights were read to patients routinely. However, consent and capacity for other than mental health care and treatment was not well documented on mental health wards and therefore not possible to evidence if this was assessed.

  The process for the peer reviews has been evaluated with a paper presented to the Quality and Safety Group on 12 March 2024.
- The trust participates in NHS benchmarking hosted by the NHS benchmarking network (NHSBN). The Benchmarking projects cover mental health and physical health and includes a core projects across the year and additional bespoke projects. Clinical and corporate colleagues are requested to input into the benchmarking process. In 2023/24, the Trust has participated in 21 projects. Reports are received back from NHSBN and key findings are reviewed by relevant care groups/corporate services with local action plans developed as appropriate. The Trust is increasingly using benchmarking outputs, enforced by the Trust policy https://www.rdash.nhs.uk/policies/nhs-benchmarking-network-policy/ and a robust framework is in place to enable this to happen, with positive engagement from service leads. The Clinical Leadership Executive (CLE) maintains oversight to identify organisational learning.
- Mulberry Ward has undergone a process for accreditation with the Royal College of Psychiatrists and are currently awaiting the outcome of the accreditation board. A bid for funding has been submitted within the Trust and depending on the outcome, the accreditation process will be rolled out to all acute adult mental health wards.

Recommendations

For RDaSH to be GOOD within the EFFECTIVE 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. Quality Outcomes for services will be agreed by end of Q3. Colleagues will be able to identify the objectives for their service.
2. The Trust will embed safety checklists as part and the Quality and safety plan, as part of the Clinical and organizational strategy.
3. The IQPR is a performance and information tool that provides the Board with accurate and timely information regarding the effectiveness of care in RDaSH. A regular review process provides opportunities to modify and develop the metrics included.
4. 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 audit and effectiveness, the improvement will be consistent across services and system.
5. 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.
6. Reduce out of area placements (care closer to home despite significant pressure) linked to the work above.

7. Provide more consistently available evidence that best practice guidelines are embedded in services.
8. Benchmark with other organisations to share, learn and improve.

Kate McCandlish, Deputy Director of Nursing
Laura Powell, Compliance Officer

We understand that some of the content of this presentation may be distressing.

If some people wish to not partake in this discussion for personal reasons this is supported.

If additional support is required this is available, please discuss with the presenter after the session.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Suicide Prevention Update	**Agenda Item**	Paper P
Sponsoring Executive	Dr Graeme Tosh, Executive Medical Director		
Report Author	Dr Graeme Tosh, Executive Medical Director Sharon Greensill, Deputy Director of Organisational Learning and Inquests		
Meeting	Board of Directors	**Date**	28 March 2024

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

It would be helpful to focus our conversation on three issues:

- How do RDaSH suicide figures align with National Trends?
- Is a Zero suicide target helpful or harmful?
- How can we better work with partners to prevent suicide?

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
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

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

This paper was prepared for Board and is intended to stimulate debate and discussion around this important issue.

Recommendation

The Board is asked to:

x	**RECEIVE** the information on our current work
x	**CONSIDER** an indicative view of the questions posed

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

Trust Risk Register		n/a
Board Assurance Framework		n/a
System / Place impact	x	How we work with others to make an impact on this enduring problem

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)

Mapping against the 10 ways to improve safety.

SUICIDE PREVENTION UPDATE TO BOARD MARCH 2023

INTRODUCTION

Over 2011-2021, there were 18,339 suicide deaths in the UK by mental health patients (an average of 1,667 deaths per year) this equates to 26% of all suicide deaths.

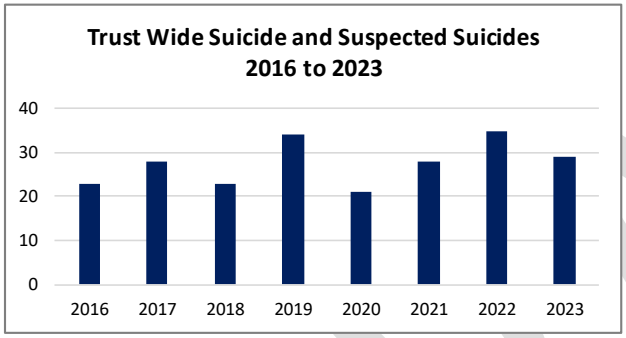
In May 2019 the burden of proof for suicide changed from the Criminal Standard (beyond reasonable doubt) to Civil Standard (on the balance of probabilities); this will likely increase the number of conclusions of suicide being returned.

This paper provides an overview of deaths by suicide in 2023 at RDaSH and details the ongoing work around suicide prevention within RDaSH and beyond, with our partner agencies.

It is intended to stimulate a debate on the topic which can inform our future work in this important area.

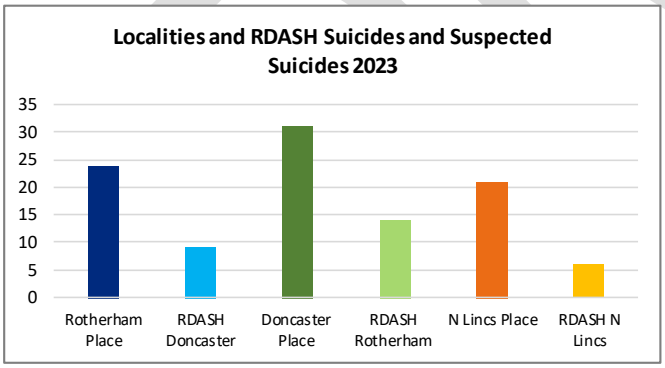
OUR DATA v NATIONAL DATA

The table below shows the number of deaths due to suicide (confirmed or suspected) by patients who were in receipt of RDaSH Trust services.



In line with national trends there was an increase in 2019, a reduction in 2020 and a further peak in 2022.

Suicides and Suspected Suicides in localities 2023



This graph shows the number of people who died by suicide in the three RDaSH localities and what proportion of those were under RDaSH services during the last 6 months of their life.

Suicides and Suspected Suicides in Mental Health Inpatients

A review of suicide by inpatients in RDaSH between 2016 to 2023 indicates there were three deaths on the inpatient wards, one by overdose and two by hanging. Several actions have been taken in relation to environmental risks as both deaths by hanging were linked to our bathroom doors which were subsequently changed.

There were no inpatient deaths by suspected or confirmed suicide in 2023.

Demographics

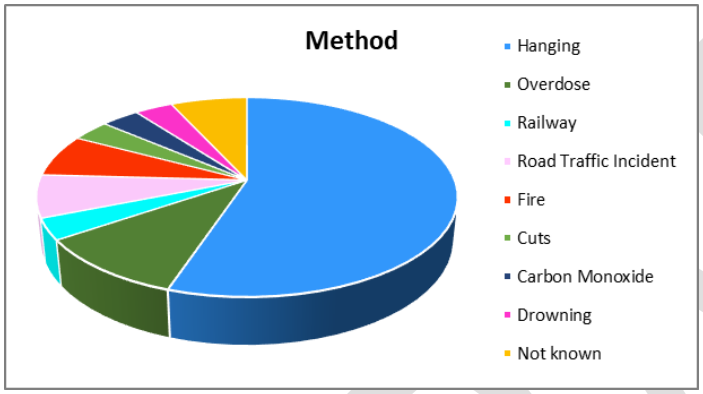
Comparing age, gender and ethnicity suicide deaths at RDaSH are in line with National Trends, the significant majority are male (66% nationally, 80% at RDaSH) with peaks in the 25-34 and 45-54 age groups. Ethnicity data nationally suggests 7% of suicides are by people from an ethnic minority group suggesting that this may be a protective characteristic, last year we had one suicide by a person of Asian background and two by Eastern European citizens.

Method of Suicide

Nationally the most common methods of suicide are hanging, self-poisoning and jumping, in that order. There has been a clear rise in deaths by hanging over the last decade.

RDaSH data is broadly in line with National Trends.

RDaSH data



Mental Illness

National data states that about 50% of people who completed suicide had diagnoses of at least two mental illnesses or disorders, indicating that clinical complexity is linked to suicide. Substance misuse (drugs and alcohol) was also a common factor as was previous history of self-harm (63%).

Team or Service

Nationally over 2010-2020, there were 5,103 patients who died by suicide in acute care settings, including crisis resolution/home treatment (13%). The most common non-acute settings were community mental health services, alcohol or drug services, and older person's mental health services in the community.
The data below shows the teams or services in RDaSH that patients have had contact with in the 6 months prior to their deaths.

Team	Number
Crisis/Home Treatment/Liaison	**12**
Drug and Alcohol	**2**
Drug and Alcohol and Crisis/Home Treatment/Liaison	**4**
OPMH	**2**
CMHT/Teams	**4**
Early Intervention team	**1**
Assertive Outreach team	**1**
Perinatal mental health	**1**
Primary Care Mental Health	**2**

Suicide Prevention

The NCISH recommends the adoption and embedding of national evidence including "10 ways to improve safety". As a trust we have adopted this model and below we outline some of the actions taken in relation to suicide prevention in the organisation. **Appendix 1** provides more information on how we have worked toward this.

Suicide prevention work with partner agencies.

The Trust works alongside partner agencies both at place and ICS levels. The Trust Lead and Care Group representatives are linked into several working groups including self-harm, drug and alcohol deaths, and deaths where physical health featured in risk factors.

The Public Health departments in each locality hold Learning panels with partner agencies including NHS, Social care, Police, third section and voluntary services. This ensures learning across their respective areas and there is a locality view of demographics which feeds into locality workstreams.

Suggested Next Steps

1. To further explore areas of demographics as identified in the National Confidential Inquiry including:
   - Diagnosis
   - If they missed their last appointment
   - One off contact with Crisis/Liaison team
   - Disengagement
   - patients with Autism/ADHD

2 Update the National Confidential Inquiry into Suicide and Homicide (NICSH) Toolkit – Baseline Assessment and Action plan by 31 March 2024.

3 The Annual Drug and Alcohol report will include a deep dive thematic analysis of suspected suicides under Drug and Alcohol services.

4 To share the Baton of Hope information with the Human Resources team for consideration around staff well-being and suicide prevention.

5 Review the Trust Suicide Prevention Action Plan by August 2024.

6 **Appendix 1**

Mapping against the 10 ways to improve safety.

10 WAYS TO IMPROVE SAFETY	
SAFER WARDS	
Ligature points and policy	• Work has been done around ligatures and a review undertaken of all in patient mental health and Forensic ligature assessments. The Trust will transfer to the new Care Quality commission Ligature risk assessment template from 1 April 2024. • Addressing the environment issues which provide the opportunity for ligature, through a risk reduction/harm minimisation programme of building work is discussed in ERICA group to ensure robust governance and oversight. • Joint review meetings have been set up in localities to be held on site and include Estates, Health and Safety, Patient Safety and Care Groups.
Observations	• In March 2021, the Trust teamed up with Oxehealth, a company that provides patient monitoring systems. The innovative technology called Oxevision. • Supportive therapeutic observation is one of the Trust's key audit programmes
Ward entry and exit	Ward and building access are subject to a further review during March 2024.
Environmental management	• There has been a redesign of the seclusion areas. This focuses on both risk and safety and patient need. • All internal bathroom doors have saloon type doors. These are load release doors that also consider patients' privacy and dignity as well as safety. • Ward and building access have been reviewed across the Trust. In North Lincs and Rotherham additional controlled access doors have been installed to provide a further level of safety
Safer Staffing Levels	• Each month, the Care Groups discuss inpatient wards safe staffing at their Quality and Safety Governance meetings. • The Trust has a patient flow team and staffing is discussed in Trust wide meetings twice daily.
Multi professional working	• Working with partner organisations remains a key intervention within services. A focus has been on developing closer relationships with services such as Drug and Alcohol services.
EARLY FOLLOW-UP ON DISCHARGE	• The Trust has a model in place for 72-hour follow up. This is monitored centrally as a performance indicator and information shared with Care Groups for monitoring compliance.
CARE PLANNING AND DELIVERY	• SOPs have been developed with the patient flow team leading on development to ensure safe, smooth processes and transitions for patients. CMHT's have a duty system is in place with at least one staff member on duty each day. • Red/Amber/ Green (RAG) Ratings are being used in Adult Mental Health services. The RAG rating system is utilised in decision

	making for frequency of visits, complexity, and risk. • There is an ongoing transformation review of Crisis, Home Treatment and Liaisons services
NO OUT OF AREA ADMISSIONS	All attempts are made to keep patients within the RDaSH footprint. The patient flow teams manage and oversee the movement of patients to out of area beds.
24-HOUR CRISIS RESOLUTION/HTT	• Each locality has a 24-hour crisis resolution/home treatment team (CRHT) with sufficiently experienced staff. All crisis responses moved to a single telephone contact in each care group. • To ensure clarity around process and MHA, a flow chart has been developed with clear instructions to follow when a Mental Health Act Assessment is requested. • Training has been provided to on call managers and doctors in relation to any specific mental health act areas including Section 140 special urgency. • There is now a dedicated service for perinatal mental health. • Crisis teams have collated details of all neighboring services Crisis and liaison services to ensure robust transferer and any information sharing.
FAMILY INVOLVEMENT	• Families are invited to be part of the PSIRF process which allows them to contribute to any learning. • Bereavement support is available to all families from the place base/ICS model. • The Trust is looking at how work can be done with families with lived experience
RISK MANAGEMENT	• Work done on risk management and assessment. Training provided places a focus on formulation and not solely on the completion of a checklist. • Training has been reviewed and a need for s more intensive level of training for some staff groups has been identified. • A task and finish group has been sent up with a plan to work with the training providers to review the higher level of training. • The Trust Is linking with other organisations and involved with a national forum which is looking at Risk Assessments
OUTREACH TEAMS	The trust has an outreach team in each locality that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services.
SERVICES FOR DUAL DIAGNOSIS	• In Doncaster, Drug and Alcohol services are delivered by RDaSH and there is a clear process for referral and assessment. Links have been developed in North Lincs with the third sector providers who will carry out in patient assessments. • In North Lincs there is a good relationship between services and in reach to the wards • Rotherham has a new Drug and Alcohol provider, and the care group are working with the provider to ensure that pathways and joint working arrangements in place previously are maintained. Meetings are held monthly
SELF-HARM	There is 24-hour access to specialist assessment and follow-up for all self-harm patients. All patients presenting at A&E for mental

	health issues receive psychosocial assessment and are provided with details of a forward plan. This includes contact numbers and details of support networks to minimize the risk at times of crisis.
INFORMATION AND SUPPORT FOR SERVICE USERS AND CARERS	• The Trust has developed a brief guide following relationship breakdown. • All teams have developed leaflets and secondary services have a welcome to the team pack. • The trust has developed several ways of communicating with patient and carers using digital platforms and the use of apps to support patient safety planning and engagement.
TRUST DRIVEN WORK	• The Trust monitors monthly through the Mortality Surveillance groups, Regulation 28 notices given to other organisations and published nationally. • Deep dives are undertaken as and when required – a review is currently being undertaken of deaths under Crisis/Home treatment teams. • Thematic analysis is done as and when required

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Objective 1	**Agenda Item**	Paper Q
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jo McDonough, Director of Strategic Development		
Meeting	Board of Directors	**Date**	28 March 2024

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

The paper is the second in a routine series covering each strategic objective. The item's purpose is to provide space to discuss the complexity and difficulties anticipated as we begin to implement. The item also maintains Board focus on our strategy.

In this case, the paper recognises the very fundamental nature of the changes implied, and their layering at service, directorate, Group and Board level. Unless we accomplish a shift in power at each level we will not meet the spirit of the objective, which will then undermine the strategy as a whole.

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

1. Nurture partnerships with patients and citizens to support good health.	x

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

	RECEIVE and discuss the issues cited in the paper

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

Trust Risk Register	x	n/a presently except in respect of PALS (promise 4)
Board Assurance Framework	x	See new BAF in papers
System / Place impact	x	Central to partnerships across place

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

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Strategic Objective 1 – Nurture partnerships with patients and citizens to support good health

Jo McDonough
Director of Strategic Development

March 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, in January 2024 we looked at Strategic Objective 5. Today we want to look at Strategic Objective 1. 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. It is recognised that Steve Forysth will lead this agenda and the paper on this occasion will be presented by Toby Lewis. The objective is however one that demands whole Board leadership.

Why we have agreed this as one of our Strategic Objectives?

We agreed that part of our strategic direction was to shift the balance of power in favour of our communities. Too often statutory partners sit in a room and make decisions on behalf of people and communities without them being in the room or their voices heard. This objective explicitly has promises to show that we mean it about what kind of organisation that puts patients and people at the heart of our decision making and how we work. We have some great examples of peers embedded in working with our services: this should be the norm for all services. We also have good examples of our community involved in our decision making through our Governors and we will expand this further involve people at every level of decision making. Volunteering can have considerable benefits for the person volunteering and for the people, communities and organisations they work with. We want to encourage and expand opportunities for volunteering. Unpaid carers in our communities and amongst our workforce are often the backbone of health and care that goes unseen and often unsupported: we will work to make sure that unpaid carers get the support they need. Finally, the voice of patients to meet individual needs will be at the heart of what we do. There are five Promises that fall under this Strategic Objective, as per table below

Promise No.	Promise	Board committee involvement	CLE group	Which plan the Promise is in
1	Employ peer support workers at the heart of every service that we offer by 2027.	People & Organisational Development	People & Teams	People and teams
2	Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Public Health, Patient Involvement and Partnerships	Equity & Inclusion	Equity and inclusion
3	Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer.	Public Health, Patient Involvement and Partnerships	Equity & Inclusion	Equity and inclusion
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 Committee	Quality & Safety	Quality and safety
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.	Public Health, Patient Involvement and Partnerships*	Clinical Leadership Executive	Equity and inclusion*

*this is a change in response to last week's Board committees and other feedback

(Promise 1) Employ peer support workers at the heart of every service that we offer by 2027

Peer support is a supported self-management intervention. It happens when people with similar long-term conditions, or health experiences, come together to support each other. This can be on a one-to-one or group setting, through building relationships of mutual acceptance and understanding. Peer support is a valuable resource for people and their families and carers; empowering them to take ownership of, and have more control over, their health and wellbeing. People develop knowledge, skills, and confidence to self-manage and address other issues that might be affecting their health, such as loneliness or self-esteem.

We have a number of great examples of peers working with and delivering services across our communities. With the benefits to themselves, communities and ourselves we will have peers in all our services over the next three years. To achieve this, we will invest in the expansion and support for peers to make this happen (and elsewhere on this agenda are proposals to start investing more from 2024/25). We will work with peers on shaping and developing how peer support can work.

Where is the challenge?

Growing the number of peers to work with all our services is going to take a concerted effort by all. Peers will need to feel supported, which needs to be nurtured and sustained. The health and wellbeing of peers will need the same level of focus as we all should have. This will require changes in our wellbeing offer, described by our prior CNO, as Wellbeing++.

Peers being involved in services has been well established for some, but new to many. Understanding of the benefits that peers can bring to services will need to be clear and understood. Opportunities of all shapes and sizes need to be identified and developed: this can't just be the role of a few people, it will need all services to play their role.

As well as the benefits to services, we will need to find people who would be willing to be peers who can recognise what benefits it could have for them. The size of growth in the number of peers to meet our Promise by 2027 is very sizeable. During 2025/6 we will need to determine whether we will employ peers direct or via partner organisations. Or both. With investment during 24/25 we will adopt both models and study whether is variable is important.

It will also be important to study and research our practice change. RDaSH has been behind a number of peer organisations in developing peer support workers, and thinking about learning will help to frame the work we want to do.

(Promise 2) Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy

Unpaid carers are the backbone of supporting health and care, with an estimated 5 million people undertaking this role in England & Wales. Unpaid carers in England and Wales contribute a staggering £445 million to the economy every day – that's £162 billion per year. To put that into context: in 2022/23, NHS England spent £181 billion on health and social care. Whilst there is a benefit to wider society it often comes at a price to carers: this includes financial, impact upon their own health and juggling the needs of work. As well as in our communities, this impact will also be felt by unpaid carers who are our colleagues.

Over the coming months, we will launch our Carers Charter to support our people with caring responsibilities and best practice to create a clear support offer for staff who are carers, including our wellbeing passport. We will also promote the right to unpaid carer's leave, which comes into place in April. We will work with places to complement their support for carers, including scoping the needs of young carers, and actions to address these needs. Overall, we expect to seek accreditation for our work on carers.

Meanwhile, the Trust needs to become outstanding at identifying and notifying carers. This will inevitably create pressure in other parts of health and care system and unacknowledged need and support will be identified. Our work will raise questions about respite provision and other structures in the wider community.

Where is the challenge?

There are significant differences between work to support carers among our teams, and in our communities, but also some commonalities.

In common is the challenge of identification. This is both about individuals not seeing themselves as carers, or indeed not wishing to be identified as such. Reducing barriers to self-identification will be critical to our work. We know from anonymised survey material that over 1500 RDaSH employees have caring responsibilities. Working to achieve a more comprehensive insight will allow us to consider how we tailor our working and employment practices to support a range of wider life needs – where presently, arguably, policies focus on a very narrow definition of caring responsibilities typically focused on children.

The other common difficulty is the so-what? What practically are we able to provide, leverage and advocate for that will better support carers' needs, and best enable them too to care. Our models of discharge and home support rely on carers, their energy and expertise.

It may be that faced with the scale of this promise, we need to think service by service about our work. An area like dementia has already had a focus on carers with the re-commissioning work across Doncaster, but it be helpful to explore that through CLE how we approach these issues, as we have done for poverty proofing, another construct which touches everywhere. Finally, we need to recognise that the Trust does not have a 'carers' department, or a carers' lead, and whilst this work is everyone role, by the end of Q1 we need to identify the time and resource needed to make real changes in the impact of our approach.

(Promise 3) Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer

Just as mentioned above regarding peer support, the benefits to people who volunteer show positive impacts of enjoyment, better mental health, meeting new people, and being able to make a difference. We have around 110 volunteers doing great things in the Trust carrying out many different roles, which reflect their own particular skills and interest. These include helping out in art groups, driving patients to and from hospital sites, providing trolley services to the wards, hospice volunteers making tea, and helping out in cafes and gardens. We recognise and value what our volunteers do: our volunteers at the Wound Care Store won the 'Volunteer of the Year' at our staff awards in November 2023.

We will plan to grow our volunteer base across all our services, and create a targeted volunteer to career pathway from our patients and public. We will make the system for recruiting volunteers more streamlined and rapid. People sometimes like to volunteer at more than one organisation, so we will develop a volunteer passporting scheme with external agencies to enable pacey onboarding of volunteers across the system. Some of our colleagues may also want to volunteer in their communities, and we will consider a specific programme in 2025/26 to help that to happen.

Where is the challenge?

On the face of it this promise is one of the more straightforward to execute. It is defined and timebound. We have a function in place to do this. And during 23/24 we have made some progress towards the goal. The transition to 24/25 seeing a manage, indeed performance managed, measure of progress may, inevitably create some tensions.

However, the real test lies in establishing worthwhile work that is rewarding for this volunteering within our organisation. Typically, services either are or are not users of volunteers, and as with apprenticeships, we need to put time into broadening the base of managers and departments who are welcoming and supporting volunteers within our services.

Part of the rationale for volunteer expansion lies in the knowledge and insight about our communities that can be garnered through a sizeable partnership with volunteers. There is urgent work to do to consider how those voices are best heard and given credence.

(Promise 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

This promise comes in two parts. The hearing and the acting. In the first instance we are reshaping how we hear, with changes to replace our YOCS arrangements and introduce online arrangements that have proved successful elsewhere. Part of that success has been in encouraging more direct staff response to comments made, and less emphasis on a central portal of response. This is intended to create dialogue.

Increasingly, we need to transition how we work to actively seek to demonstrate the change dividend from engagement. There are great examples inside our Trust, perhaps especially in Children's services, of this occurring already but the promise envisages more impactful and scaled change.

What it also envisages is an NHS comfortable with responding differently to different needs. And able to personalise care. This is central to at least two domains of our CQC work.

Where is the challenge?

We will need to develop a range of methods that people can give their feedback and help shape services: for example, whilst surveys have their place and can be effective in some instances they may not be right nor enough. We will need to be open to different methods of good practice that exists, and willing to be innovative in trying new ways with patients. Importantly, patients will need to see and feel that they have been listened to. We will need patients to know how their feedback has been acted upon, and if we can't then why. We need to be open and direct when we do not act on feedback, recognising it nonetheless has value. Our current engagement with bodies like Healthwatch may provide some interesting learning about our response and capability in this field.

As we develop our accreditation and involvement methods, we need to be mindful of patient feedback. We have already that the RCP accreditation work we do will have patients at their heart, as we seek to do with peer reviews and PLACE visits. The challenge here is to normalise this practice, and integrate it with the pace at which we need to operate. This can be done but is often seen as a reason not do this work.

Not everyone who uses or may use our services wants to be 'involved' or 'engaged'. This should be recognised as it is, and we need to consider carefully how we hear silent voices and neither discount them, nor use them to discount those speaking up.

Is this promise, more than any other, one where the skills of other sectors, including the commercial sector may be needed?

(Promise 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

There are levels and layers to this promise, and the good cannot be halted while we try to find excellent. We have made commitments already to do several things:

- Use our governors as patient representatives within the business of the board
- Work with patients in our CLE groups and create a shadow CLE group
- Involve our patients inside the management of our care groups and directorates building on current best practice
- Devote 80% of our energy in this space to joining in and leaning into existing spaces and places within our communities

The membership proposition is less well developed, and over the next two months an initial exploratory options paper is being produced. We are fortunate to have several thousand interested members. We need to consider with them their needs and wants, and adopt levels of approach to meet what will be diverse needs. This does not mean we have bronze, silver and gold membership, but it does mean that we are able to work with people as they are and want to be.

Our challenge

We really need to get 'under the skin' of what we, in conjunction with our communities, want involvement at every level of decision making to look like. For some people that might mean attending meetings: often our language can be jargonistic and bureaucratic meaning people can feel excluded from taking part. Also, we need to make sure that it doesn't feel tokenistic for people who give up their time to get involved.

As well as working with people to be involved in decision making, building upon the skills and knowledge they will bring to decision making, we will also need to work internally to change the power dynamic. This will be where were we will see community power being strengthen in our decision-making structures (which will mean for some people conceding power).

The NHS system, and its regulation, does not prevent us doing this. But it can sometimes militate against us doing it. Either because that system comes with secrecy or speed that excludes. The real hard yards may lie in the impact of patients, carers and communities on the agenda. Of course, we seek their help with our agenda, but our agenda may need to step back to meet a different agenda or agendas. That will be a challenge of managerialism, and to action planning, and scorecards. It will require adaptive capacity.

This curiosity lies at the very heart of the leadership development proposition we are presently finalising.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Board Assurance Framework	**Agenda Item**	Paper R
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	28 March 2024

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

The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the achievement of the board's strategic objectives. Reflecting on the new clinical and operational strategy approved for the period 2023 – 2028 a new BAF has been developed initially through the executive group.

Importantly, the revised set of risks are significantly more aligned to the specific strategic objectives – hence they, with much greater clarity, are the things that really could get in the way of delivery. They also recognise a longer-term outlook.

The paper presents for each strategic objective a number of risks, but then identifies the two or three risks that will be the initial focus. We would expect over coming weeks to hone and composite some of those risks into a more manageable number.

Once support is received, further work will be undertaken at the Board's timeout in April to consider in greater detail the risk scores, risk appetite and controls and mitigating actions to be implemented in order to manage the risks. The management process for this is outlined in the paper and is different to previous approaches.

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?)

The paper represents the output from two discussions within the Executive Group and a discussion with a Non-Executive Director representative and is presented to the Board of Directors for the first time.

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

The Board of Directors is asked to:

x	**RECEIVE** and **NOTE** the progress with the development of the Board Assurance Framework
x	**SUPPORT** the proposed strategic risks, in particular the proposed key risks, mindful of the intention to hone / rationalize these further, to a manageable number.
x	**NOTE** the intention to consider the strategic risks further at the Board's timeout in April 2024 – with the intention of identifying for each agreed key risk a risk score, risk appetite, mitigating actions, lead Board Committee and lead Executive.

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

Trust Risk Register	x	
Board Assurance Framework	x	

System / Place impact	x						
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	
Appendix (please list)							
None							

Board Assurance Framework

1. Background

1.1 The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the board's strategic objectives. It is important to distinguish the BAF from the risk register. The latter reflects the challenges to the organisation's functioning on a year by year, week by week basis. It is a live document that will show identification, mitigation and escalation of key risks faced by teams across the organisation. In contrast, the BAF predominantly identifies external factors which could interrupt delivery of the organisation's objectives over the medium term.

1.2 The intention is that the Board is focused on mitigating the likelihood, or more typically the impact, of these factors.

2. BAF 2024

2.1 The refreshed BAF needs to reflect the Clinical and Operational Strategy 2023 to 2028. This new Strategy, its focus on the power in our communities and its structured approach to deliver the objectives and promises it contains, requires an adjusted approach to the BAF.

2.2 After considering a variety of approaches and options, we have decided to directly tie our BAF to the objectives of the strategy.

2.3 Through facilitated discussions with the Executive Group, an initial set of forty risks were identified. These are presented in the table overleaf with reference also to the relevant strategic objective.

2.4 Following further review, a sub-set of sixteen risks were agreed as being the 'key' risks – those that had a heightened possibility of impacting on delivery if they came to fruition. These are marked on the table overleaf with ✪.

2.5 In order to ensure that the BAF is workable and effective and that the Board (and its Committees) can appropriately manage the risks, sixteen as a cohort of risks may be considered excessive. There is some commonality between a number of risks and hence there will be a further iteration to hone these risks into a more manageable set. For example, there are key risks noted in the table in respect of strategic objectives one, two and five that are very much aligned to working effectively with the right partners and the community, that could be brought together.

3. Reconciliation to the previous BAF

3.1 The **BAF**, in place since 2022, comprised seven strategic risks – pointed towards the delivery of the previous Strategy (refresh). The seven BAF risks are:

SR1 - 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
SR2 - 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.

SR3 - 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
SR4 - 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.
SR5 - 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.
SR6 - 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.
SR7 - If a significant destabilising event occurs then the delivery of services, financial performance and wellbeing of staff may be impacted

3.2 This approach, at a time of transition, outlined a different type of underlying risk, perhaps more associated with issues or the impact of a failure to execute the plan.

3.3 Moving ahead with the revised BAF and revised approach does not automatically mean the previous strategic risks are no longer applicable or relevant to the Trust. Nor does it mean that it they have de-escalated and have become operational. As highlighted at the start of this section, there is a difference between the BAF risks and the operational risk registers.

3.4 However, it is important for the Board to understand that the strategic risks that no longer form part of the BAF maintain a relevance to the Trust and to be aware that for example:

- There remains a risk register entry pertaining to the delivery of the current financial plan (previous SR3); that there are related risks relating to the governance structure, information flow, policies, Governors etc (previous SR6); that there is a compliance with EPRR Core Standards risk (previous SR7); that there are risks on the register relating to patient safety, patient experience, clinical effectiveness and regulatory compliance (previous SR5); and

- This is as well as the inclusion of consistent risks that flow from the previous BAF to the proposed new one relating to organisational capacity / cultural capacity and capability (previous SR1 and 2) and the importance of partnerships (previous SR4)

3.5 Once the refreshed strategic objectives are confirmed, a more detailed ‘reconciliation’ will be undertaken to ensure that the coverage described above is in place within risk registers.

4. Next Steps

4.1 The next step will be to consider the agreed strategic risks further at the Board’s timeout in April 2024 – with the intention of identifying for each a risk score, risk appetite, mitigating actions, lead Board Committee and lead Executive.

4.2 This process will enhance that previously in place with greater clarity and expectation on the respective roles of the Committee and perhaps more so, with the identified lead

Executive, who will, through May further develop the component parts of the BAF before the full BAF is presented to the Board at its next meeting in May 2024.

The management of the BAF week-to-week

4.3 Because these are the major strategic risks we face, it is right that mitigating them should consume time and energy among the most senior management. Whereas in the past a named director would, via the Board's committees, consider the score as it evolved, our 2024/25 approach will be different.

a) Each finalised BAF risk will have a mitigation plan developed by the responsible director, working with colleagues and across EG. The focus will be on what we can do, and are doing, to reduce the likelihood or mitigate the impact. The director will be asked to deliver that plan, mobilising colleagues as required. EG will be used routinely to peer-check our collective efforts. Directors' objectives will explicitly recognise their BAF leadership.

b) As noted above, BAF risks will be held within a given Board assurance committee and routinely discussed.

c) However, there will also be three reviews across the year (July/November/February) where the director of corporate assurance and the audit committee chair meet the responsible director to review progress. These reviews will be purposive and supportive, but also anticipate not just progress of effort and actions, but difference.

5. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the progress with the development of the Board Assurance Framework

SUPPORT the proposed strategic risks, in particular the proposed key risks, mindful of the intention to hone / rationalize these further, to a manageable number.

NOTE the intention to consider the strategic risks further at the Board's timeout in April 2024 – with the intention of identifying for each agreed key risk a risk score, risk appetite, mitigating actions, lead Board Committee and lead Executive.

Philip Gowland
Director of Corporate Assurance
21 March 2024

Step One: What could get in the way?	Key	Step Two: Mitigating Actions / Controls	Step Three: Assurance that the controls are working
SO1 – Nurture partnerships with patients and citizens to support good health.			
Competing 'offers' or opportunities to communities from other partners and organisations			
The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities	★		
The challenge of delivering the new approach in a traditional NHS regulated organisation			
Lack of funding for, and space to integrate, a very large number of Peer Support Workers			
Sufficient opportunities are not created for an increasing and large number of volunteers	★		
Digital inequalities prevent engagement and involvement and remove or hinder communication mechanisms	★		
Ability to recognise and deliver against different nurturing requirements / Acceptance of ambivalence			
SO2 – Create equity of access, employment, and experience to address differences in outcome.			
The economic and workforce pressures to standardise and be uniform/consistent, work against our desire to make the differences necessary to tackle Health Inequalities			
Difficulty annually generating apprenticeship opportunities and jobs for apprentices because of a lack of turnover / career progression in 'lower' banded roles	★		
Capability and capacity amongst RDASH leaders to work with communities, including marginalised groups.	★		
Lack of diversity or inability to preference those who are excluded			
Regulatory / NHS E belief that Health Inequalities are not within the remit of providers to tackle			
Challenges generating data and / or evidence to support interventions to address Health Inequalities	★		
Acceptance to the notion that we will actively introduce inequalities (e.g. red card)			
SO3 – Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services.			
Capacity/Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies	★		
The aspiration to focus on clinical outcomes moves ahead of (or quicker than) the organisational capability to frame creditable measures			
Trust unable to fund and / or to deploy staff capacity / growth required by waiting time pledges			
Disagreement between public organisations leads to instability among the coalition that together, are required to take forward Home First work across our places.			
A lack of ambition and experimentation inhibits our ability to change early years' service offers where we need to depart from national universal norms			
Public acceptability of new models of care	★		
Organisational capability to affect change			

SO4 – Deliver high quality and therapeutic bed-based care on our own sites and in other settings.			
Market failure prevents the development of independent sector alternative provision beyond the NHS inpatient wards			
Out of area placements continue because the funding and clinical model does not keep pace with demography	★		
Scarcity of training places stands in the way of filling funded roles envisaged by the Trust's improvement plans			
Capital regime and approval processes make radical change too slow to match need and make timely progress			
Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk	★		
Incongruence with other partners plans (in respect of their bed bases)			
A mis-understanding of difference in understanding of what is intended by 'high quality and therapeutic'	★		
SO5 – Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			
University partners are not able to maintain or increase capacity and to support sufficient educational places			
The community's perception of social value is not aligned to that of the Trust	★		
A lack of public transport or investment by local authority partners and the unavailability of 'green' transport infrastructure e.g. electric charging points			
The Trust's inability to identify and then nurture the 'right' partnerships to cause change, growth, improvement and progress	★		
The future growth of the RLW means it becomes unaffordable			
The Trust lacks the cultural capability and competence on wider issues	★		
The Trust is unable to tackle issues whilst operating in a hostile environment, nationally. (for example racism, homophobia, etc)			
Non-specific to the SOs, but taking the whole Strategy……			
Insufficient organisational capacity and capability	★		
Organisational culture not in line with the agreed values			
Long term (five year) financial plan presents increased challenge, requiring action that removes the opportunity for investment and innovation			
The 'performance' (or risks) of other partners within the systems we operate deteriorates (or increases) with detrimental knock-on impact			
Not investing in digital skills, capacity and solutions to enable transformational improvements to improve clinical processes, drive efficiency, improve connectivity and facilitate greater use of data.	★		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – **February 2024**	**Agenda Item**	Paper S
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**	28 March 2024

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

The latest report maintains trends seen over the past two reports:

- There continues to be sustained improvement in several of the Quality & Safety metrics: % of VTE assessments (QS08x); inpatients commenced with a falls assessment within 72 hours (QS37x) and numbers of episodes of seclusion receiving an internal MDT within 5 hours (QS31x)
- To note delivery on Perinatal Mental Health services (OP07x), with projection of delivery for end of year forecast. Also, adults accessing mental health services (OP13dx) which is now above the YTD target and projection of delivery of the end of year target. People accessing CYP services (OP13ax) continues to demonstrate a strong upward trajectory, with intensive work to try to ensure delivery of this annual target.
- There is an increasing concern about the number of out of area placements, reflected in the increased score on the risk register and a programme of intensive work is being developed across services, partners, and systems to address this in 24/25.
- YTD agency spend is £341k higher than the corresponding period last year. We are forecasting to spend £8.4m by year end which is £2m above the NHSE cap. Additional control measures form a significant part of our savings plan for 2024/25.

Alignment to strategic objectives	
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

Clinical Leadership Executive and relevant committees of the Board

Recommendation

The Board is asked to:

	NOTE reported performance and consider areas of prolonged under achievement

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,						
BAF	x	SR3						
System / Place impact	x							
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)

Appendix1 SPC Icon Description

Integrated Quality Performance Report

March 2024 Review

Data as at 29 February 2024

Contents

1.0 Executive Report

This report outlines the February 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 3 recorded waits have been investigated and are all related to data quality as all 3 individuals have received treatment. Once the clinical system is updated the number of waits over 65 weeks is zero. The number of available beds on the virtual ward is 60 with occupancy in February peaking to 48 patients on the 29th of the month. We continue to develop new pathways to expand utilisation, being further encouraged with acute partners. They have also expanded several effective winter schemes which end in March; however, additional funding has bene secured from commissioners for April 2024 for the community IV initiative.

Within Childrens services there is a reported increase in performance in February 2024 for children and young people (CYP) accessing services (OP13a), During February it was identified that a further cohort of contacts were incorrectly excluded from the reporting. This amendment was made to the reporting during the first week in March which has significantly increased the performance to 9,415 just short of the year to data target of 9512. A high level of scrutiny and activity continues to support with achievement of the end of year target but there remains approximately 650 contacts to achieve by the end of the year.

Our Children's Eating Disorder service continues to perform well with all most urgent cases received into the service seen within 1 week (OP15) and 94.12% of our children and young people referred into service are seen within 4 weeks (OP14).

In terms of OP13d the metric in relation to adults and older people accessing community mental health services with 2+ contacts performance has seen an upward trajectory across all localities, and we are reporting achievement of the Trust wide (Actual 9016, 8533) , Rotherham (Actual 3126, Target 2900) and Doncaster (Actual 3459, Target 3041) target. However, caution is necessary as this is a rolling 12 month position a focus and activity to sustain performance continues throughout March . In North Lincs (Actual 2253, Target 2592) where there is a significant stretch a plan is in place to drive activity to support those individuals who are having one or no clinical contacts. In 2024/25 there is an amendment to this metric where the focus is on transformed services only, therefore we are seeking to reduce the targets to align to this change)

A continued concern remains around Talking Therapies access rates where we are forecasting not to achieve the year-to-date and Quarter 4 access target (OP03). Although considerable work is under way to increase the access rate; demand is still below the capacity. (Trust wide reporting actual of 2684 against a year-to-date target of 4093). There is a focus on the demand side with a move away from just a reliance on social communications, but active engagement with different communities not previously accessed and strengthening of pathways with other services. We have continued with social media campaigns and the development of workshops to Support World Menopause Day and Long-Term Conditions Workshops focusing on Managing Pulmonary Conditions and Pain Management. Recovery rates above the target of 50% have been maintained across all 3 localities.

In terms of our inappropriate out of area placements at the end of February 28 patients were in a provider outside of the RDaSH footprint. This remains an area of significant 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.

1.0 Executive Report

It is noted that we are demonstrating increasing quality and safety for our patients and service users with month on month improvement across a number of our metrics.

The percentage of Venous thromboembolism assessments (QS08) completed within 24 hours has shown a notable increase from 86.01% to 92.5% in February. Physical health wards have conducted a deep dive and are conducting weekly audits which are acted on if the Venous Thromboembolism assessment is not fully completed. There are issues with receiving the data timely for Hazel and Hawthorn from the Acute trust which means the assessment cannot be fully completed, this is incident reported and investigated on an individual basis including liaison with the acute Trust. An audit was conducted by the clinical systems team which confirmed reporting is flowing correctly at Care Group Level. The audit highlighted inconsistencies in clinical recording which are being addressed through training at a ward level.

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 February has improved to 83.33%. Following a deep dive by the Mental Health Act Manager we can report that 85.71% of patients are receiving an MDT 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, all 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.

Safer staffing has sustained month on month performance reporting 94.44% in February and January with 17/18 wards reporting compliance for both months remaining above the target. However, this needs to sit alongside vacancies in key groups such as the medical body. The risks associated with staffing (sickness and vacancies) and significant agency spending are actively monitored and managed. Care Groups use the risk registers to identify and dynamically manage risks and these are being reviewed regularly through the Risk Management Group.

The total number of detained patients who abscond from acute adult and OP inpatient mental health units (QS20) has breached the zero target. With performance reported as one case is it noted that this is the same patient that absconded from the ward in December and went AWOL on escorted leave in January. The patient has since been located and is back in Mulberry House subject to a serious incident investigation. All incidents are discussed in the Daily Incident Meetings and After-Action reviews are completed for all individual cases.

There is a month-on-month improvement in patients commenced with falls assessment in 72 hours with performance reported in February to 95.70% remaining above the 94% target for two consecutive months (QS37). Four patients didn't receive a falls assessment within 72 hours in February compared with thirteen in January. It is also noted that a deep dive of the January data indicated a number of valid exceptions which would indicate six patients had not received an assessment within 72 hours. This has been addressed at ward level and there remains a strong focus on improving this and all 6 patients have been reviewed for learning.

There is an acknowledgement that performance for inpatients with a MUST assessment is significantly below Trust target. However, there has been a month-on-month improvement since June onwards and a notable increase to 64.08% for February from 54.73% in January and 45% in December. An audit was conducted by the clinical systems team which confirmed reporting is flowing correctly. The audit highlighted inconsistencies in clinical recording which are being addressed through training at Care Group Level. This has been escalated to the Quality and Safety CLE sub-group for a more focused approach across the Trust. A deep dive has highlighted a need for a structured approach to the monitoring of the MUST completion, this has included the ability to view and in month report which allows teams to manage non-compliance.

1.0 Executive Report

It is important to note in the workforce domain that there has been a slight deterioration in absence levels from 5.82% to 5.87%. The increase was seen across all areas with the exception of Children's Care Group (increase of 1.07% in month), but it should be noted that Children's Care Group has the lowest year to date absence within the Care Groups of 4.89% The largest reduction was in Corporate with a reduction of 1.43% followed by Physical Health and Neurodiversity of 1.37%.

A focus on Performance and Development Review compliance across the Trust has seen an increase from 80.97% of individuals having a PDR within 12 months in January to 83.90% in February. There remains focus and targeted communications in place to support with achieving compliance.

Footnote : Please Note Due to Late availability of TPP files over the weekend, IQPR data is as at the 8th March 2024. Next available refresh is scheduled for Wednesday 13th March 2024.

2.0 - Performance – In Focus

Indicators for February 2023/2024 TRUST

Performance

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01x (N)	People first episode in psychosis started treatment in 2 wks		13/15	86.67%		82.00%	>= 60%	82.00%
OP02x (N)	People completing Talking Therapies moving to recovery		314/591	53.13%		51.00%	>= 50%	49.00%
OP03x (N)	People accessing Talking Therapies			1320		2704	>= 20565	14724
OP05x (N)	People in physical health crisis assessed within 2 hours		78/92	84.78%		86.00%	>= 70%	88.00%
OP07x (N)	Women receiving support from perinatal mental health service			0		42	>= 571	477
OP08ax (N)	18 Wks RTT for consultant led Learning Disabilities		38/45	84.44%		86.00%	>= 92%	67.00%
OP08bx (L)	18 wks RTT for AHP led Physical Services		392/405	96.79%		97.00%	>= 92%	98.00%
OP10ax (N)	>65 Wks wait for consultant led LD			0		0	= 0	0
OP10bx (L)	>65 wks waits for AHP led Physical Services			1		1	= 0	2
OP12x (N)	People discharged from MH inpatients followed up in 72 hrs		45/60	75.00%		84.00%	>= 60%	86.00%
OP13ax (N)	People accessing CYP services with >= 1 contact			8577		8577	>= 9512	8577
OP13bx (N)	People accessing CYP services >= 2 contacts and paired score		767/4224	18.16%		18.00%	>= 20%	19.00%
OP13cx (N)	Adults accessing community mental health services			0		0	>= 8249	0
OP13dx (N)	Adults accessing community mental health services (DW)			8994		8994	>= 8249	8994
OP14x (N)	People (CYP) with routine eating disorders seen within 4		96/102	94.12%		94.00%	>= 95%	93.00%
OP15x (N)	People (CYP) with urgent eating disorders seen within 1 wk		4/4	100.00%		100.00%	>= 95%	100.00%
OP17x (N)	Inappropriate out of area acute mental health bed days			791		1440	<= 1093	6441
OP19 (N)	MHSDS score for data quality maturity index (DQMI)		983/1000	98.30%		98.00%	>= 95%	98.00%
OP54 (L)	People cared for on virtual wards			60		60	>= 130	60

Narrative

OP02 – Recovery rates have improved over the last month with an increase from 49.24% to 53.12%. Year to date position remains below 50% however there is a plan in place to sustain performance in order to ensure this meets the target as we move into April 2024.

OP03 – This is a place target and once Ieso (994) and RDaSH (14.724) activity is factored in actual year to date (YTD) performance is 15,718. This remains below the YTD target of 20,565. Focus remains on the Q4 Access rate.

OP07 – On track and forecasting to meet the 23/24 Long Term Plan target This is the place target RDaSH (477) and Maternal Mental Health Service (SHSC) (131) activity is factored in the YTD performance is reported as 608 above the YTD target of 571.

OP08a – The 7 breaches are currently under investigation. To establish if they are true waits. This will be completed by the end of March 2024.

OP10b The 2 breaches are confirmed as data quality with all individuals having received treatment. No individuals are waiting longer than 65 weeks.

OP13a – An improvement in performance this month. When place activity is factored into the actual value YTD is 9415 (RDaSH 8577, Kooth 777/Mind 61) and remains slightly below the YTD target of 9512

OP13b –Performance has dropped in month to 18.16%

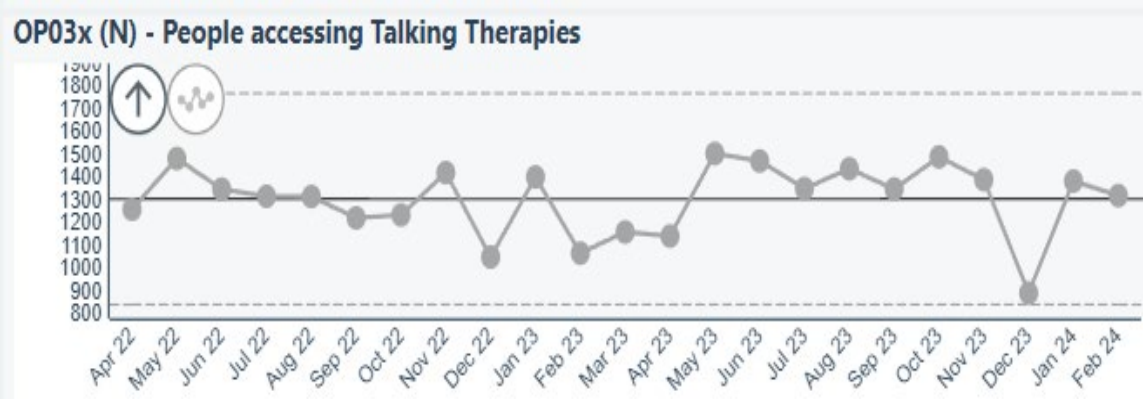
OP13c – Performance is reported and available on the 12th Mar.

OP13D – Performance has seen an upward trajectory across all localities is reporting 8994 and is above the YTD target of 8249.

OP14a – Children and young people with urgent eating disorders seen within 4 weeks has improved in month reporting 94.12 % against the 95% target. (OP15) Urgent cases are seen within 1 week with performance remaining at 100%.

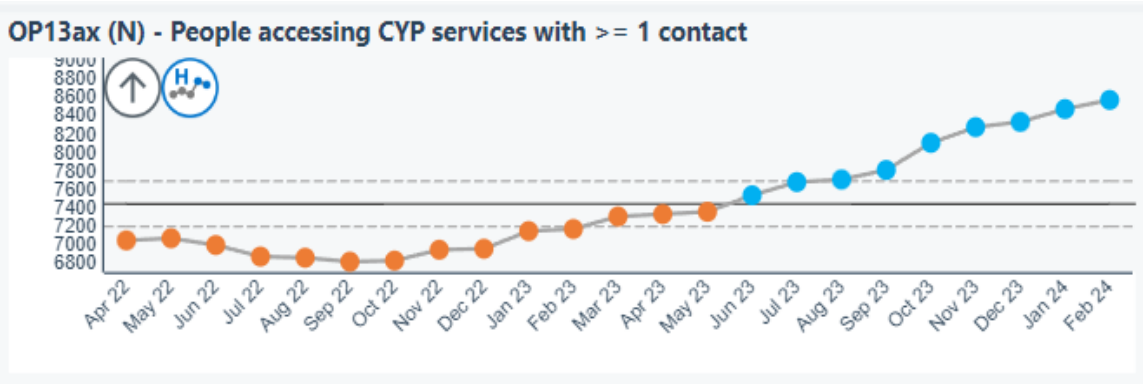
OP17 – Individuals placed inappropriately out of area due to lack of available beds across the Trust is reported as 791 days in February.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

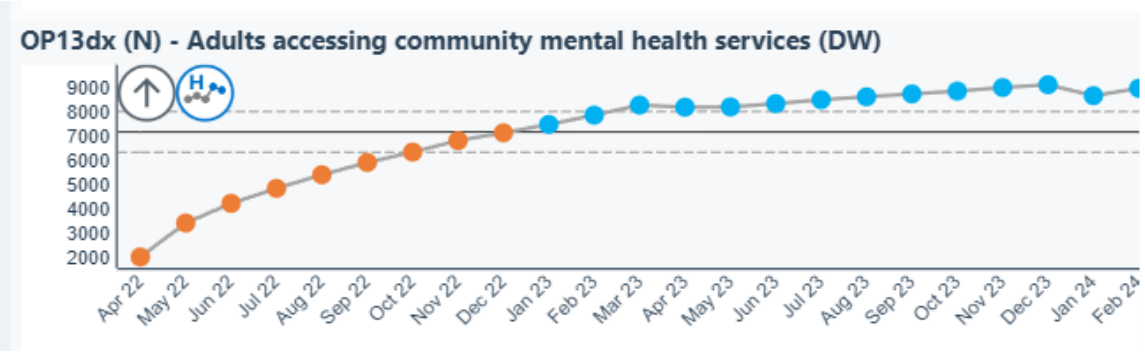
The Talking Therapies access rate (OP03) remains below the national target. Although considerable work is under way to increase the access rate demand on this pathway . There is a focus on the demand side with a move away from just a reliance on communications, but active engagement with different communities not previously accessed and strengthening of pathways with other services. We have continued with social media campaigns and the development of workshops to Support World Menopause Day and Long Term Conditions Workshops focusing on Managing Pulmonary Conditions and Pain Management. Recovery rates above the target of 50% have been maintained across all 3 localities.



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 graph represents the RDaSH contribution of 8,577 and when the activity from Kooth in Doncaster 777 and Mind 61 North Lincs is factored in the performance is reported as 9,415 against the YTD target of 9,258.

A dedicated task and finish group continue to meet weekly. Focus remains on reviewing approximately 400 clinical records to identify and rectify any clinical recording errors for CYP seen on referral into service. Support is been provided to update and amend any relevant contacts with this piece of work commencing from the 12th Feb 2024 and to complete 15th March 2024

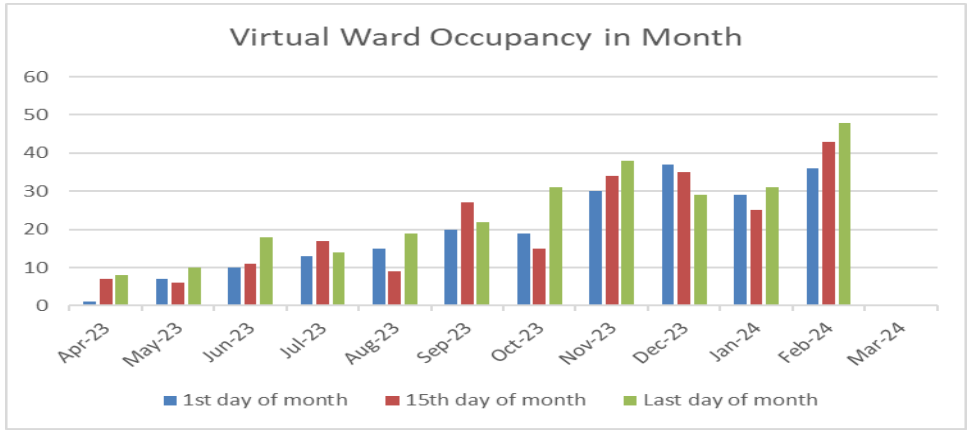


Trend, Reason and Action

At a trust wide level performance has seen a month on month improvement with activity reported as 8,994 at the end of February. It is noted that the end of year target at a Trustwide, Rotherham and Doncaster level have all achieved the end of year targets, with focus on sustaining current performance through to the end of March. In Lincolnshire where there is a significant stretch target, work continues with a focus on driving activity to support those individuals who are having one or no clinical contacts.

2.1 Performance In Focus - Exceptions

OP54a Monthly Occupancy – Virtual Wards, Bed days



Trend, Reason and Action

The number of available beds on the virtual ward is 60 with occupied beds remaining with average occupancy in February as 42 and a peak of 48 at the end of February. The graph provides a detailed breakdown of the month on month occupancy for our virtual wards on the 1st, 15th and the last day of the calendar month. When compared to other providers of Virtual Ward within North East and Yorkshire (25 providers) 18 providers have lower capacity than Doncaster with RDaSH reporting an occupancy rate of 73% (5th out of the 25 providers). 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. 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.

3.0 Quality & Safety In Focus

Indicators for February 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%	860/1000	86.00%		93.00%	= 100%	93.00%
QS05x (N)	Number of MRSA infections (Monthly)	= 0		0	Q4 = 0	0	= 0	0
QS06x (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q4 = 0	1	= 0	1
QS07x (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q4 = 0	0	= 0	0
QS08x (N)	No patients aged >=16 admitted with completed VTE	>= 95%	124/134	92.54%	Q4 >= 95%	89.00%	>= 95%	86.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		17/18	94.44%		94.00%	>= 90%	94.00%
QS19x (L)	Number of AWOL's from low secure units (Amber Lodge)			0		0	= 0	0
QS20x (L)	No detained patients absconded acute adult/OP inpatient MH			1		2	= 0	31
QS21a (L)	Physical aggression incidents mod or above to staff		0/95	0.00%		1.00%		1.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats		0/0	- nan(ind)				
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		1	Q4 = 0	1	= 0	1
QS27x (L)	Ligature incidents mod or above all inpatient areas		0/8	0.00%		6.00%	<= 10%	8.00%
QS29x (L)	Number of racist incidents against staff members			0		9	= 0	46
QS31x (L)	Episodes of Seclusion - Internal MDT within 5 hours		5/6	83.33%		79.00%	= 100%	66.00%
QS36x (N)	Inpatients that have a completed MUST assessment		91/142	64.08%		59.00%	= 100%	47.00%
QS37x (L)	Inpatients commenced with falls assessment in 72 hrs		89/93	95.70%		94.00%	= 100%	95.00%
QS38x (L)	Moderate/High falls requiring a structured review	= 100%	0/100	0.00%	Q4 = 100%		= 100%	50.00%

Narrative

QS04 – The 1 breach is completed within timescale from an RDaSH perspective and the only outstanding element is the ICB signoff.

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 92.54% in February from 86.01% in January and 82.22% in October.

QS15 – Safer staffing has sustained performance at 94.44%

QS20 – The total number of detained patients who abscond from acute adult and OP inpatient mental health units has breached the zero target. There is one individual case of a patient absconding from the ward and is subject to patient safety investigation which is ongoing but within timeframe. The other are patients that are going on leave and failing to return in a timely way.

QS23 – the one incident reported is a data recording error and is due to be amended.

QS29 - We continue on our journey to become an Anti Racist organisation and the work around supporting patients with our authorities to have a zero acceptance level of abuse continues and as we work through our latest data we will be getting a better understanding of all racist incidents.

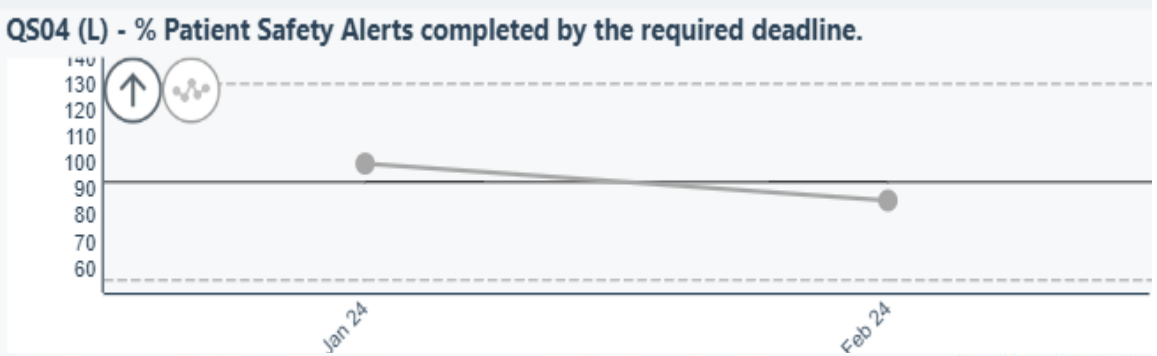
QS31 – The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for February.

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 95.70% in February.

QS38 - It has been identified that 0 falls were reported as being moderate or above for February 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 percentage of patient safety alerts completed by the required deadline has breached the 100% target for February. IQPR is showing 86% are completed. We have received 7 alerts for February with 1 not completed by the required deadline. Internal changes have been made to comply with all actions from the alert. Further work is needed with third party providers in the ICB's which is being scheduled for quarter 1 of 2024/25. Non-compliance with closing the alert has been added to the Trust risk register

Trend, Reason and Action

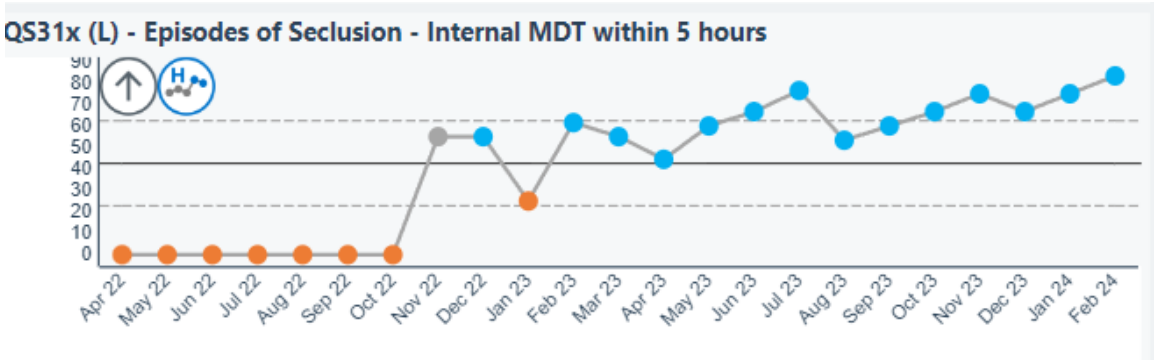
The percentage of VTE assessments completed within 24 hours has shown a notable increase to 92.54% in February from 86.01% in January. Physical health wards have conducted a deep dive and are conducting weekly audits which are acted on if the VTE assessment is not fully completed. There are issues with receiving the data timely for Hazel and Hawthorn from the Acute trust which means the VTE cannot be fully completed, this is incident reported and investigated on an individual basis including liaison with the acute Trust. An audit was conducted by the clinical systems team which confirmed reporting is flowing correctly at Care Group Level. The audit highlighted inconsistencies in clinical recording which are being addressed through training at ward level. It has been agreed to schedule a further audit in Quarter 2 of 2024/25 with oversight provided by the Quality and Safety Group.

Trend, Reason and Action

IQPR is reporting 0 racist incidents for February. Following a deep dive the number of racist incidents against staff members has shown a decrease to 1 in February from the month on month increase for the previous three months with nine reported in the month of January, five in December from three reported in November.

All incidents are discussed at the Daily Incident meetings which has created a greater awareness of reporting incidents. 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 to report them to the Police as a hate crime. This measure is currently being explored to be owned jointly by HR and Quality and Safety.

3.1 Quality and Safety In Focus - Exceptions

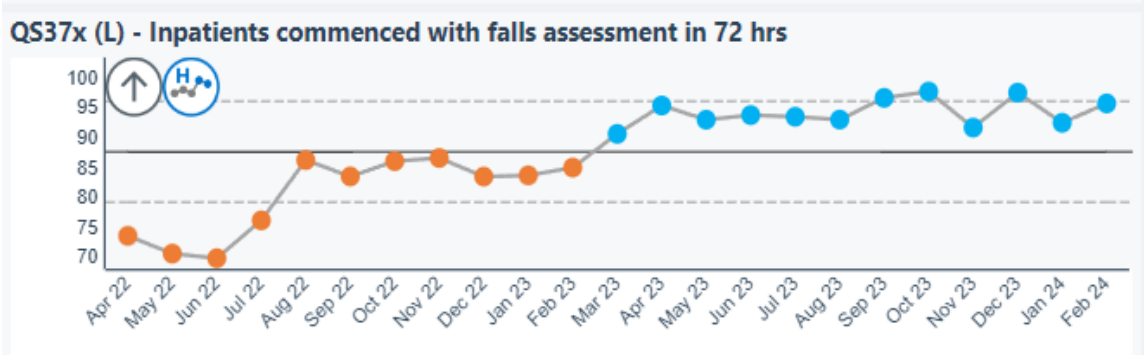


Trend, Reason and Action

The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for February. IQPR is showing 83.33% of patients are receiving an assessment in February. Following a deep dive by the Mental Health Act Manager we can report that 85.71% of patients are receiving an MDT assessment within timescale. Showing an increase from the 80% reported in January. 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

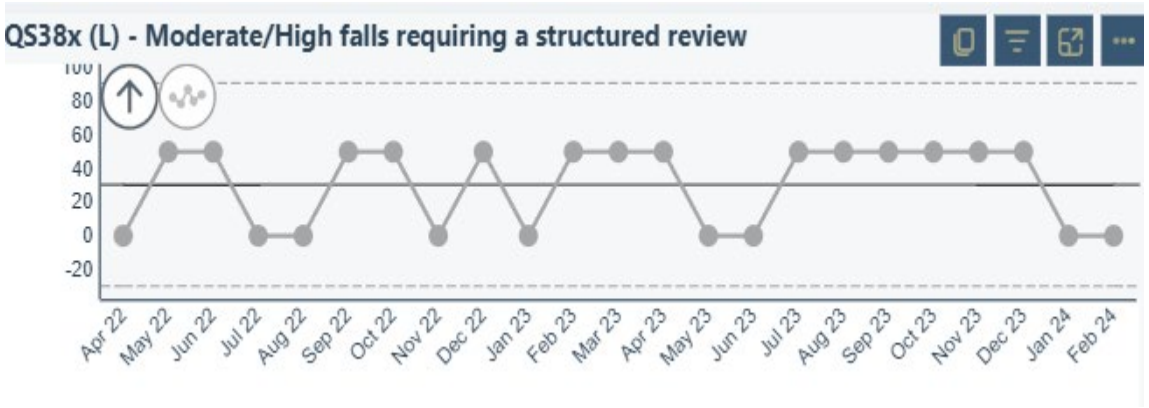
There is an acknowledgement that current reporting is significantly below the Trust target. however, there has been a month-on-month improvement since June onwards and a notable increase to 64.08% for February from 54.73% in January and 45% in December. An audit was conducted by the clinical systems team which confirmed reporting is flowing correctly. The audit highlighted inconsistencies in clinical recording which are being addressed through training at a ward level. This has been escalated to the Quality and Safety group for a more focused approach across the Trust. A deep dive has highlighted a need for a structured approach to the monitoring of the MUST completion with additional oversight provided by the Safety and Quality Group. Daily monitoring is now in place and a further dip sampling exercise will take place in Quarter 2 of 2024.



Trend, Reason and Action

The number of Inpatients receiving a falls assessment within 72 hours have seen an increase to 95.70% in February from 91.40% in January. 4 patients didn't receive a falls assessment within 72 hours in February compared with 13 which were missed in January. On deep dive of the January data there were some valid exceptions, so the final figure was just 6 patients who were missed and this has been addressed at ward level. A great improvement and the falls leads remain vigilant in their monitoring of this KPI.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

It has been identified that 0 falls were reported over the last 2 months as being moderate or above therefore 100% compliant with this KPI for January and February.

4.0 People and Organisational Development – In Focus

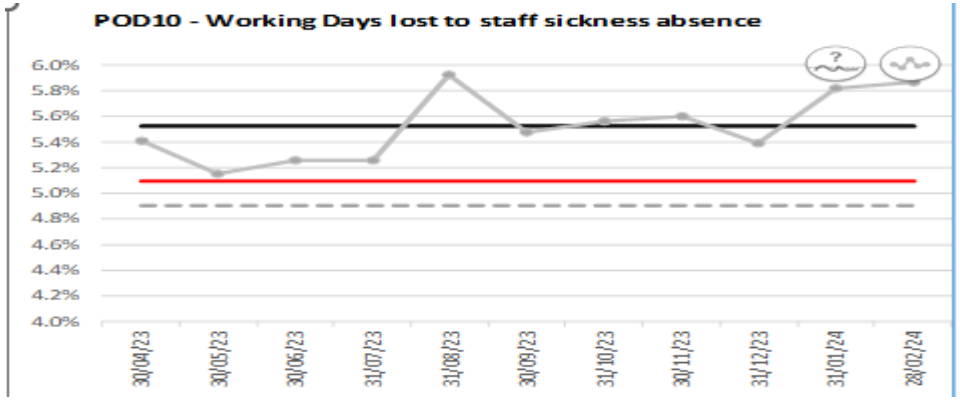
Indicators for February 2023/2024 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	9.67%		10.00%		10.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.87%		6.00%		6.00%
POD12 (L)	Number staff who have had an annual flu vaccination		2456		2456	= 0.7	2456
POD15 (L)	Number of Consultant Vacancies	<= 10	15		15		15
POD16 (L)	Qualified nursing vacancies	<= 10%	7.24%		8.00%		8.00%
POD17 (L)	Support worker vacancies	<= 10%	3.43%		3.00%		3.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	83.90%		84.00%		84.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	92.11%		92.00%		92.00%
POD23 (L)	Number of individuals currently suspended from employment		4				
POD24 (L)	Average suspension length in calendar days	<= 150	116		116		116
POD25 (L)	Recruitment completed within 12 weeks		91.67%				
POD26 (L)	Compliance for safeguarding children's training		82.78%				
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		84.92%		86.00%		86.00%

Narrative

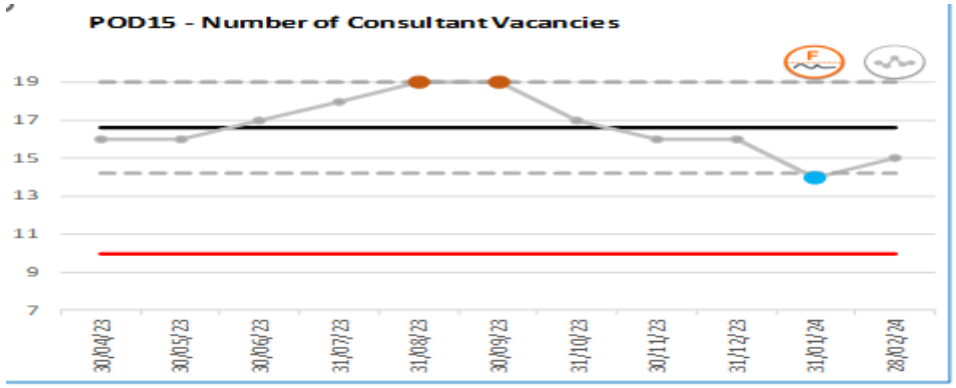
POD10 - In January the in month sickness absence % increased 5.82% to 5.87%. The increase was seen across all areas with the exception of Children's Care Group (increase of 1.07% in month) but it should be noted that Children's Care Group has the lowest year to date absence within the Care Groups of 4.89% The largest reduction was in Corporate with a reduction of 1.43% followed by Physical Health and Neurodiversity of 1.37%. Some corporate areas still have absence at 4% so we are closely managing this
POD12 – At the end of December the Trust had vaccinated 2459 individuals, with a Trust target of 3000.
POD15 – The Trust continues to experience challenges recruiting to Consultant vacancies. We have secured GMC sponsorship and have a pipeline of 12 ST4 doctors to join us through 2024. NHS professionals engagement is assisting with improved medical cover (and reducing significant costs too)
POD 18 – Improvement in PDR compliance from 80.97% to 83.90%. Focused and targeted communications are in place to support with achieving compliance. Delivery Reviews in all areas have assisted with this focus and sets have been set for colleagues – all before end of April 2024
POD 23 and POD 24 - The suspension data is within the Trust target remains unchanged from last month. 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. The hearing for one case was scheduled for late February however due to unexpected absence of an RCN regional representative who is supporting the individual this has been rearranged for March 2024.
POD26 and POD 27 - Trust Level 1 and 2 (both adult and child are compliant) but level 3 for adult and child are amber. This is a focus for the CG Directors of Nursing and will continue to be monitored through delivery reviews.

4.1 People and Organisational Development - Exceptions



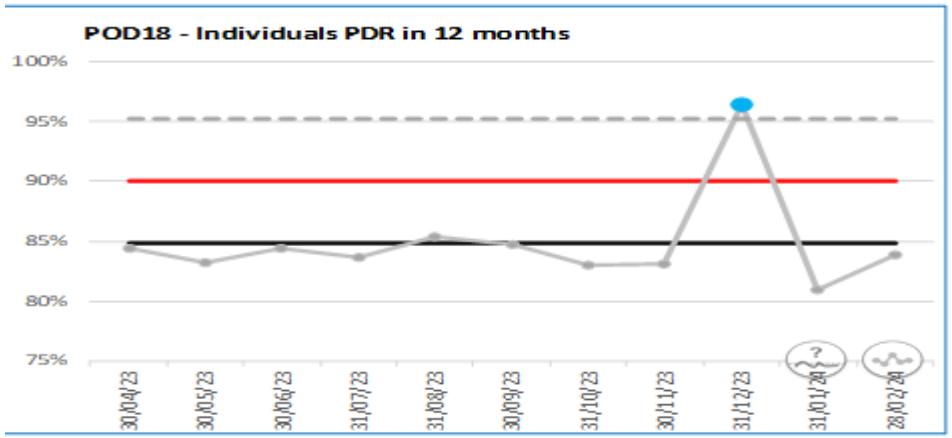
Trend, Reason and Action

POD10 - In February the in month sickness absence % increased 5.82% to 5.87%. The increase was seen across all areas with the exception of Children's Care Group (increase of 1.07% in month) but it should be noted that Children's Care Group has the lowest year to date absence within the Care Groups of 4.89% The largest reduction was in Corporate with a reduction of 1.43% followed by Physical Health and Neurodiversity of 1.37% however it Is noted that some corporate areas have absence of 4% so this is closely monitored.



Trend, Reason and Action

POD15 – The Trust continues to experience challenges recruiting to Consultant vacancies. This will again be a priority next year. We have secured GMC sponsorship and have a pipeline of 12 ST4 doctors to join us through 2024. NHS professionals engagement is assisting with improved medical cover (and reducing significant costs too)



Trend, Reason and Action

POD18 – Delivery Review supported with improvement in PDR compliance from 80.97% to 83.90% Delivery Reviews in all areas have assisted with this focus and sets have been set for colleagues – all before end of April 2024

5.0 Finance – In Focus

Finance				
Indicator	**Metric**	**Target £000**	**Actual £000**	**Variance £000**
FIN01	YTD Actual vs Budget	**4,209**	**1,736**	**- 2,473**
FIN02	Forecast Outturn vs Budget	**6,150**	**3,173**	**- 2,977**
FIN03	In month actuals vs In Month forecast	**1,097**	**1,685**	**588**
FiIN04	YTD efficiency target vs actual savings	**9,167**	**7,212**	**- 1,955**
FIN05	Annual savings target vs forecast savings (R&NR)	**10,000**	**9,066**	**- 934**
FIN06	Annual savings target vs forecast savings (R only)	**10,000**	**8,983**	**- 1,017**
FIN07	Agency spend % of total pay bill (YTD)	**3.6%**	**4.5%**	**0.9%**

Narrative

FIN01 - At the end of February we are reporting a deficit position of £1.7m, £2.47m better than plan.
FIN02 - The trust is forecasting a deficit of £3.2m 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 has deteriorated due to an increase in spend against department budgets and a reduction in income due to late confirmation of notice given to a service.
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 - The total value of the savings forecast to be delivered against the plan on a full year effect basis is £9.0m.
FIN06 – The vast majority of savings identified on the full year effect basis are recurrent (£8.9m)
FIN07 - At month 11 year to date agency spend is £341k higher than the corresponding period last year. The Trust has been set an agency cap by NHSE. We are forecasting to spend £8.4m by year end which is £2m above the cap. Reducing agency spend is a key national and local priority for 24/25. Additional control measures are being implemented and this forms a significant part of our savings plan for 2024/25. We are aiming to reduce agency spend by at least £1.5m in 24/25. If all agency staff had been on NHS contracts in 23/24 this would have saved the Trust £2.4m by the end of February 2024. The majority of agency costs (97%) is on placements longer than 3 months

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.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** 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 a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** 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 a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(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 11 Finance Report	**Agenda Item**	Paper Si
Sponsoring Executive	Ian Currell, Executive Director of Finance & Performance		
Report Author	Amy Denning & Rob Kirkby, Assistant Directors of Finance		
Meeting	Board of Directors	**Date**	28 March 2024

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

The Trust is reporting a forecasted deficit of £3.17m against the initial planned deficit of £6.15m. Included in this is £3.5m reduction of income from South Yorkshire ICB to help reduce the system planning gap of £109m. There is an increased risk on this year end forecast of £0.6m which could increase the year end deficit to £3.8m

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 11 the full year value of schemes delivered so far is £8.9m.

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?)

Recommendation

The Trust Board 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 – Financial Stability					
System / Place impact	x						
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)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

FINANCE REPORT
FOR THE PERIOD ENDED 29 FEBRUARY 2024

1 Introduction

This report sets out the financial position of Rotherham Doncaster and South Humber NHS Foundation Trust as of 29 February 2024, month 11 of the 2023-24 financial year.

Below is a summary of the key financial indicators the Trust is measured against:

29/02/2024	Executive Summary / Key Performance Indicators					
No.	Performance Indicator	NHSE Annual Plan	NHSE YTD Plan	NHSE YTD Actual	Year end Forecast	Narrative
1a	SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	£6.15m	£4.21m	£1.74m	£3.00m	The Trust position at the end of February is a deficit of £1.74m, £2.47m better than plan. The position includes a surplus of £0.03m for Flourish. The year to date underspend & the additional £0.75m received from NHSE for the Adult Eating Disorder Provider Collaborative has now been fully utilised.
	Adjusted performance (for system reporting purposes)	£6.15m	£4.21m	£1.86m	£3.17m	This position reflexts the technical adjustments added or removed from the actual surplus deficit, for system reporting purposes in the PFR
1b	Income	£209.73m	£192.28m	£199.15m	£215.54m	Year to date income is higher than the plan submitted to NHSE at the beginning of the year by £6.87m. This is linked to additional pay award funding & other additional income received which is in part offset with additional expenditure.
1c	Expenditure	£215.88m	£196.49m	£201.01m	£218.72m	Expenditure at the end of February is £4.52m higher than the original plan, this relates to additional costs for the pay award and is offset in income.
2	Agency Cap	£6.30m	£5.59m	£7.15m	£7.80m	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 February the Trust is £1.56m 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	£42.66m	£36.00m	£40.00m	At the end of February the Trust cash balance is £36.00m. Cash for the remaining quarter to 31.3.24 has been reforecast to £40.00m.
4	Capital	£6.66m	£5.37m	£5.36m	£7.06m	Capital Programme expenditure has a small underspend at the end of February. To 23/24 actuals are forecast to be £7.06m versus plan of £6.66m for full year.
5	Savings Programme	£10.00m	£9.17m	£7.15m	£7.80m	The trust has delivered £7.15m of recurrent savings to date, the full year effect of which is £7.78m. £10.3m of plans have been identified and we are forecasting to achieve £7.78m in 23/24.
6	Better Payments	95%	95%	85.0%	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 February the Trust was paying 85.0% 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 11 is a deficit of £1.74m, £2.47m better than plan. This is a deterioration compared to the £0.05m deficit in month 10. The adverse movement relates to spending plans in care groups, corporate directorates, and the update of balance sheet reconciliation ahead of the financial year end. The position includes £3.2m of system support, to help close the SY ICB planning gap. (FYE of this will be £3.5m). The main drivers of this position are vacancies across the care groups, the delivery of the savings plans, and the planned contingency not being required in full.

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 group as at the end of month 11.

Groups	YTD Budget £'000	YTD Actuals £'000	Variance £'000
Doncaster AMH & Learning Disabilities	41,568	41,099	-469
Physical Health & Neurodiversity	34,421	33,695	-726
Rotherham AMH	26,000	25,262	-738
North Lincs AMH & Talking Therapies	20,129	19,538	-591
Children's	25,927	25,337	-590
Total Operations	**148,045**	**144,931**	**-3,114**
Corporate	32,062	30,850	-1,212
Trust Central & Reserves	6,938	8,458	1,520
Contract Income	-182,836	-182,518	318
Flourish CIC	0	-32	-32
AED Provider Collaborative	0	47	47
Group Position	**4,209**	**1,736**	**- 2,473**

System Performance Position	**4,209**	**1,858**	**- 2,351**

Operational services & Corporate departments continued to underspend at the end of February. The key themes being reported in month 11 continue to be staffing challenges in inpatients services and challenges in recruitment across various services. 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 has now been offset by the system support agreed with the ICB to help close the planning gap as expected.

Vacancy Factors

Each care group has a vacancy factor within their pay budget, the breakdown of these is shown below. The Trust will be rebasing vacancy factors as part of 2024-25 planning to ensure a consistent approach is taken across all areas.

Group	Pay Budgets excl VF	Vacancy Factor	VF %
Childrens	£27,984,767	-£381,405	-1.4%
Corporate	£21,791,052	-£69,049	-0.3%
Doncaster AMH & Learning Disabilities	£38,644,052	-£1,042,904	-2.7%
Estates & Facilities	£6,063,860	-£46,000	-0.8%
North Lincs AMH & Talking Therapies	£22,747,929	-£1,292,057	-5.7%
Physical Health & Neurodiversity	£32,997,951	-£1,247,275	-3.8%
Rotherham AMH	£28,332,684	-£1,225,449	-4.3%
Grand Total	**£178,562,295**	**-£5,304,139**	**-3.0%**

Year End Forecast

The year end forecast position is a deficit of £3.2m, this includes a £3.5m system support income reduction from South Yorkshire ICB to help reduce the system planning gap of £109m. There are potential risks of £0.6m which could increase the year end deficit to £3.8m.

This forecast includes two technical items for NHSE system reporting purposes. The first is a £0.5m improvement which results from the Trust's 22-23 deficit improving by this value between draft and final accounts submissions. The second technical adjustment is an adverse movement of £0.7m linked to the remeasurement of the PFI lease on an IFRS16 basis.

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 11 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	393
Doncaster MH - Crisis & Liaison Vacancies	800	594
Doncaster MH - Drugs & Alcohol Service Grant	314	24
Doncaster MH - ADHD Staffing	125	23
Doncaster MH - Rough Sleepers Initiative	46	0
Doncaster PH - Ageing Well	1,190	87
Doncaster PH - Virtual Ward	837	136
Doncaster PH - District Nursing Vacancies	400	0
Rotherham - CMHT Transformation	664	126
Childrens - Neuro Vacancies	533	28
Childrens - Crisis	469	45
Childrens - Epilepsy Staffing	51	29
North Lincs - Crisis & Liaison Vacancies	400	0
North Lincs - Inpatient Staffing	318	234
Total	**6,750**	**1,718**

Care Group	Budget given above 22/23 outturn	YTD slippage	YTD expected slippage	YTD variance to expected slippage
Doncaster MH	1,888	1,033	679	-353
Doncaster PH	2,427	223	630	407
Rotherham	664	126	240	114
Childrens	1,053	102	310	208
North Lincs	718	234	441	207
Total	**6,750**	**1,718**	**2,300**	**582**

* 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 £7.15m on agency in 23-24 which is 4.5% 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 32.7% (34.8% in month 10) or £1.6m year to date.
- Medical pay makes up 9.7% of the Trusts total pay bill but 55.4% of agency spend. 27.8% 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 eleven 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 £7.8m in year 23/24.

Throughout February 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 92% of all scheme assessments. There is 1 impact assessments still to be reviewed, and a further 12 assessments are either awaiting submission for review or have outstanding questions.

To date £7.2m worth of savings have been delivered recurrently, the full-year-effect of these is £8.9m. The table below provides a split of these savings by directorate:

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	£ 1,071,498	£ 846,914	-£ 224,584	£ 923,906	-£ 245,000
Doncaster Mental Health	£ 2,098,075	£ 1,923,235	£ 1,223,586	-£ 699,649	£ 1,334,821	-£ 763,254
Rotherham Care Group	£ 1,666,229	£ 1,527,377	£ 1,360,901	-£ 166,475	£ 1,484,620	-£ 181,609
North Lincolnshire Care Group	£ 801,466	£ 734,678	£ 409,844	-£ 324,834	£ 447,102	-£ 354,364
Childrens Care Group	£ 1,073,119	£ 983,692	£ 984,501	£ 808	£ 1,074,001	£ 882
Talking Therapies	£ 250,591	£ 229,709	£ 230,083	£ 375	£ 251,000	£ 409
Finance	£ 180,956	£ 165,876	£ 184,419	£ 18,543	£ 201,185	£ 20,229
Estates & Facilities	£ 509,523	£ 467,063	£ 184,421	-£ 282,642	£ 201,186	-£ 308,337
Governance	£ 174,060	£ 159,555	£ 154,811	-£ 4,744	£ 168,885	-£ 5,175
Operations Management	£ 121,581	£ 111,449	£ 78,449	-£ 33,000	£ 85,581	-£ 36,000
Medical	£ 228,743	£ 209,681	£ 181,499	-£ 28,182	£ 197,999	-£ 30,744
People & OD	£ 308,949	£ 283,203	£ 272,021	-£ 11,182	£ 296,750	-£ 12,199
Nursing & Quality	£ 190,012	£ 174,178	£ 174,167	-£ 11	£ 190,000	-£ 12
Health Informatics	£ 253,243	£ 232,139	£ 232,833	£ 694	£ 254,000	£ 757
Strategy	£ 32,936	£ 30,191	£ 30,250	£ 60	£ 33,000	£ 65
Depreciation & Interest Costs	£ 500,000	£ 458,333	£ 599,455	£ 141,122	£ 653,951	£ 153,951
Consultancy Reduction	£ 441,612	£ 404,811	£ -	-£ 404,811	£ -	-£ 441,612
Total	**£ 10,000,000**	**£ 9,166,667**	**£ 7,148,154**	**-£ 2,018,513**	**£ 7,797,986**	**-£ 2,202,014**

The Trust operates within two Integrated Care Systems: South Yorkshire ICS and Humber and North Yorkshire Health and Care Partnership. Each year efficiency savings are applied to the Trust's income from each system, and the Trust also runs it's own savings programme to support in enabling the achievement if its financial plan. Each system may need to deliver additional savings and may request that the Trust supports in achieving additional savings to overcome any unforeseen pressures or risks. The Trust's Board of Directors will be informed if any such request is made by the systems.

3.0 Debtors

Outstanding debtors ageing for the Trust (including Flourish) to 29 February 24 was as follows:

Debtor Collection Period	Feb-24	Jan-24
	Debtors	Debtors
Up to 30 Days	1,230	1,069
31 - 60 Days	111	138
61 - 90 Days	88	141
Over 90 Days	551	460
Totals	1980	1808

February 24 debtors were lower than January 24 for 31-60 days and 61-90 days whilst over 90 days has shown a small increase.

3.1 Creditors

The Trust's overall Better Payment Practice Code (BPPC) for NHS and Non-NHS creditors for February 2024 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 February 2024.This was expected and has been shared with FDE 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	Jan-24	Feb-24
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%	86.65%	86.89%
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%	84.77%	84.73%
Combined PSPP by value	**90.53%**	**92.50%**	**90.70%**	**85.41%**	**84.29%**	**83.27%**	**83.81%**	**84.51%**	**84.29%**	**84.97%**	**85.10%**
NHS - % number paid within 30 days	99.19%	99.20%	96.60%	91.88%	89.95%	89.71%	89.84%	90.07%	90.56%	90.28%	90.28%
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%	81.40%	81.93%
Combined PSPP by number paid	**93.43%**	**87.72%**	**87.40%**	**84.04%**	**81.96%**	**81.34%**	**81.67%**	**81.52%**	**82.00%**	**82.18%**	**82.64%**
Cumulative % value paid within 30 days	**90.53%**	**91.47%**	**86.80%**	**85.4%**	**84.30%**	**83.27%**	**83.81%**	**84.51%**	**84.29%**	**84.97%**	**85.10%**
Target	**95.00%**	**95.00%**	**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	Feb-24 Creditors	Jan-24 Creditors
Up to 30 Days	171	442
31 - 60 Days	142	367
61 - 90 Days	49	127
Over 90 Days	81	207
Totals	**443**	**1143**

3.2 Liquidity

At 29 February 2024, the Trust had £36.00m (£36.7m including third party funds) in cash against a plan of £42.7m. 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 £578k.

£'000	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Actual Cash	39,923	38,432	36,634	43,885	39,312	37,677	36,192	38,504	39,015	39,507	37,414	36,031

3.3 Bank / Investment Policy

Total interest earned year to date is £1,907k. Interest earned on deposited funds in February was £182k, increased from £178k for January. The Bank of England base rate did not change from the previous month.

	Feb-24	Interest	Jan-24	Interest
	£'000	Rate	£'000	Rate
GBS Account	**35,351**		**36,405**	
National Loan Fund				
NatWest accounts				
Collaboration Bank	**253**		**449**	
Instant access deposit account	**150**		**150**	
Current accounts - RDaSH	**95**		**36**	
Bank accounts – Flourish	**578**		**761**	
Lloyds Bank Cash investment	**302**		**270**	
Petty cash interest total:	**19**		**19**	
	36,748		**38,090**	
Less Third-Party Funds	**-716**		**-677**	
	36,032		**37,413**	
Interest Earned				
GBS	182	5.14%	178	5.14%
	182		**178**	

A total of £716k held within the cash balances for the Trust are third party funds mainly held on behalf of patients who require financial assistance to manage their own funds.

3.4 Capital Expenditure

Total capital spend to 29 February 2024 was £5,366k against a plan of £5,371k. 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. The Trust received additional capital funding to overspend on the original plan by £400k. This is shown in the forecast table below.

Performance at M11	YTD Plan	YTD Actuals	YTD Variance
	£'000s	£'000s	£'000s
Capital Programme	5,371	5,366	5

Forecast Performance	Annual Plan	Forecast	Forecast Variance
	£'000s	£'000s	£'000s
Capital Programme	6,660	7,060	-400

4.0 Charitable Funds

The current Charitable Fund balances at 29 February 2024 market valuation were £2,535k. The book value balance is £2,303k and unrealised gain is £232k.

Charitable Funds are invested through Investec. The investments are monitored regularly by the Charitable Funds Committee.

5.0 Recommendations

The meeting is asked to:

Review and note the issues raised in this Financial Report.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Risk Report as at 18 March 2024	**Agenda Item**	Paper T
Sponsoring Executive	Phil Gowland, Director of Corporate Assurance / Board Secretary		
Report Author	Jane Charlesworth, Corporate Assurance Manager		
Meeting	Board of Directors	**Date**	28 March 2024

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

A previously reported the number of live risks has grown and stands now at 250 live risks as at 18 March 2024 (compared to 104 live risks in March 2023.)

Following moderation by the Risk Management Group in March and as reported to the Clinical Leadership Group (CLE), there is now one extreme-rated risk relating to patient flow and the number of out of area beds (risk lead Chief Operating Officer).

In line with the revised Risk Management Framework the reporting of risk to the Board from April 2024 onwards, will be by exception in relation to any extreme risks only. The Audit Committee will continue to receive reports on the delivery and implementation of the Risk Management Framework as part of the system of internal control oversight. The Risk Management Group is the key operational forum for discussing risk, although it also features within the monthly delivery review process with care groups and corporate services.

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?)

The Board has to date received a report at each meeting relating to risk management. This updated report reflects on the most recent position including the outcome of the moderation of risk (supporting the new extreme risk) by the Risk Management Group in March 2024.

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 in particular the escalation of O10/19 as extreme and to note the mitigating actions stated.

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	
System / Place impact		

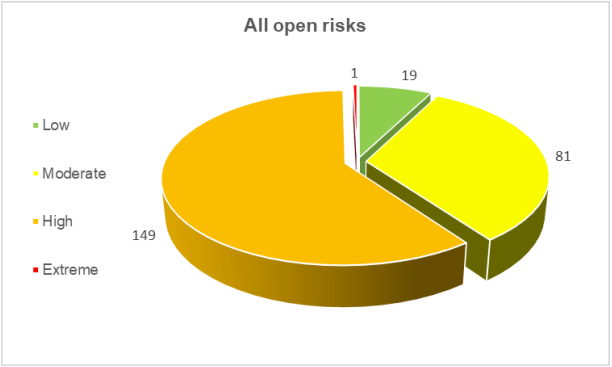
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Appendix A – Risk Background Information

1. OPERATIONAL RISKS

There are currently 406 risks across the Trust risk registers (as at 18 March 2024), 250 of which are classified as 'Live' risks and 156 are classified as 'Tolerated' risks.



The 250 'Live' operational risks are at varying levels of mitigation ➲

By way of comparison:

last report – January 2024, there were 237 live operational risks.

this time last year – March 2023, there were 104 live operational risks.

In March 2024 a high risk was escalated to Extreme, supported by the Risk Management Group acknowledging that the risk had increased, continues to escalate and reflects the current patient flow challenges. The risk lead is the Chief operating Officer and it is summarised below with the controls that are being utilised to mitigate:

Risk	Score	Controls	Target score	Last update
O 10/19 If the patient flow into and through the Mental Health inpatient units is not improved then the trust will continue to place people in Out of area acute beds impacting on negative patient and family experience, increasing wait times and delivery against National KPIs.	I x 3 L x 5 RS = 15	• Patient Flow team to support active management of beds through the Care Groups • Bed state reporting. • Friday planning meeting in place to bring structure to managing beds over the weekend. • Daily PIC/OAP tracker has been implemented to provide greater oversight of all patients irrespective of location. • Care Group Director approval required prior to any placement. • Multidisciplinary Team Improving Admission & Discharge Pathways Events schedule din and taking place. • 24/7 Patient Flow Duty Manager Function	I x 3 L x 2 RS = 6	At the end of February 28 patients were in a provider outside of the RDaSH footprint. This remains an area of significant 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. We continue to experience challenges with long lengths of stay, an overall decline in our discharge rates from the inpatient wards and the number of patients who are clinically ready for discharge (but delayed) which is impacting on our ability to have the correct capacity to facilitate new admissions and return patients from out of area. There are a number of patients clinically ready for discharge (but delayed). This has been escalated to our COO and the Care Groups.

High risks include any risk with a score of 12, 10, 9 or 8. The Board of Directors receives notice of the number of risks scoring '12' - currently there are 54 risks with a score of 12. Presented below is a summary of those high-rated (score of 12) risks, by risk register and theme (linked to the strategic risks). The most prominent theme (for the high (12+) scoring risks) is 'standards of care' (18 risks). The themes will be revised going forward and aligned to new Board Assurance Framework once developed.

Register / Theme	Children's Care Group	Doncaster AMH & LD Care Group	Physical Health & Neurodiversity Care Group	North Lincolnshire AMH & Talking Therapies Care Group	Rotherham AMH Care Group	Operations	Corporate Assurance	Finance	Estates	Health Informatics	Medical & Pharmacy	Nursing & Quality	People & OD	Strategy	Total
Standards of Care	1	6	1		3	2					2	1		2	**18**
Destablising Events					1	1			2	2					**6**
Recruitment & Retention	1		3	1	1	1					1	3			**11**
Culture & Development					1				3		1				**5**
Financial Stability		1	2	1		1					3			1	**9**
Governance															**0**
Collaboration			2		1						2				**5**
Total	**2**	**7**	**8**	**2**	**7**	**5**	**0**	**0**	**5**	**2**	**9**	**4**	**0**	**3**	**54**

N.B. Risks are allocated by their primary theme only.

2. RECOMMENDATION

The Board is asked to:
RECEIVE and NOTE the latest position regarding operational risks in particular the escalation of O10/19 as extreme and to note the mitigating actions stated.

APPENDIX A

RISK BACKGROUND INFORMATION

The identification and proactive management and mitigation of operational risk is key to ensuring the Trust's activities and services are delivered effectively.

All risk registers have an 'owner' who has the responsibility for maintaining the risk and providing updates. A 'Risk Lead' is allocated to each operational risk and they are responsible for ensuring that any changes to the risk are captured, that related actions are implemented, and that the risk is regularly reviewed and updated.

The Trust's risk assessment scoring methodology is based on the NPSA matrix whereby the level of risk is assigned.

High Risk	Extreme Risk
Low Risk	Moderate Risk

		Likelihood Score				
		1	2	3	4	5
Impact Score		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

The severity of a risk is determined by assessing its' impact and likelihood and subsequently scoring as 'low', 'moderate', 'high' or 'extreme'.

Any risk rated between 15 and 25 is classed as extreme and must be moderated and the risk scoring agreed by the Risk Management Group.

Live risks - those risks that the Trust is actively treating in order to mitigate the risk level down to the identified target level of acceptable risk.

Tolerated risks - 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. These are classified as tolerated risks, are usually scored as 'Moderate' or 'Low' and are subject to an annual review by the risk lead.

The Board of Directors is responsible for the implementation of the Risk Management Framework and for overseeing the effectiveness of processes for the identification, assessment, management, and mitigation of risk.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	South Yorkshire Mental Health and Learning Disabilities and Autism Provider Collaborative (SY MHLDA PC) – Joint Working Agreement and Terms of Reference	**Agenda Item**	Paper U
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	28 March 2024

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

Within the Chief Executive's Report (Paper L and Annex 5) the Board has been provided with the latest update in respect of the work of the Provider Collaborative. A part of the discussion of that meeting in January 2024 was aimed at further clarifying the future relationship between the current specialised commissioning governance arrangements and the Board of the SY MHLDA PC.

As a result, a number of changes were proposed to the terms of reference and were subsequently supported by the Provider Collaborative Board. Given that the original joint working agreement and terms of reference were presented to and approved by the Trust's Board, these proposed changes are presented for approval. The three changes focus on the receipt and consideration of strategic and annual plans; and of regular performance reports; and the engagement of the Provider Collaborative Board on major commissioning or de-commissioning decisions.

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

3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	x
4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	x
Business as usual	x

Previous consideration

The Board of Directors received a briefing relating to the governance arrangements and approved the Joint Working Agreement and Terms of Reference in March 2023.

Recommendation

The Board of Directors is asked to:

x	**AGREE** the amendments proposed to the terms of reference and joint working arrangements described within the paper.

Impact

Trust Risk Register							
Board Assurance Framework	x	SR4 – Partnership working					
System / Place impact	x	Collaborative working across the ICB					
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)

Diagram to illustrate the Provider Collaborative relationships.

South Yorkshire Mental Health, Learning Disability & Autism (MHLDA) Board

Relationship between SYB Specialised Commissioning and SY MHLDA PC Board – Revised Terms of Reference

March 2024

1. Purpose

In January 2024, the SY MHLDA PC Board clarified the future relationship between the current specialised commissioning governance arrangements and the Board of the SY MHLDA PC. The purpose of this paper is to highlight to member Boards the subsequent amendments to the Terms of Reference that have been made to strengthen this future relationship.

These changes have been considered and agreed by the members of the SY MHLDA PC Board. Given their role in originally agreeing the terms of reference and joint working agreement, Trust Board members are also being asked to agree these amendments.

2. The role of this Collaborative in the oversight of the Specialised Commissioning arrangements for Tier 4 CAMHS, AED and Forensic Services

Each provider Trust holds individual responsibility for the administration of their contracts but works together in using the hub's services and in working alongside NHSE. The SYB's Specialised Provider Collaborative currently hosts a Partnership Board, which is a provider shared board, shared among those leading the indicated 3 services, with additional stakeholders from SHSC as members and the ICB and the SY MHLDA Provider Collaborative as attendees.

At SY MHLDA PC Board in December the role of the SY MHLDA PC in the oversight of the Specialised Commissioning arrangements for Tier 4 Child & Adolescent Mental Health Services (CAMHS), Adult Eating Disorders and Forensic Services was discussed. It was agreed that there was a need to retain the existing Partnership Board as a separate forum to maintain programme oversight of the specialised collaboratives and share learning in a focused way. However, there was acceptance that the term Board may create some confusion, not least given that NHS Trust Board's retain individual ownership, and that the Board of the MHLDA Provider Collaborative is an important and recognised part of the SLE/ICB landscape. The proposal is therefore that the previous Partnership Board becomes a Steering Group. This change in nomenclature is reflected in the revised terms of Reference.

In addition, the SY MHLDA PC Board discussed and agreed suggested amendments to the Terms of Reference of the Specialist Commissioning Partnership Board (now the Steering Group) and the SY MHLDA PC Board Terms of Reference and Joint Working Arrangement to reflect the changing landscape. The amendments are highlighted below for ease of reference rather than appending the full documents, but these are available if required. A relationship diagram is included at Appendix One for reference.

The changes have been made to align with the following points:

- Ensure that annual plans and key strategic documents associated with the three services and the funded hub functions are reviewed and considered by the Collaborative Board prior to their adoption and approval elsewhere.

- Provide for formal engagement with the Board prior to any major commissioning or de-commissioning decisions, including long term material agreements or the development of procurement exercises.

- Receive a regular report for information on matters of finance, risk, clinical safety, and performance given the broader oversight role in sectoral services expected of the collaborative by the ICB.

Further amendments to the Terms of Reference might be necessary as the potential commissioning and delivery models for Eating Disorder services across South Yorkshire are considered and operationalised.

3. Next Steps

Following agreement of the revised Terms of Reference and JWA, communications will be drafted to make the relationships clear.

The SY MHLDA PC workplan will be amended and we will consider how to formulate and organise the risk registers of both groups to ensure risks are appropriately highlighted and that route of management and accountability is clear.

4. Recommendation

Board is asked to agree the amendments proposed to the terms of reference and joint working arrangements described within the paper.

Marie Purdue, Managing Director, SY MHLDA PC

Appendix – Diagram to illustrate the Provider Collaborative relationships