NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 29 May 2025 at 10.00am
The Centre, Brinsworth Lane, Brinsworth, Rotherham, S60 5BU

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Sarah Fulton-Tindall	Note Information		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Standing items				
5	Minutes of the meeting held in public on the 27 March 2025	Decision	KL	B
6	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
7	Quality Committee	Assurance	RF	D
8	Audit Committee	Assurance	KG	E
9	Mental Health Act Committee	Assurance	RF	F
10	People & Organisational Development Committee	Assurance	RB	G
11	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	H
12	Finance, Digital & Estates Committee	Assurance	PV	I
13	Trust People Council	Assurance	KL	J
14	Chief Executive's Report inc PSIRF Policy approval	Information / Decision	TL	K
15	Staff Survey – Areas of Focus	Decision	CH	L
BREAK (11.30am)				
16	CQC Readiness: Safe, Effective, Caring and Responsive	Decision	SF	M
17	Freedom to Speak Up update (Inc the FTSU Guardian James Hatfield)	Assurance	SF	N
18	Plans for Approval: • Quality and Safety Plan • Equity and Inclusion Plan	Decision	TL	O
Patient Story				
19	Human Trafficking and Modern Slavery – Multiple Trust Services	Information	JG	Verb

RDaSH nurturing the power in our communities

20	2024/25 Serious Patient Safety Incidents – Learning update	Information	SF	P
21	CQC Readiness: Well-Led	Information	PG	Q
22	Reduction of Inappropriate Out of Area Placements	Information	RC	R
Operating Performance / Governance / Risk Management				
23	Integrated Quality Performance Report (IQPR)	Assurance	TL	S
24	Promises and Priorities Scorecard	Assurance	TL	T
25	Strategic Delivery Risks	Assurance	PG	U
26	Operational Risk Report	Assurance	PG	V
27	Fit and Proper Person Test	Assurance	PG	W
Papers for Information				
28	Infection Prevention and Control Annual Report	Information	SF	X
29	Safeguarding Annual Report	Information	SF	Y
Supporting Papers (previously presented at Committee)				
30	Learning from Deaths Annual Report	Information	KL	Z
31	Any Other Urgent Business (to be notified in advance)		KL	Verb
32	Any risks that the Board wishes the Risk Management Group to consider			
33	Public Questions *			
	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	
34	*Minutes of the meeting held on the 27 March 2025 and 24 April 2025 (private sessions)*	*Decision*	KL	AA
35	*Matters Arising and Follow up Action List (private sessions)*	*Decision*		BB
36	*Reflections on the patient story*	*Discussion*		Verb
37	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC

*** Public Questions:**

Questions from the public may be raised at the meeting where they relate to the papers being presented that day. Alternatively, questions on any subject may 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 will take place on Thursday 24 July 2025 10am at The Arc, 2 Lichfield Avenue, Scunthorpe, DN17 1QL

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	29 May 2025

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.
- There are changes to the register, since the last meeting that include the removal of interests relating to Prof Janusz Jankowski and the addition of Maria Clark to the register.

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?)

Paper presented to each public Board meeting

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

The Board is asked to:

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

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

Trust Risk Register							
Strategic Delivery Risks							
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

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 • Non-Executive Director at Locala Community Interest Company
Toby Lewis, Chief Executive	• Nil
Richard Banks, Director of Health Informatics	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Rachael Blake, Non-Executive Director	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • Elected Member - City of Doncaster Council • Director - Bawtry Community Library

Name / Position	Interests Declared
Richard Chillery, Chief Operating Officer	• Nil
Maria Clark **Non-Executive Director**	• **Lay Examiner for the Royal College of Obstetrics and Gynaecology** • **School appeals and Chair of the Independent Review Panel, Barnsley MBC** • **Grant making panel member for the Three Guiness Trust** • **Solicitor, Taylor Emmet Solicitors** • **Lay member National Institute of Clinical Excellence (NICE)** • **Associate Hospital Manager at Leeds and York Partnerships NHS FT and Derbyshire Healthcare NHS FT** • **Volunteer - Stroke Rehab Services Review, Joined Up Care Derbyshire** • **Voluntary Research Ethics Committee Member, Ministry of Defence** • **Voluntary Patient Safety Partner and Patient Advisory Forum member – NHS England** • **Voluntary member of the Research Ethics Committee, University of Sheffield** • **Voluntary Board member (non-voting) College of general Dentistry**
Dr Richard Falk, Non-Executive Director	• Nil
Steve Forsyth, Chief Nursing Officer	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative • Fellow of the Queens Nursing Institute (QNI). • Member of Asian Professionals National Alliance • Member of British Indian Nurses Association • Member of Jabali Men's Network • Member of Nola Ishmael Executive Nurses
Kathryn Gillatt, Non-Executive Director	• Non-Executive Director at the NHS Business Services Authority and Chair of the Audit and Risk Committee. • Sole trader of a Finance and Business Consultancy.
Philip Gowland, Board Secretary and Director of Corporate Assurance	• Wife is Primary Care Strategic Lead employed by RDaSH.
Dr Jude Graham, Director of Psychological Professionals and 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.

Name / Position	Interests Declared
Carlene Holden, Director of People and Organisational Development	• Governor and Vice-Chair at Brighter Futures Learning Partnership Trust – Hungerhill School, Doncaster.
Jo McDonough, Director of Strategic Development	• Nil
Izaaz Mohammed, Director of Finance and Estates	• Chair of Governing Body – Westmoor Primary School, Church Lane, Dewsbury, West Yorkshire.
Dr Diarmid Sinclair, Chief Medical Officer	• Nil
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.
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 • Director of Marsh and Vickers Coaching Limited

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 27 MARCH 2025 AT 09.30AM CAST THEATRE, WATERDALE, DONCASTER, DN1 3BU

PRESENT

Kathryn Lavery	Chair
Rachael Blake	Non-Executive Director
Richard Chillery	Chief Operating Officer
Sarah Fulton-Tindall	Non-Executive Director
Steve Forsyth	Chief Nurse
Kathryn Gillatt	Non-Executive Director
Carlene Holden	Director of People and Organisational Development
Toby Lewis	Chief Executive
Izaaz Mohammed	Director of Finance and Estates
Dr Diarmid Sinclair	Chief Medical Officer
Dave Vallance	Non-Executive Director
Pauline Vickers	Non-Executive Director
Dr Janusz Jankowski (v)	Non-Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Lea Fountain (v)	NeXT Director
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Jude Graham	Director for Psychological Professions and Therapies
Jo McDonough	Director of Strategic Development
Sarah Dean	Corporate Assurance Officer (Minutes)
Emily Andrews	Staff Story
Melanie Mitchell	Staff Story

7 members of staff and 4 Governors were in attendance

Ref		Action
Bpu 25/03/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Dr Richard Falk. Mrs Lavery noted that with additional financial discussion required, she had agreed to defer discussion of agenda Item 24, the enabling and delivery plans, to the Board timeout. She drew attention to the day-before issue of an addendum to agenda Item 16, 2025 to 2026 Financial Plan, with paper copies available. This addendum recognised negotiations with the ICB over the past 48 hours which had resulted in a recommended balanced plan, albeit with elevated risk associated with the High Dependency Unit (HDU) dependency.	
Bpu 25/03/02	**Quoracy** Mrs Lavery declared the meeting was quorate.	

Bpu 25/03/03	**Declarations of Interest** Mrs Lavery presented the declarations of Interest report which outlined that there were changes to the register declared since the last meeting relating to Mr Mohammed and Mr Forsyth. **The Board received and noted the changes to the Declarations of Interest Report.**	
	STAFF STORY	
Bpu 25/03/04	**Staff Story – Adult Neurodiversity Service** Mrs Lavery welcomed Emily and Melanie to the meeting to share their story and experience of working in the adult neurodiversity service. Emily and Melanie shared they were both ADHD practitioners (attention deficit hyperactivity disorder). Emily was new to the team and new to prescribing, whereas Melanie had worked within the team for the past year. Emily acknowledged the organisation had made commitments and investment into the service to address ADHD assessment and waiting times. Emily and Melanie highlighted the importance of reducing waiting lists for assessment and provide high quality care. The ADHD referral point had changed including the role of Band 5 staff in triaging and managing referrals, which helped the management of referrals with thorough assessment and gathering of information to provide personalised care for patients, accurate diagnoses and appropriate treatment plans. They highlighted the importance of patient safety, including managing complex cases and ensuring patients receiving the right level of care and support. The challenges the team had faced included managing large caseloads, prescribing and medicines management with regular follow up, the mental and emotional toll on colleagues, and need for better health, safety and wellbeing support such as fit for purpose staff base. Emily and Melanie shared examples of how medication had positively impacted patients' lives. The ADHD team would be exploring non-pharmacological interventions, such as psychosocial support, to complement medication and provide holistic care for patients. Mr Lewis reflected the sheer sense of responsibilities the team were carrying to address waiting times, and questioned how the organisation could support the team to balance that burden. Dr Graham offered the team support, and acknowledged the service was high paced and makes a real impact on those with lived experience. Mr Lewis reflected on the point there was no base for the whole team and noted this would change as part of estate transformation plans – funded in the capital plan for 25/26. Ms Blake queried whether there were peer support and voluntary sectors which could provide additional support. Melanie advised there were not many voluntary services which specialised in autism however the service did link in with the local voluntary autism service.	

	Mr Chillery highlighted the challenges the ADHD team faced and was important to hear, acknowledging it was not always cognisant of how many cases were being managed in the community. Mr Chillery explained managing ward environments were challenging when on the ward, but recognised community was different and not always able to handover cases when taking annual leave. Mr Forsyth agreed the burden of responsibilities and period of care when handing over was very different in the community compared to inpatient ward care. Mrs Lavery and the Board thanked Emily and Melanie for taking the time to speak about their experiences and noted the intended reflection time later on the agenda.	
Emily and Melanie left the meeting at 10.00 am		
STANDING ITEMS		
Bpu 25/03/05	**Minutes of the previous Board of Directors meeting held on the 30 January 2025** **The Board approved the minutes of the meeting held on the 30 January 2025 as an accurate record.**	
Bpu 25/03/06	**Matters Arising and Follow up Action Log** Mr Lewis referenced the backlog of Structured Judgement Reviews (SJR) discussed at the last meeting (Item Bpu 25/01/07). From 31 March 2025, additional resource was in place to address the backlog of SJRs. He reminded the Board that from, April 1 2025 SJRs would work differently and would only be undertaken in certain circumstances aligned to our PSIRF approach. The outcome of the Good Governance Improvement (GGI) review, discussed at the last meeting (Item Bpu 25/01/06) had been received and would be shared with Board members in the forthcoming Well-Led paper. Mr Forsyth referred to the previous minute regarding Promise 3 (Item Bpu 25/01/18) and confirmed it accurately recorded his contribution to the discussion but clarified that the current position with respect to volunteers was that there were 220 volunteers, with a further 80 offers pending (offers made in writing to individuals). There were no other 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. With reference to closed action Bpu 24/09/19, Mrs Lavery advised she had met with Ms Fulton-Tindall to discuss the role of Board Security Champion, noting a job description had been identified. Mr Forsyth reported the commencement of a full reaudit and recovery plan into the next quarter of Mental Capacity Act (MCA). This work needed to beyond a focus on training compliance.	**PG**

	In relation to open action Bpu 24/09/25, Mr Chillery advised pathways for mental health (OP08d) had made significant improvement towards achieving the 92% target and would continue to be reported via the Integrated Quality Performance Report (IQPR). **The Board agreed to close this action.** Mr Lewis recommended the consideration by the Risk Management Group, of a risk of disengagement, noting the Trust had received a Regulation 28 regarding disengagement (open action Bpu 25/01/21b).	**PG**
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
Bpu 25/03/07	**Report from the Quality Committee (QC)** Mr Vallance, on behalf of Dr Falk, presented the paper and gave the key highlights. The annual safe staffing declaration provided assurance the organisation was compliant with national standards (in patient areas only). The Committee took assurance of the direction of travel for the safe staffing workstreams. Mr Lewis reminded the Board that the staffing establishments for 2025 to 2026 had been set and would not change unless there was a clear egregious difference and professional judgement to patient safety that required a revisit. With regards to the MHOST acuity tool (recommended tool for use for mental health bed-based services) this was a supportive tool, but it was made clear that clinical professional judgement would take precedent. MHOST in 25/26 would influence workforce planning, as MHOST in 2024/25 had. Steve Forsyth confirmed that that was the intention and supported this. Progress had been made against Health, Safety and Security plans including Violence Prevention and Reduction Standard (VPR). The Committee felt clarification was required around the future reporting arrangements for the health and safety plan, to avoid duplication of work between Committees (the Quality Committee and Finance, Digital and Estates Committee). The Committee noted the recovery plans to address backlogs in respect of SJRs and complaints. The digital programme for safe quality care was positively received and highlighted the importance of data quality in patient care. Mr Vallance wished to record the Committee's appreciation to Dr Jankowski for his contribution whilst a member of the Committee. **The Board received and noted the report from the Quality Committee.**	
Bpu 25/03/08	**Report from the Audit Committee** Ms Gillatt presented the paper and highlighted three points to the Board. The Counter Fraud, Bribery and Corruption work was on target to deliver the plan with no matters of concern to report.	

	Internal audit had issued three audit reports since the last meeting (strategic delivery risk management- significant assurance; estates helpdesk implementation - limited assurance; and policy management framework - moderate assurance). Follow up work on audit actions remained strong with continued oversight and progress through audit action leads. The interim Head of Internal Audit opinion was likely to be 'moderate' and this would be received at the next Committee meeting in April. The final accounts timetable and plan was noted, including the recent interim audit work. Ms Gillatt highlighted the emerging issues relating to the treatment of St John's Hospice within the balance sheet (donated assets). Work was underway to resolve this matter and dependent upon the outcome a prior year adjustment / representation of the accounts may be necessary. Mr Mohammed advised this work would not impact on his ability to make the necessary submissions for 2024 to 2025 accounts in line with the timetable. Responding to a question from Mr Lewis, he noted that any prior year adjustment implications would be discussed with the accountable officer in coming days, should they prove necessary. Mr Mohammed provided positive feedback from his meetings with the external auditors Deloitte, noting the interim audit so far had gone well. **The Board received and noted the report from the Audit Committee.**	**IM**
Bpu 25/03/09	**Report from the Mental Health Act (MHA) Committee** Ms Fulton-Tindall presented the paper and highlighted key points. There had been two CQC MHA inspection visits which had identified a consistent theme around personalised care planning. This had also been identified as part of the annual MHA performance reporting. A review of personalised care planning was underway to provide clarity of what constituted a personalised care plan. MHA seclusion remained a challenge particularly the accurate recording of the seclusion on the electronic patient record system. Positive progress had been made against sustaining MHA level 3 training compliance. Further improvements had also been made in MHA reporting in relation to correctly recording Consent to Treatment and Section 132 Rights. The Committee positively received a MHA patient and carer feedback report, this would be built on as part of the delivery of Promise 4. Mr Chillery referred to Care Group Delivery Reviews, advising the care groups were requested to review what their future training needs analysis would be over the next year including care planning. Ms Holden advised support was being provided to improve training compliance with focus across MHA level 3 and Reducing Restrictive Interventions. There were 52 staff non compliant with training (including some exceptions such as long term sickness). Additional courses were available to those staff during March, April and May 2025. She understood that only 2 individual remained unaccounted for.	

	The Board received and noted the report from the Mental Health Act Committee.	
Bpu 25/03/10	**Report from the People & Organisational Development (POD) Committee** Mrs Vickers presented the paper and highlighted key points. Sickness absence had slightly increased to 6.28%. A task and finish group would be undertaking a deep dive review and a revised policy (Supporting health, wellbeing and managing attendance policy) would be launched in April 2025. This had been widely discussed within CLE. The vacancy position was closing in to target of 3.3% (less than 100 vacancies) with efforts continuing to manage turnover and improve the vacancy rate to 2.5% for 2025 to 2026. Following the emergency closure of Brambles ward in Rotherham, a meeting took place with the Deanery to discuss the impact of clinical service re-design on education and training. Ms Holden provided feedback from that meeting, stating there were in total seven resident doctors who were impacted by the ward closure. The seven resident doctors had since reported positive training experiences from working in a blended approach across the communities as a result of the closure of the Brambles ward. Mr Lewis noted the importance of the Deanery's formal guidance in relation to junior doctor placements and training programme but also drew attention to the informal nature of the visit, which was not a quality escalation. A formal response by the end of May would be submitted by himself and Dr Sinclair. The Leadership Development Offer (LDO) launched in January with cohort one; a second cohort would commence from April 2025 and again this included several community partners. **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 25/03/11	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Mr Vallance, on behalf of Dr Falk, presented the paper. Regarding eating disorders, it was noted the Ellern Mede unit at Moorgate was closed with the relocation (with the patients' full agreement) of long term patients to London, noting there had since been improved patient outcomes. The Strategic Delivery Risk (SDR3) focus was on building relationships with primary care, highlighting the importance of engagement and raising awareness of the services available across the organisation amongst staff and with primary care. The Poverty Proofing workstream (Promise 6) had collaborated with the Citizens Advice Bureau. This would provide money and debt advice for patients and staff. Ms Holden added the hardship grant was also	

	available for staff. Funding of £35k from the investment fund was agreed to support some patients in relation to transport costs. Health inequalities data highlighted there were higher Did Not Attend (DNA) rates in deprived areas across Rotherham which stood at 42%. Work was underway to reduce this. Health inequalities data would be included in the IQPR and presented to the Board on a regular basis. Mrs McDonough referred to the eating disorders collaborative and clarified the extra package of care had reduced significantly. However that did not bring any funds back into the organisation and was not a financial gain. Dr Graham commented it was a real investment to help people travel to appointments, triangulating with the fact that vacancies were being filled so people could be seen and attend appointments. Mrs Lavery reflected the organisation was making changes which would make a real difference to communities such as support for travel to appointments. Mr Lewis explained the transport support protocol would have to provide people with the funds in advance to use for transport and not putting people out of pocket, rather than the traditional way of claiming back travel expenditure. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	**TL / RB**
Bpu 25/03/12	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper and highlighted estates compliance remained an area of focus, in particular fire safety although it was an improving picture. It was noted fire assessments were due to be completed by the end of March 2025 and external specialist support was being provided. A sustainable, forward plan was in place in relation to fire safety compliance. Regarding the estates enabling plan, there would be further exploration for potential funding solutions including land disposal, system capital allocation, national programmes, and off-balance sheet schemes. Mrs Vickers extended the offer to Board members to discuss the estates enabling plan funding options. The draft finance plan 2025 to 2026 was received, noting work would continue to develop the finance plan and it would be discussed later on the Board's agenda. The clinical coding audit report provided assurance there was a robust process in place and to a high standard. The report positively highlighted the achievement of quality in clinical coding undertaken across the organisation. Mr Lewis noted it was encouraging that each group was confident in delivering its financial plan this year. Mr Mohammed explained there had been a lot of focus, scrutiny and increased grip on directorate level review of budgets, controlled spend and non-recurrent funds, and	

	budgets would be signed off on the basis of all 23 directorates for the first time. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 25/03/13	**Report from the Remuneration Committee** Mrs Lavery presented the paper and highlighted the discussions. Mr Lewis suggested increasing confidence that a new VSM (very senior manager) pay framework would be published soon, and that it would be received at a future meeting of the Committee. **The Board received and noted the report from the Remuneration Committee.**	
Bpu 25/03/14	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report and one item which was not contained in his report in relation to the recent Government changes affecting carers and disability allowances. Mr Lewis recognised the changing welfare landscape ahead and reminded the Board of the organisation's commitments and delivery of Promises (examples such as Real Living Wage and Poverty Proofing) and suggested that the Board should continue to consider whether these were proportionate response to the challenge communities now face. The new interim general practice (GP) contract was worth noting. The conclusion to the dispute should allow the Trust to move forward with Shared Care Agreements. Conversely the lower priority for annual health checks was noted. Future medical education and placements would be reviewed, considering the positive reflections from the Deanery. The structure of the medical education leadership would also be strategically strengthened to create a team support of education for future resident doctors. The most important step within those changes would be embedding the team within the CMO's directorate, with Diarmid Sinclair holding the accountability. Mr Lewis noted there would be potential changes to the curriculum specifically the Sheffield School of Psychiatry to approach all age services. The potential changes in education arrangements could support the Neighbourhood Health workstream for community-based services, which would look to re-introduce 'generalism' in care models which have moved for some time towards sub-specialisation. The first community geriatrician was due to join the organisation as part of bringing together the wider specialist physical and mental health services. This important role and change would support how the organisation worked with system partners to support older adults. Discussions with the ICB remain ongoing to fund a second community geriatrician, potentially through winter 2025 to 2026. Following the Board's discussion on violence and on RRI practices in November 2024, the implementation of an RRI advocacy role in each	

	ward team would be undertaken during Q1. This work would be led by care group senior nurses and overseen through the High Quality Therapeutic Care (HQTC) Taskforce. The RRI training would also be enhanced. Mr Lewis advised there would likely be a change in the ward behavioural landscape from July when out of area placements would cease, recognising the importance of having the RRI advocate roles in place from Q2. Mr Lewis noted the Board would seek to confirm in May, for the staff survey, as it had done for CQC ratings, what the organisational aim truly would be over the period to 2028. In response to Dr Graham, Mr Lewis stated he believed the recent Government announcements may cause some interruption of relationships and to potential national programmes of work, but did not foresee delays with any organisational plans. Mr Lewis cautioned that the Board would need to remain mindful and aware of these changes and that there may be implications from provider led arrangements and commissioning, this could in turn present both risk and opportunities. Mr Lewis had arranged to meet with senior leaders next week in direct response to the Government 'reset' and the potential implications for the organisation and other non NHS clinical services across Rotherham, Doncaster and North Lincolnshire. Mr Lewis reminded the Board a new NHS 10 year plan was be due to be published in June 2025. With regards to 'think directorate', Mr Vallance noted the Quality Committee received the clinical audit and effectiveness report and queried whether this would provide encouragement for directorates to understand clinical effectiveness. Mr Lewis agreed and advised the directorates continued a development journey and data flow and quality measures for directorates would continue to develop, including the DIALOG+ tool deployment to be delivered during 2025. Mr Chillery referred to potential impacts around Section 117, case management of specialist placements, and continuing healthcare checklist assessments. Although it was too soon to identify any risks, Mr Chillery advised they would continue to be monitored and related to the risk register should that be necessary. In response to Mrs Gillatt, Mr Lewis advised there would be no change at present to the Standing Financial Instructions or Schemes of Delegation arising from the 'Think Directorate' development works. Regarding any change in model and potential operational or strategic risks, he anticipated the biannual risk appetite review would be undertaken at the Board time out in April. With regards to 'think directorate' and whether clinical research would be considered for directorates' quality measures, Mr Lewis stated the Research and Innovation Plan did include certain academic research outside the organisation specifically in management leadership disciplines that would support the organisational strategic plan and promises. A recent case from the children's care group delivery review discussed innovative changes to service they were leading on which involved creating a culture of clinical research and experiments. Mr	**CH** **PG**

	Lewis highlighted it was important to have the balance of locally led clinical research and strategic plans. Ms Fulton-Tindall referred to the Government 'reset', noting public funding would be changing and questioned how likely this would impact on delivery of promise 23 (investment in residential care). Mr Lewis replied that he believed this would be an opportunity to expand work across Place. This work had already commenced in Doncaster with commitment to divert NHS resource into the public health budget, and the ability to offer social care services via Flourish (Community Interest Company). Mr Mohammed referred to supporting system partners with estate challenges and the potential to develop new models of working. Mr Lewis responded that conversations would continue to create triangulated relationships with care homes, hospitals and primary care, and build on delivering Promise 23. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	
Bpu 25/03/15	**2024/25 Serious Patient Safety Incidents – Learning** Mr Forsyth presented the paper. All patient safety incidents were responded to with immediate learning discussed at the time of the incident, including significant learning from serious incidents. All reviews form part of the Patient Safety Incident Response Framework (PSIRF) and learning from those serious incidents identified the theme to improve data quality such as patient records and care plans. Following restructure within the nursing and facilities directorate, there was a clear remedial action plan in place to conclude those serious incident reviews which had exceeded six months to complete. Mr Vallance sought clarity on what the report was seeking to tell us, as many of the PSIIs were not yet completed from 2024/25. Ms Fulton-Tindall also questioned whether the paper set out learning or symptoms from case review. Mr Lewis suggested that what was needed was the learning, the forward measure and an understanding for these most serious of patient safety incidents about when and how we would know change had occurred. Mr Forsyth acknowledged that the paper did not contain that material and emphasised the scale of work to be done in forthcoming weeks to address these concerns. Mrs Lavery suggested that the paper needed to be resubmitted in May, with the wider detail included and work completed. She welcomed the openness of the discussion and emphasised that the Board must carry in its mind clarity about the PSIIs we have each year. Mr Forsyth emphasised there were initial learnings from implementing the new standards of the PSIRF to take forward to provide further assurance and demonstrate learning from incidents. An example would be the learnings and significant sustained changes made following a serious incident and Regulation 28 around ageless service response to crisis out of hours. Those changes would pre-empt or stop a further similar incident from occurring again within the organisation.	

	In response to Mrs Gillatt and Ms Blake, Mr Forsyth explained the PSIRF management processes and expectations, highlighting the role of daily safety huddles and regular meetings with matrons to review serious incidents. It was noted some investigations could involve multiple organisations, have exceptions to timescales such as legal and criminal investigations, and have systemwide learnings and change. Mr Forsyth advised the scrutiny and oversight of patient safety incidents would continue to be reported through the Quality Committee and Quality and Safety Group. The oversight of patient safety incidents and the learning model would be presented to Board annually. Mr Lewis requested a learning report was presented to the Quality Committee and Board in May with focus on the most serious patient safety incidents during the previous 12 months, and what lessons have been learnt as a result of those incidents (as part of the one-year anniversary of educational learning). **The Board received and noted the lessons learned from patient safety incidents concluded year to date. The Board noted the intention to include 12 months' work for 24/25 quality account and outlined actions in response to the learnings. The Board would receive an annual review of the serious harm to patients.**	**SF**
Bpu 25/03/16	**Promise 26** Ms Holden presented the paper which provided an update following the previous discussion at Board in September 2024. Ms Holden reminded the Board that delivery of promise 26 was much broader than anti racism but rather all elements of discrimination and promoting inclusion. The 2024 Staff Survey results were highlighted, recognising the support provided following the national summer riots. There had been some positive improvements from staff experiences of discrimination of racism, but recognition that further work was required. The initial 10 point action plan had been further refined with consultation taking place with wider colleagues and networks. The plan would continue to focus on key areas identified by colleagues and would continuously be reviewed whether success or not. Ms Holden referred to the suggested areas of focus for each network, noting the success measures and work which would be undertaken. Ms Fulton-Tindall stated it was positive to see the networks within the organisation taking forward the initial 10 point plan, and recommended an area of focus could be older people discrimination, noting the discussion by the Board at its timeout in February. Ms Holden agreed to explore older people discrimination to understand the 'other' discrimination reported via the 2024 Staff Survey and shape the Trust response. Ms Holden agreed to share the initial 10 point plan with Governors. Mrs Vickers stated she supported the approach for the organisation's networks to drive forward the 10 point plan, noting that disability	**CH** **CH**

	discrimination had increased compared to 2023 staff survey. Ms Holden confirmed work was underway to explore the staff survey results to understand what additional support was required for colleagues and line managers, noting there had been significant investment through a reasonable adjustments budget. Ms McDonough declared she was the executive sponsor of the disability network (DAWN) and aware that a higher proportion of colleagues declare in the staff survey their disability, compared to what is declared on their electronic staff record. It was important to educate and raise staff awareness, promoting reasonable adjustments, providing peer support, training and wider cultural support, whilst balancing the complexities and relationships between individual needs of colleagues and line managers (and not one size fits all approach). In response to Mr Mohammed, Ms Holden advised there were various network and engagement events and the People Pulse Survey continued to roll out on a quarterly basis, which would provide an additional form of feedback and sense check as to whether the 10 point plan had any impact on reducing discrimination. Dr Graham reflected there were other promises which would also support promise 26 and bring an element of diversity of people with protected characteristics such as those with lived experience and providing peer support workers. Mr Banks reflected on reverse mentoring which Board members had undertaken in previous years. The learning from those programmes included individuals felt not responded to with reasonable adjustments and being able to contribute to the workforce in a full time capacity, putting pressure on performance and meeting targets. Mr Banks stated this did raise the risk of losing the right people in the right roles, and why it was important to identify and support those individuals. **The Board received and noted the Promise 26 update and ongoing workstreams and commitments, noting the staff survey results associated with Promise 26.**	
Bpu 25/03/17	**Older People's Services: proposed changes in 2025/26** Mrs Lavery introduced the paper, highlighting this would be an important decision for the Board to take in respect of the Older People's Services proposed changes. Mrs Lavery summarised the rational for the change paper being presented to board, explaining that there is a recommendation to make a choice to move to a mixed provision across Trust, which is a model other Trusts have adopted, but is a less frequently adopted model of care both regionally and nationally. In addition one option would overturn the submitted financial plan. Dr Graham introduced the paper and detailed the changes required in older people services with the associated rationale. Previous concerns had been raised in relation to the provision and consistency of older people's inpatient services and medical staffing. This had been brought into focus following the recent emergency closure of Brambles ward in Rotherham. An intense but extensive process of engagement around options had taken place since January, and those details were appended to the paper itself. Dr Graham recognised the amount of engagement and expertise provided both internally and externally to	

create the paper and preferred recommendation, noting there was not one single model that was advocated nationally and therefore the organisation would be able to make an operational choice.

The recommendation and proposal would be Option two, a three-site mixed ward model for older people's service with an enhanced community care provision. The recommendation would support the organisational strategy and objectives to provide care closer to home to those people served. Clear quality indicators had been produced which would monitor any effect of change, these included patient safety, staff and carer experience. She noted that if those could not be met by 2026 then a revised cross site specialised model may need to be considered, and that that is reflected in the recommendations.

Dr Graham reassured the Board that since the emergency closure of Brambles ward in December, data had been closely monitored daily such as patient safety incidents, patient flow and bed occupancy. The data showed that there had been no older adult out of area placements in this time, and there remained six older adult beds available at the time of presenting this paper to the Board. These factors further support the proposed option as a model of care for older people to support people to be cared for as close to home as possible.

Mrs Lavery stated clinical expert opinion was sought from Board members not in attendance, and summarised Dr Falk's opinion that distinct older peoples inpatient care was not financially sustainable. The idea of subjecting patients and their carers at such a vulnerable time in their lives was something to be avoided if at all possible. Dr Falk was aware of the trauma caused to patients when requiring transfer from care homes to inpatient care. Dr Falk supported the proposal of a mixed model of care and reassured that quality markers were being applied to the proposed mixed model with review later in 2026.

Mrs Lavery summarised Dr Jankowski's opinion that he was in support of the proposal, noting funding was likely to become even more difficult from 2026. Having out of area care was not great unless superior expertise was given, stating there needs to be a more homogeneous model of care across the organisation and supporting partnerships.

Dr Sinclair noted the mixed model of care in place for North Lincolnshire and Doncaster residents had been successful. From experience the organisation can adapt good practice in Rotherham with the correct environmental changes and close monitoring of quality indicators in place, and recognised the longer term benefits and short term expectations or risks.

Mr Forsyth referred to the monitoring of quality and safety indicators. Data to date had not shown any increase in patient harm incidents and those incidents reported were either low level or no harm.

Ms Blake stated she understood the proposal and recommendation made and confirmed her support to the principle of providing patient care closer to home noting this would also support the current climate and recent Government decisions. Ms Blake asked if Dr Graham could elaborate on the engagement that had been undertaken. Dr Graham

	responded that there had been consultation with internal and external experts who had experience of using a mixed model of care, as well as those who had not had experience of a mixed model of care, between January to March 2025, in addition there had been contact with local care partner providers. Mr Vallance referred to South West Yorkshire NHS Foundation Trust who undertook public consultation, noting this was due to change in location and deemed to be significant. Mr Vallance stated he felt reassured the organisation would not be required to undertake a wider consultation on the older adult service proposal. Mr Vallance referred to the next steps of the recommendation, any environmental changes for consideration and staff skills mix required to support the model of care. Regarding the environment, Mr Forsyth explained there would need to be environmental adjustments to best support the mixed ward population considering Royal College of Psychiatry guidance. Dr Graham referred to gender balance, and stated that the current ward also meets the national standard required for single sex accommodation, as all bedrooms are single occupancy with en suite, and the direct care staff have the ability to concertina the ward should it become necessary. Mr Chillery referred to the emergency closure of Brambles ward and emphasised this was not premeditated and a joint decision carefully made with the senior operational colleagues. Mr Chillery noted that the Care Group Nurse Director along with the Rotherham care group leadership team continued to engage with staff during the interim closure of Brambles ward. Mrs Lavery asked Mr Lewis to summarise the recommendation and reflect on the discussion. He acknowledged with gratitude all colleagues who had contributed and expressed their views on this subject, recognising the multiple opportunities to hear the diversity of clinical perspectives. He highlighted the need for a balanced approach to decision making between service areas and suggested the development of an older person's financial precept, to reassure ourselves from 2025 - 2028 that, for example these services were not being disproportionately cut over a three-year cycle. Mr Lewis discussed the plan to invest in community-based services for older adults across three geographies, aiming to enhance local care and reduce the need for out of area placements. The decision to adopt a blended localist model involved collaboration across geographies to share expertise and resources. Should the blended localist model not work within eighteen months to two years, the decision would be revisited and a more specialist model would be considered. **The Board received and noted the older peoples service paper, noting the change in service model outlined in the preferred option.** **The Board acknowledged the move to mixed provision was the less common option nationally and regionally.** **The Board approved the recommendations made and agreed to reconsider the success of the change against the cited KPIs and other measures of impact in March 2026. The Board acknowledged**	

	any move to a separate specialist bed-based model would likely be contingent on statutory consultation.	
The Board gave thanks to Dr Jankowski for his support to the Board and its Committees, noting this was his last meeting.		
Bpu 25/03/18	**Trust Bed base – Forward look to 2028** Mr Chillery presented the paper and explained the focus was primarily the adult mental health inpatient provision. Mr Chillery acknowledged there had been two purposeful ward closures during the last two years, with enhanced community support in assertive outreach services. The decision just made confirmed a third change. Extensive work was required to address the complexities of bed modelling, admissions, length of stay occupancy rate and discharge rates. Three modelling scenarios were included in the appendix. Mr Chillery advised scenario two, bed model demonstrated a reduced length of stay. If successful, while ambitious this would then meet current adult mental health demand. Mr Chillery therefore confirmed that he felt that it was possible to agree that there would, as the paper outlined, be no further ward closures in adult mental health for at least the period of the Trust Strategy (to 2028) Mr Chillery advised work continued to focus on reducing out of area placements which interlinked with the HQTC programme of work. He advised of the complexities of reducing length of stay in mental health provision. To meet demand, the discharge rate needed to increase approximately by three patients per week across the five adult mental health wards. This goal was considered achievable but required significant effort and coordination. The key change agent would be clinical decision making on the wards. The patient flow team would continue to work with community teams and local authorities across Place, considering safer alternatives to admissions and working consistently to address 7 day working admission and discharges. There remained concern regarding medical vacancies and leadership gaps in order to achieve sustainable change. Integrating community services with ward practices was discussed as a critical factor in improving patient flow. This involved ensuring that community case workers were actively involved in the discharge planning process. It was noted the organisation would be investing in “local” specialist inpatient facilities such as a High Dependency Unit (HDU) to address reinvestment in mental health services. At a later date a paper addressing the issues related to length of stay and discharge rates would be presented to the Board to provide further insights and strategies to improve these metrics. **The Board received and noted the Trust Bed Base Forward Look to 2028, and acknowledged there would be no further ward closures in adult mental health for at least the period of the Trust Strategy. The national policy imperatives to reduce length of stays in acute**	

	mental health and there continued to be significant work towards reducing length of stays. The Board would continue to receive regular tracking data against occupancy, bed days and average length of stay (potentially IQPR).	
Bpu 25/03/19	**2025/26 Financial Plan (including Investment Fund bids)** Mr Mohammed presented the paper including the addendum circulated prior to the meeting, copies of which were tabled during the meeting. The revised financial plan included in the paper and addendum was a balanced plan. It was confirmed the organisation had secured £3.8m of new, recurrent funds from the system to achieve this balanced plan, with confirmation from the ICB of additional funding flowing from October 2025 for the provision of a high dependency rehabilitation unit. Critical to meeting the financial plan was the successful delivery of savings plans, delivering the out of area plan (£3m savings) and workforce plans (including sustaining our 24/25 elimination of agency use). Mr Mohammed highlighted the need to reduce out of area placements as the key variable, recognising that if at mid-year this was not achieved then items from his private paper may need to be accelerated. Mr Mohammed highlighted the alignment of the financial plan to the NHS England oversight framework, with progress updates provided against each measure to reflect the submission of a balanced plan. The organisational workforce had increased by 21% since the pandemic and work was underway to understand how much of this was linked to previous financial investments and plans, as against incremental changes pre-2023. Mr Lewis highlighted the lack of contingency in the financial plan and the importance of timely and effective implementation of the plan, meaning any delays or failures in meeting the savings targets could have significant financial risk. Mr Lewis stated it was crucial the target to reduce out of area placements by two thirds be achieved in the last three quarters of the year. He thanked colleagues for the hard work to achieve corporate savings at an extended level, drawing attention to the bias of savings schemes over the past two years in that regard. Mrs Lavery provided her thanks on behalf of the Board to Mr Mohammed and Mr Lewis for their contributions over recent days, and acknowledged the effort made with stakeholders and system partners to producing the financial plans and settle outstanding financial matters. Mrs Vickers confirmed her full support to the financial plans and as Chair of the FDE Committee recognised the challenges faced across the financial system, noting the financial plan provided clear focus for financial delivery. In response to Ms Gillatt, Mr Mohammed stated the cash balances remained at approximately £35m. As the financial plan remained balanced, the organisation did not require any cash support.	

	Regarding the plans to reduce out of area placements, Mr Chillery noted that a plan in this regard would come to the Board in May. He remained cautious about the scale and speed of change needed. **The Board received and noted the 2025/26 Financial Plan, recognising the continued effort to settle outstanding financial matters with system partners and reliance of full year delivery savings plans. The Board recognised the challenges across the national financial landscape and 'difficult choices' may be required to move the organisation to an underlying balance in 2026/27.**	
Bpu 25/03/20	**Health and Safety Update including Ligature Risk Assessment Review** Mr Forsyth presented the paper and provided a progress summary against key actions undertaken to address health and safety concerns previously discussed at Board, including a ligature risk assessment review. There had been an area of focus and improvement undertaken over the last six months to address health and safety. All fire safety risk assessments were scheduled to be completed by the end of March 2025. Ongoing fire safety improvement works would be addressed within the Capital plans. There was a clear ligature risk assessment work plan in place. This included a review of the ligature risk assessment policy and national guidance. Work continued to replace the remaining anti ligature doors in mental health inpatient areas. Estates work was planned to install anti-climb fencing to address safety and risks identified within the garden spaces at Swallownest Court, Rotherham. Mr Lewis confirmed there was limited contingency funds for any potential material large scale ligature remediation that sat outside of the agreed Capital plans, emphasising the need for cost effective solution for additional identified health and safety programmes of work. In response, Mr Forsyth stated the Ligature Policy was updated in December to reflect guidance, with the complete review of all identified ligature risks according to the new CQC framework. There was a clear view of what ligature risks remain and mitigation in place to manage those areas. Mr Forsyth acknowledged that while significant progress had been made, there were still ongoing challenges in managing ligature risks stating although no area could be ligature free, the importance of identifying and reducing ligatures remained a key area of focus. The ligature risk assessment work plan would provide continuous monitoring and review of dynamic environmental ligature risks, both fixed and non-fixed ligature assessments, alongside the learning from incidents with immediate remedial actions where necessary to maintain safety standards. Mr Lewis acknowledged although there was a minor works programme in place which supported £150k per quarter across the organisation, this was a competitive space (not solely to address health and safety work	

	programmes), was clinically led and prioritised by risk rating. Mr Lewis reminded the Board the minor works programme was not a contingency for any large-scale ligature remedial work not already identified within the capital plans. Mr Forsyth highlighted there was a very clear process in place in identifying health and safety contraventions to manage those within that current budget, with the commitment and investment by the organisation on the replacement anti ligature door programme. **The Board received and noted the Health and Safety Update including Ligature Risk Assessment Review. The Board recognised the work completed since October 2024, noting there remain no major capital dependent ligature or other safety steps.**	
Bpu 25/03/21	**Apprentice Levy** Ms Holden presented the paper highlighting the work undertaken to exceed the apprentice levy spend by 2025 and delivery of Promise 9. The recruitment process had been revised to include Apprentice First to support lower banded colleagues and improve career opportunities. The apprenticeship levy would nationally be replaced by a Skills and Growth levy. It was hoped the new levy would address the different apprenticeship offers and provide more opportunity to exceed the apprentice levy spend. Ms Holden described the plans underway to develop the four structured access programmes for vulnerable groups and success measures, stating the POD Committee would continue to have oversight of the progress made to exceed the apprentice levy and delivery of Promise 9 during Q1 and Q2. Current forecast stood at 73% of utilising the apprentice levy in 2024 to 2025, with the levy budget for 2025 to 2026 expected to be higher due to the reduced staff turnover and annual national pay award. Plans had been identified to fully spend the levy during 2025 to 2026 by widening the participation to apprenticeships and offer of continuous professional development training or non credited training. Some levy funds would be transferred to support voluntary community partners across systems and delivery of programmes relevant to promise 9. Plans were in place to address clinical expansion and workforce planning, maximising the levy and training expenditure. Additionally, the PDR and appraisal approach would support staff development and a positive impact on the apprentice levy. Mrs Lavery reflected on the recent Government announcements around welfare and financial changes and recognised the workforce opportunities would encourage and support communities in entering employment and utlising the apprenticeship levy. Mrs Vickers referred to the positive changes to come as part of the apprentice levy and queried whether apprenticeship opportunities would be part of career conversations during the appraisal process. Ms Holden stated it was important to discuss career opportunities during appraisals including potential apprenticeship opportunities. In response to the apprentice levy spend, Ms Holden explained current spend was	

	73% with the remainder 27% to be carried over into the next financial year rather than returned to the Treasury. Dr Graham recognised the positive national changes to the apprentice levy and apprentice opportunities this would create. **The Board received and noted the Apprentice Levy update report**.	
Bpu 25/03/22	**2024/25 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)** Mr Forsyth presented the paper and highlighted the nine RIDDOR incidents reported in the period April 2024 to March 2025. Analysis and learning of the RIDDOR incidents showed there was no commonality or specific theme year on year, with numbers remaining static. Learning was being addressed within the organisation and shared during patient safety huddles as well as via the health and safety forum. Mr Forsyth shared examples of learning from falls such as addressing staff who were not compliant with uniform dress code and footwear in clinical areas and trip hazards. A trial was also underway with People Safe regarding lone working devices, this would help identify when a person had fallen and alert People Safe. Ms Fulton-Tindall noted the number of assaults on staff and questioned what preventative action had been taken. Mr Forsyth explained work continued to enhance lone working arrangements and to further support the improved reporting culture and response to violence and aggression to staff. Changes were being made to the RRI training and disengagement training. Mr Lewis asked whether the authors had full confidence in the reporting process, and Ms Holden confirmed that she did not. Mr Lewis highlighted there were two road traffic incidents occurred within the reporting period that were not contained within the RIDDOR report. Mr Lewis proposed to add to his Chief Executive's report details of RIDDOR incidents to enhance transparency and ensure the Board were regularly updated on safety incidents and actions taken throughout 2025/26. **The Board received and noted the RIDDOR report during the period April 2024 to March 2025, noting near real time reporting of RIDDOR incidents would feature as an Annex in future CEO reports.**	**TL**
Bpu 25/03/23	**Our Enabling and Delivery Plans** The Board noted the item would be deferred to a future meeting and would be discussed at Board time out in April.	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 25/03/24	**Operational Risk Report – Extreme Risks / High Impact – Low Likelihood Risks** Mr Gowland presented the paper which highlighted the current position in relation to the extreme risks. There were six extreme risks on the register. At the last board meeting, a total of six extreme risks was reported, one risk had since been de-escalated while another new risk had been escalated to extreme status.	

	Previously reported extreme risks included the management of out of area placements and neurodiversity waiting times as discussed earlier. The report also identified risks which had high impact but low likelihood. Mr Gowland explained the importance of the Board to have continued oversight. Mrs Vickers referred to the delivery of Promise 19 ending out of area placements and asked whether there were associated financial risks. In response, Mr Lewis confirmed the saving target for ending out of area placements was not presently identified as a risk. Regarding the newly identified extreme risk (DCGMH 6/23), Mr Lewis noted this was a longstanding risk relating to medical staffing gap of an older people's consultant (OPMH) within the Doncaster Adult Mental Health Care Group. Mr Lewis requested the Risk Management Group review whether the risk description and score was appropriate due to the medical staffing gap being low and whether this could result in patients coming to harm. In response to Mr Lewis, Mr Forsyth confirmed the high impact and low likelihood risk around ligature alarms (NLCG 11/23) solely related to Laurel Ward, with plans in place to install as part of Phase 3 and Phase 4 of the Capital Plans. **The Board received and noted the Operational Risk Report update, including extreme risks and risks identified as high impact with low likelihood.**	**SF**
Bpu 25/03/25	**Strategic Delivery Risks (SDR) 2024/25 – Year End Report** Mr Gowland presented the report, reminding the Board of the revised approach taken within the last year to strategic risk management with enhanced reporting and oversight through its committees. Significant assurance was received from internal audit on the refreshed approach to strategic risk management. It was noted some recommendations were made to further enhance formatting to clearly demonstrate the link between strategic risk controls and respective assurances. Work would continue to progress the five SDRs through executive leads and with respective committees. Mrs Lavery acknowledged the revised SDR approach had progressed throughout the year and that it was positive to see the significant assurance received from internal audit. Mrs Gillatt questioned the confidence of reaching SDR targets and whether reassessment was required. Mr Gowland answered this work would be pivotal during Q1 and acknowledged the development of the SDRs would include more specifics on assurances, current scoring, target assessments and measures in place. Mr Gowland referred to the proposed future reporting arrangements, and explained it would allow for progress to be made in the intervening periods but provide the right focus for Board and its committees regarding SDRs.	

	The Board received and noted the Strategy Delivery Risks 2024/25 report, noting significant assurance from internal audit and the planned next steps to enhance reporting arrangements.	
Bpu 25/03/26	**Integrated Quality Performance Report (IQPR)** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for February 2025, and stated he anticipated seven of the "Top 10" would be delivered at the end of year target. There had been significant improvements (reduction) in Section 136 breaches and seclusion rates. Mr Chillery advised challenges remained in meeting some performance metrics, and particularly the ADHD trajectory remained higher than target with work underway to address sustained progress with a revised trajectory. Although the number of ligature incidents had increased, analysis showed this was related to three specific patients. Mr Mohammed confirmed the year end forecast was a surplus of circa £544k (FIN03). Mr Lewis acknowledged some indicators may start to rise before they reach target, an example was the ending of out of area placements may result in higher demand of seclusion suites. **The Board received and noted the Integrated Quality Performance Report**.	
Bpu 25/03/27	**Promises and Priorities Scorecard** Mr Lewis presented the paper which highlighted the progress made on the specific promises and the need to focus on delivery in the coming year. It was noted progress on promises and success measures would feature in the trust's annual report. The scorecard provided an assessment of work already completed as well as key priorities to move towards delivery into 2025 to 2026 and beyond. The promises had been considered by the clinical leadership executive (CLE) and segmented to show the work required over the coming months. Mr Lewis recognised the real effort that had taken place to achieve delivery of some of the promises to date, as well as those which continued to be progressed. Quick mobilisation would be required over the coming months of some promises, noting the need for better communication and understanding among staff the importance of focusing on key priorities and learning from successful initiatives. The Board reflected on the promises and scorecard. Mr Lewis informed that progress had been made for strategic objectives one and five and advised the promise measures and models continue to be progressed and tested to seek assurance. Communication of the promises and priorities would continue with leadership teams through the leadership development offer. In preparation for the annual members meeting, Mr Lewis agreed to explore how community feedback could be captured and shared with community partners within the event.	**TL**

	The Board supported the current state assessments outlined for success measures and noted the critical success factors for early 2025 to 2026 improvement outlined. The Board recognised the segmentation of promises' relative priority agreed with CLE and would continue to focus Board time on testing the depth and pace of change required. **The Board received and noted the Promises / Priorities Scorecard update on the work to date and expectations in 2025/26.**	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 25/03/28	**Supporting Papers** 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: • Annual Safe Staffing Declaration 2024/25 • Eliminating Mixed Sex Accommodation Annual Declaration • Mortality Report • Guardian of Safe Working Hours Report Mr Lewis noted the safe staffing declaration was solely in relation to inpatient care. A separate piece of work was underway to review community safe staffing via the Quality Committee. **The Board received and noted the additional reports for information.**	
Bpu 25/03/29	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/03/30	**Any risks that the Board wishes the Risk Management Group (RMG) to consider** The Board recommended the following: • Disengagement (linked to previous Regulation 28 and open action Bpu 25/01/21b) • Financial Plan 2025 – 2026 critically required timely delivery for all CIP plans • Mixed Sex Accommodation. Although national guidance stated the organisation was compliant, Mr Lewis recommended consideration should be given to any other associated risks with mixed sex accommodation.	**SF / PG**
Bpu 25/03/31	**Public Questions** There were no questions raised by members of the public.	
Bpu 25/03/32	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.*'	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS : MAY 2025 **PAPER C – ACTION LOG**

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/07/12	**Report from the Quality Committee – MCA compliance** There will be a full review and recovery plan of MCA compliance – recommended to be presented to QC in Q3/Q4.	SF	**29 May 2025:** further work in this area is incorporated into the CQC readiness work at Paper M.	Propose to Close
Bpu 24/11/16	**CQC Readiness: Well-Led** Important for the Board to remain sighted and engaged in the progress with the readiness for assessment.	PG	**29 May 2025:** Paper Q on today's agenda provides the Board of Directors with an update on this topic.	Propose to Close
Bpu 25/03/06	**Matters Arising and Follow up Action Log** The outcome of the Good Governance Improvement (GGI) review would be shared with Board members.	PG	**29 May 2025:** The GGI Report is referenced within the agenda (Paper Q) Well-Led and is appended to the papers for this meeting.	Propose to Close
Bpu 25/03/08	**Report from the Audit Committee** Any prior year adjustment implications would be discussed with the accountable officer in coming days, should they prove necessary.	IM	**29 May 2025:** The matter was further discussed with the external auditors and no prior year adjustments are necessary.	Propose to Close
Bpu 25/03/14a	**Chief Executive's Report** The Board would seek to confirm in May, for the staff survey, as it had done for CQC ratings, what the organisational aim truly would be over the period to 2028.	CH	**29 May 2025:** Paper L on the agenda today.	Propose to Close
Bpu 25/03/16b	**Promise 26** The initial 10-point action would be shared with Governors.	CH	**29 May 2025:** This plan has been circulated to the Council of Governors.	Propose to Close
Bpu 25/03/16a	**Promise 26** Ms Holden agreed to explore older people discrimination to understand the 'other' discrimination reported via the 2024 Staff Survey and shape the Trust response.	CH	**29 May 2025:** The issue of other discrimination has been included now within the extended action plan (now an 11-point action plan) – see above.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/03/22	**2024/25 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)** Real time reporting of RIDDOR incidents would feature as an additional Annex in future CEO reports.	TL	**29 May 2025:** Details of RIDDOR incidents are appended to the Chief Executive's Report (Paper K) and will be so in all future meetings.	Propose to Close
Bpu 25/03/14b	**Chief Executive's Report** A biannual risk appetite review would be undertaken at the Board time out in April.	PG	**29 May 2025:** The Board of Directors timeout in April included a session relating to risk appetite and the categorisation of risks (for which a risk appetite would be assigned to each). Paper V on today's agenda includes an updated position on this work, with appendices provided in Agenda Pack B.	Propose to Close
Bpu 25/03/15	**2024/25 Serious Patient Safety Incidents – Learning** Mr Lewis requested a learning report was presented to the Quality Committee and Board in May with focus on the most serious patient safety incidents during the previous 12 months, and what lessons have been learnt as a result of those incidents (as part of the one-year anniversary of educational learning).	SF	**29 May 2025:** Paper P on the agenda today responds to this action.	Propose to Close
Bpu 25/03/30	**Any risks that the Board wishes the Risk Management Group (RMG) to consider** The Board recommended the following: • Disengagement (linked to previous Regulation 28 and open action Bpu 25/01/21b) • Financial Plan 2025 – 2026 critically required timely delivery for all CIP plans • Mixed Sex Accommodation. Although national guidance stated the organisation was compliant, Mr Lewis recommended consideration should be given to any other associated risks with mixed sex accommodation.	SF / PG	**May 2025**: updates as follows: • Update is included in the table above re: Bpu 24/05/15a and Bpu 25/01/21b • Risk F1/25 - owner Izaaz Mohammed; score 9 (3x3) added to the register. • Dr Graham's paper to CLE in August 2024 on this topic included reference to associated risks linked to mixed sex accommodation.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/03/11	**Report from the Public Health, Patient Involvement & Partnerships Committee** Health inequalities data would be included in the IQPR and presented to the Board on a regular basis.	TL / RB	**29 May 2025:** Within the CEX Report an update notes the three key steps that will be achieved by the Board meeting in **July 2025** with respect to Health inequalities Data.	Open
Bpu 24/11/19	**Productivity at RDaSH 2025/26** Concerns were raised in respect of the RDaSH geography and the work required with primary care to improve the referral process into CMHTs. Mr Lewis requested a further update on this work within the next 6 months.	IM	**29 May 2025:** Update report to be presented to the Board in **July 2025**.	Open
Bpu 24/05/15a	**Chief Executive's Report** <u>Response to Regulation 28's</u> To consider progress on actions arising from the two regulation 28s received during 2023. 1) relating to the review of the disengagement policy (from Reg 28 received by the Trust) 2) relating to Eating Disorders Services (from Reg 28 sent to NHS England).	TL	**29 May 2025**: Within the Chief Executive's Report today (item 2.5) an update on the previously received regulation 28 letters is provided. Within that update, there is the intent to leave within this action log, an open action such that the Board can, through an update to it in Q4 25/26, know whether the changes in respect of our new Engagement policy have been effective.	Open
Bpu 25/01/17	**Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)** To further understand the 973 posts that we didn't have in 2018/19 and if these were new posts or posts that remained vacant.	TL	**29 May 2025:** The conclusion of this work will be included in the 'Plan B' report that will be presented to the Board of Directors in **July 2025.**	Open
Bpu 25/01/21b	**Operational Risk Report – Disengagement risk** To clarify if there was a risk regarding mental health disengagement on the risk register.	PG	**29 May 2025:** Risk MP2/25 - owner Dr Sinclair; score of 9 (3 x 3) is active on the register. Engagement and Disengagement Policy drafted and discussed by CLE May 2025; will return to CLE in June for final approval. Robust monitoring arrangements to be introduced to support implementation. This item is linked to Bpu 24/05/15a above.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/09/21	**Out of Area Placement Risk Share** Mr Mohammed and Mr Lewis to continue negotiations with HNY ICB / North Lincs Place to achieve an equitable OOA placement risk share, in line with the parameters agreed for SY.	IM	**29 May 2025:** despite nine months of sustained work (including written escalation to the ICB CEO) it appears unlikely that we can secure the agreed Board position of parity. A detailed QSIA and EIA document will be developed during June, and a material risk entered onto the risk register. It is suggested that this action replaces the former entry and responsibility transfer to the CEO and COO.	Open
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention, by January 2025.	TL	**29 May 2025:** Relevant executive colleagues met to progress the 25/26 'Support and Intervention model' with particular reference to issues of safety. The resultant model will be further considered and go live during Q1.	Open
Bpu 25/03/24	**Operational Risk Report – Extreme Risks / High Impact – Low Likelihood Risks** Regarding the newly identified extreme risk (DCGMH 6/23), Mr Lewis requested the Risk Management Group review whether the risk description and score was appropriate due to the medical staffing gap being low (1 vacancy) and whether this could result in patients coming to harm.	SF	**29 May 2025:** Risk was discussed within RMG and remains on the extreme risk given current gaps in medical staffing.	Open
Bpu 25/03/27	**Promises and Priorities Scorecard** In preparation for the annual members meeting, Mr Lewis agreed to explore how community feedback could be captured and shared with community partners within the event.	TL	**29 May 2025:** This has been progressed and a draft from patient leaders is being prepared. In reviewing how the AMM goes, we will consider how effective that has been both with the shadow CLE and Council of Governors.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper D
Date of meeting:	21 May 2025		
Attendees:	Dr Richard Falk (Chair), Dave Vallance, Maria Clark, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery, Dr Jude Graham, Richard Banks and David Vickers.		
Apologies:	No apologies received.		
Matters of concern or key risks to escalate to the Board:	Concern raised around the absence of the Medicines Management report at the last two meetings – interim update requested on any significant medicines management issues.		
Key points of discussion relevant to the Board:	**Meeting Format** - The Committee introduced a new meeting format based on the four domains of safety, experience, quality, and PSIRF (Patient Safety Incident Response Framework) within the quality & safety plan. The aim was to avoid duplication, streamline processes and ensure a focused deep dive on important areas. The Committee considered an evaluation being undertaken by the Board in 6-12 months to review the new format. **CQC Readiness –** The Committee received the self-assessment ratings based on the CQC domains of safe, caring, effective, and responsive following a review of the available data sources. It was agreed to continue monitoring the process to ensure that the ratings were supported by robust and scrutinised data. This was an item for further discussion on the Board agenda. **Patient Safety Incident Investigations (PSII) –** The Committee noted the new matrix for assessing incidents which provided a structured approach to categorising incidents and determining the appropriate response based on their severity and impact. **Integrated Quality Performance Report (April 2025 data)** – Continued improvement being made for VTE and MUST assessments, the Committee noted the new 12-hour falls assessment metric and discussed the importance of contextual data and the challenges with ADHD waiting times. **Annual Mortality Report 2024/25** – The Committee noted the current position in respect of Regulation 28 notices and the trajectory to address the backlog of Structured Judgement Reviews (SJR). The challenges associated around the quoracy of the Prevention and Learning from Future Deaths Group (PLFDG) were noted.		
Positive highlights of note:	**Volunteer Story -** The Committee positively received a volunteer story related to Promise 3, highlighting the positive impact of volunteering on individuals and the organisation. Quality Committee wish James well and thank him for the time he spent reflecting his journey from volunteer to RDaSHian. Reflections made on the ability for Committee members to focus on the matters presented, readable pack of papers enabled rigour and scrutiny applied to the governance matters within remit of the ToR.		
Matters for information:	Update received on the unannounced CQC inspections on the adult inpatient mental health wards and psychiatric intensive care units - no formal feedback received to date. **Patient Feedback** – Update received on the continued success of care opinion and the importance of using feedback to drive service improvements.		
Decisions made:	Promise 3 is to be correctly aligned to PHPIaPC		
Actions agreed:	RDaSH CQC self-assessment process approved and to be scrutinised at Board of Directors, May 2025		

Dr Richard Falk, Non-Executive Director (Chair of Quality Committee)
Report to the Board of Directors meeting scheduled for 29 May 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	2 April 2025		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers and Dr Richard Falk. In addition: Izaaz Mohammed, Jane Charlesworth, Jill Savoury, Laura Brookshaw (360 Assurance), Matthew Curtis (360 Assurance), Kay Meats (360 Assurance), Matt Treharne-Clarke (360 Assurance), Caroline Jamieson (Deloitte), Stuart Kenny (Deloitte).		
Apologies:	Phil Gowland, Steve Forsyth.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Counter Fraud, Bribery and Corruption Progress -** The Counter Fraud Functional Standard Return (CFFSR) was in a healthy state, it was anticipated that the trust would receive an overall green score. The risk component was anticipated to be rated as amber as there was a need for an updated risk assessment within the trust – scheduled for Q1 2025/26. **Internal Audit Progress Report -** Three audit reports were issued, MAST training review (significant assurance), Promises 3, 4 and 5 review (significant assurance), Fit and Proper Persons Test (interim) – further testing planned in April. **Interim Head of Internal Audit Opinion 2024/25** – Indicative opinion of moderate assurance indicated based on the work completed up to the 25 March 2025. This would be reassessed to reflect on the work completed after this date and moderated across the wider client base before the production of the final opinion. **Annual Report and Accounts Preparations 2024/25 –** • The accounting treatment for St John's Hospice reported previously is still under consideration. • The External Audit Planning Report received that focused on the elements associated with the 2024/25 year-end audit work. • Materiality levels were set at 2% of forecasted total operating income, with performance materiality increased to 65% to enhance testing efficiency. • Key risks for 2024/25 are validity of accruals, management override of controls, and property valuations. • Annual Report preparations were on track with a planned submission to NHS England and Parliament by the 30 June 2025.		
Positive highlights of note:	**Risk Management Framework -** The Committee noted the positive progress being made by the Risk Management Group in terms of the efforts to increase the number of risks and to embed risk management practices and address key risks within the trust. **Internal Audit Progress Report** • Follow up audit actions are in a good position with 85% of the high and medium being closed on time and 90% of all risks being closed on time.		
Matters presented for information or noting:			

Decisions made:	
Actions agreed:	**Clinical Audit Plan 2025/26** – Further understanding required around the approach to pace and prioritisation of the clinical audit process, particularly when national reports were issued. **AC and QC assurance and oversight of Clinical Audit** – Clarification required to ensure that AC and QC do not duplicate assurance and oversight. **Risk Management Framework –** The Committee requested to see further insight into the movement of risks to enable sightedness on the direction of travel.

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

Report to the Board of Directors meeting scheduled for 29 May 2025.

OTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	16 April 2025		
Attendees:	Sarah Fulton Tindall (Chair), Dr Jude Graham. Dr Richard Falk, Toby Lewis, Dr Diarmid Sinclair, David Vickers.		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**Report on the use of Seclusion Quarter 3 and 4 2024-25** The Committee noted that regular reviews of the IQPR standards are undertaken, one of which was that consultants carry out a review of a patient within 5 hours of seclusion (see later section for quarter 4 figures). As seclusion is one of the focus areas for the Committee, it received, for information, an initial report of a deep dive looking at how the seclusion suites were being used in terms of frequency, length and the quality of the reviews undertaken. Whilst the report identified some challenging areas, such as the very low compliance rate of independent medical reviews being undertaken when a patient had been in seclusion for longer than 8 hours - for which an urgent review was being undertaken - it was noted that seclusion was being considered across the Board by a range of Committees and groups and would result in a full report for the Trust in due course.		
Key points of discussion relevant to the Board:	**Mental Health Act Compliance Report Quarter 4 2024-25** There were 451 detentions during quarter 4, of which 2 were unlawful. **Matron and Medical Scrutiny Compliance** - there were 2 occasions where medical recommendations did not meet the criteria for detention resulting in people being unlawfully detained. A review of the scrutiny process had resulted in this being updated and the matron's check removed as it was not deemed to be adding value and, therefore, prolonging the process unnecessarily. **Consent to Treatment** – Consent to Treatment compliance at 3 months stood at 100%, with Psychiatric Medication compliance showing a sustained improvement: Rotherham 94% (17 out of 18 occasions); Doncaster 91% (10 out of 11) and North Lincs achieving 100% (9 out of 9). Consent to Treatment on Admission was showing above 90% Trust-wide, but the Committee was also keen to see how each individual care group was performing, to understand whether, or not, their compliance was meeting this threshold. **Section 132 Rights** – there was sustained improvement in the reading of Section 132 rights: Rotherham 94% (116 out of 123); Doncaster 94% (144 out of 154) and North Lincs 93% (71 out of 78) although more work needs to be done. It was also noted that data collection and reporting of Section 132 rights at a local level would be changing, with the new arrangements expected to go live on 22 April 2025.		

	Mental Health Act Performance Report Quarter 4 2024-25 **Section 136 Assessments within 24 hours** – there was 1 case out of 126 where Section 136 assessments were not undertaken within the 24-hour period. **MHA Incidents** - of the 13 Mental Health Act incidents, 6 were labelled as Category D (major), however, it was noted there were 450 incidents, therefore, the overall percentage was low. **Blanket Restrictions** - there were 4 blanket restrictions that remained open as of 31st March 2025, all of which related to laundry and sensory rooms. It was noted that a review of the governance for blanket restrictions would be undertaken. In particular, advice has been received from the CQC that laundry rooms should be locked, which are currently not within the Trust's portfolio. A ward-by-ward review would be included to specifically address this. **Seclusion** – some improvement was seen in the 5-hour review of incidents: January 70% (7 out of 10); February 100% (13 out of 13) and March 75% (6 out of 8). **Section 17 Leave Report** The Section 17 audit report into the leave functionality in SystmOne had identified there was no robust evidence of post leave assessments having been undertaken, therefore, a review of the nursing visualisation had been carried out with senior nursing staff and a wider consultation with all nursing staff, during April 2025. The Section 17 functionality in SystmOne was reviewed with changes expected to be implemented in May 2025.
Positive highlights of note:	**Consent to Examination, Care and Treatment** The Committee received for information the link to a vlog entitled, 'Consent to Examination, Care and Treatment', newly produced by the communications team and narrated by Dr Senaratne. The Committee felt that the short vlog conveyed the messages and information simply and effectively in a concise and accessible visual format.
Matters for information:	**MHA Training and RRI Training Compliance** The Committee deferred consideration of both MHA and RRI training compliance until the next meeting, when it would receive an update from the Director of Human Resources and Organisational Development, which would incorporate the latest position on the number of those who were long term non-compliant.
Decisions made:	
Actions agreed:	

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Act Committee
Report to the Board of Directors meeting scheduled for 29 May 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper G
Date of meeting:	16 April 2025		
Attendees:	Rachael Blake (Chair), Dave Vallance, Pauline Vickers, Carlene Holden, Dr Jude Graham, Lea Fountain, Ian Spowart, Richard Rimmington.		
Apologies:	Richard Chillery, Steve Forsyth		
Matters of concern or key risks to escalate to the Board:	**Engagement:** Concern was raised around the level of colleague's trust in the organisation as 44% did not believe that the organisation would take their concerns seriously (FTSU) and the response in the staff survey around the organisation taking action to prevent an incident happening again.		
Key points of discussion relevant to the Board:	**Integrated Quality Performance Report:** Sickness absence was on an upwards trajectory currently at 6.41%. The trust's new sickness absence policy went live on 1 April 2025 and awareness training has taken place to equip managers with the right skill set to focus on supporting health and well-being of staff. **Staff Survey Results** staff survey results which had a 56% response rate. Key areas for action would be learning, appraisals and disability discrimination. The quarterly people pulse survey would include local questions to gather qualitative data to help understand 'other discrimination'.		
Positive highlights of note:	**Integrated Quality Performance Report** positive progress made on consultant vacancies after significant period in red.		
Matters for information / noting:	None		
Decisions made:	None		
Actions agreed:	None		

Rachael Blake, Non-Executive Director and Chair of the People and Organisational Development Committee.

Report to the Board of Directors meeting scheduled for 29 May 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper H
Date of meeting:	21 May 2025		
Attendees:	Dave Vallance (Chair), Dr Richard Falk, Carlene Holden, Jo McDonough, Toby Lewis, Maria Clark, Jo Cox, Joy Bullivant, Phil Gowland, Nicola Abdy.		
Apologies:	Diarmid Sinclair.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Promise 3, Volunteers:** The updated position was provided with 246 volunteers recruited to date. Further update to be provided at the next meeting which will include a trajectory and actions to meet the 350 volunteer target. To ensure we are making the right impact for our patients and our volunteer body, an evaluation will be undertaken in quarter 4. **Promise 8, Perinatal Mental Health Services:** This service has been agreed as the fifth area of the RDASH 5 to create and deliver five impactful changes in inequalities. While further definition of the specific local issue(s) is needed, work will include partnership working with maternity services in identifying areas of change and increased referral and engagement with diverse communities to understand barriers and shape services accordingly. **Health Inequalities Data Report:** Work is ongoing to improve data reporting. The challenges were noted, and it is expected that a more comprehensive data set will be reported in July 2025.		
Positive highlights of note:	**Flourish** performance on the financial improvement was noted.		
Matters presented for information or noting:	**Equity and Inclusion Plan:** to be presented to Board in May 2025. **Health and Wellbeing Board Priorities –** Rotherham 2025-30 draft plan **Proposed future South Yorkshire Eating Disorder Pathway**		
Decisions made:	None		
Actions agreed:	None.		

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 29 May 2025.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper I
Date of meeting:	16 April 2025		
Attendees:	Pauline Vickers (Chair), Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Richard Banks, Ian Spowart, Jane Charlesworth, Richard Rimmington.		
Apologies:	Richard Chillery		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Estates Update** – implementation of the estates helpdesk system continue for planned preventative and reactive maintenance. External support is being provided by the Sewell Group to optimise the system ensuring reporting and maintenance workflows are configured efficiently, with formal 'go live' date planned in May 2025. £1.8m of national capital programme funding has been secured to support the provision of a High Dependency Rehabilitation Unit and Phase 4 of the Great Oaks project. Funding and design discussion for the Frailty Centre of Excellence have taken place and in the initial design process. **Month 11 Finance Report and Month 12 verbal update.** At Month 12 the Trust had achieved a £512k surplus (better than plan) with all care groups and corporate directorates meeting their targets. The £6.6m savings targets had been achieved, however £0.5m was nonrecurrent and had therefore been included into the 2025/26 savings plan. Schemes for 2025/26 had been identified and were going through the QSIA process. The 2024/25 capital allocation was achieved. The Elizabeth quarter deal was agreed before the end of the 2024/25 financial year. **Finance Plan 2025-2026 Update (including Savings Programme)**. The plan had previously been submitted to the Board with an addendum, noting this would take the organisation from the initial deficit plan to a balanced plan, recognising the additional recurrent income of £3.8m secured from funders in arriving at this position. There is zero contingency in the plan therefore delivery of the CIP schemes will be key to achieving the plan. Work on the 2026-27 savings programme needed to start early in the year, this involved identifying potential savings categories and understanding the changes required to achieve a recurrent balance.		
Positive highlights of note:	**Cyber Security**. The Trust continues to work towards national cyber security standards of safe practice and mandatory submissions. Progress continues to support completion of the 2024/2025 Data Security and Protection Toolkit (DSPT) submission against all fifteen assertions by June 2025 deadline.		
Matters presented for information or noting:			
Decisions made:	No decisions were made.		
Actions agreed:	A further update on the refreshed medium term finance plan would be brought to a future meeting.		

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

Report to the Board of Directors meeting scheduled for 29 May 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper J
Date of meeting:	30 April 2025		
Attendees:	Kath Lavery, Glyn Butcher (Patient rep), Cheryl Gowland (Interim Chair of Carers Network), Jacqui Hallam (Chair of Women's Network), James Hatfield (Freedom to Speak Up Guardian), Carlene Holden, Toby Lewis, Tinashe Mahaso (Chair of REACH Network), Simon Mullins (JLNC Staff Side Chair), Jennie Gaul (Staff Governor), Victoria Stocks (Staff Governor), Amanda Ambler (Chair of DAWN Network), Atique Arif (Volunteer), Prachi Goulding (Staff Governor), Jessica Williams (Staff Governor), Vicki Mitchell (Co-Chair of Rainbow Network), Emma Wilsher (Staff Governor)		
Apologies:	Dave Vallance (Chair), Dr Nav Ahluwalia (Senior doctors committee), Babur Yusufi (GOSWH), John Whitehall (Unison Steward/JCC Staff Side Chair), Laura Wiltshire (Co-Chair of Rainbow Network), Mike Senevirate (Staff Governor)		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Voice scorecard**. A graphical representation of the voice scorecard had been produced, noting there would be further exploration of equality, diversity and inclusion data on systems such as Radar and Care Opinion. **NHS changes and implications for culture**. Noted over the next two years, NHS England would merge with the Department for Health and Social Care. The publication of the NHS 10 Year Plan was expected around June 2025 and anticipate a major reset of the financial and operating model of the NHS. The organisations finance plan 2025 – 2026 was a balanced plan, recognising the challenges across the future national financial landscape. **Health and Wellbeing Vision**. The Health and Wellbeing (HWB) vision had been refreshed and continued to be shaped with wider socialisation and feedback encouraged with various groups, committees and the HWB Champions. **Staff Survey Results**. The 2024 results had been shared with various groups, networks, committees and Board, noting an overall response rate of 57%, an increase of 4% from the previous year. Each of our 23 Directorates will identify areas they wish to focus on locally as well as central areas of focus.		
Positive highlights of note:	**Real Living Wage**. Commitment had been made to paying the real living wage and implemented from 1 April, this reflects the financial plans and part of Promise 25. Work continued to achieve real living wage accreditation. **Promise 26 Wider Aspects**. Promise 26 was much broader than anti racism but rather all elements of discrimination and promoting inclusion. There remained ongoing commitment and workstreams from the each of the organisations inclusion networks to deliver a 10 point plan, noting the staff survey results associated with Promise 26. Following the last Board meeting this plan had now expanded to 11 points to include age discrimination.		
Matters presented for information or noting:	**Remote working:** workstreams continue to develop the revised framework to better support individuals, teams and services to work flexibly, with deliverable timescales identified to Quarter 1 and 2.		
Decisions made:	None		
Actions agreed:	None		

Kath Lavery, Chair (on behalf of Dave Vallance, Non-Executive Director and Chair of the Trust People Council)
Report to the Board of Directors meeting scheduled for 29 May 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper K
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 May 2025

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

We focused consistently on learning in 2024/25: creating learning half days, reforming our training arrangements and budgeting, and investing in PSIRF; as well as leadership development at most levels. This focus remains in 2025/26, and *our learning/education focused Board is again scheduled for July*. The Board papers in March and May (today) testify to the intention to make that a focus at the most senior level, but also to some of the 'growing pains' in doing so. The opportunity to again explore PSII learnings, and to consider our real assessment of safety, caring, effective and responsive domains, demonstrate an overwhelming desire to make sure we hold up an honest mirror to what works – and to be led by patient voices in doing so. This ambition needs to be in mind as we consider whether to agree our PSIRF policy.

The report outlines actions taken in April and May. Inevitably these include work to embed our approved financial and operational plan, as well as a contribution to the system-wide work to manage the NHS reset. The chair has repeatedly identified a risk that this focus distracts us into an NHS-mostly space, distant from our strategic mission. Given that concern, it is helpful to note, in the concluding paragraphs of this report, our work on housing, with the third sector, alongside GPs, and in tackling debt and poverty. It will be important for managers and staff across the Trust to hear from a range of Board voices over coming weeks that this remains our intent, because it represents the 'what and how' of tackling the inequalities - and high cost of harm that residents face, often managed by costly 'downstream care'.

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** the first bi-monthly RIDDOR report as we work to ensure health and safety practice improves
X	**APPROVE** the revised PSIRF policy for the Trust (a matter reserved for the BOD)

Impact

Trust Risk Register	X	NF 2/23, O 10/19, F 1/24, F 1/25, F 2/25, F 3/25, NF 1/24, NF 6/25, MP 11/24, MP 13/24, MP 14/24, MP 15/24, O 5/24
Board Assurance Framework (SDR)	X	Primary care contract changes - SDR 3 Health Inequalities Data - SDR2
System / Place impact	X	See text, multiple reference to system / place re: financial positions of ICB – alongside potential structural adjustments

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: CLE summary April and May 2025
Annex 2: Current register of Trust vacancies April 2025
Annex 3: National publications April/May 2025
Annex 4: South Yorkshire Collaborative Board summary – March 2025 and May 2025
Annex 5: April RIDDOR report for the Trust
Annex 6: Revised PSIRF policy for the Trust, effective June 1st 2025

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

May 2025

1.1 In March, I reported that "the overwhelming focus on promises 14 and 19 operationally will be critical to H1 (April-Sept 2025) – alongside our 'make or break' focus on the health inequalities work to which we committed in 2023". The Board considers today planned work needed to stop around twenty people **needing to be placed out of area inappropriately** – and in July we will consider trajectories to meet our four-week maximum wait. At a time when financial focus can seem overwhelming, and when the 10-year plan may, in its 3+7 approach, appear 'back to basics', it is crucial that the Board remains resolute in improving patients' experience of care, and investing preventively to stop 'failure demand' and human misery.

1.2 The pre-audited accounts **for 2024/25 show that the Trust again achieved non-recurrent breakeven**, as we did in 2023/24. The balanced plan submitted by the Board for 2025/26 represents progress: however, since submission, a sudden change of financial rules exposes us to the risk that deficit support will be removed before 2026/27 (it having been made ostensibly contingent on ICB wide financial success). Within my private report, I discuss the timetable for work to achieve our 'plan b' financial sustainability plans, targeting recurrent balance from April 2026, for the first time in six years. In support of these aims, a very detailed exercise in budget sign off (and delegation) has been completed across the Trust during April, which is explained in this report. I am grateful to colleagues in the finance team, people teams, and within all six groups, who have worked hard to meet the ask – and to consider clinical risk carefully.

1.3 The 'reset' of the NHS, with abolition in due course of NHS England, changes to the role and workforce of ICBs, and a revised operating and financial model for 2026/27, continues to consume attention. As a Trust leadership team, we are working closely with ICB colleagues, both to support them as individuals, and to consider how the Trust might best contribute to collaborative working in the future. **For 2025/26, we have taken on significant new operational and financial risk**, for adult eating disorders and for out of area placements. There remain areas of practice, for example, continuing healthcare responsibility, where our skills and natural pathways may be assisted by further assumption of roles previously done by others. We have also stepped in to provide expert corporate support to Primary Care Doncaster.

1.4 During early May, we had **an 'unannounced' inspection of our acute and PICU services** across all three sites from the Care Quality Commission. These are services evaluated as Requires Improvement in 2019, and where our own analysis suggests further room for improvement – culminating in the launch of our High Quality Therapeutic Care Taskforce earlier this year. The Board's goal remains to move Trust services to a good rating across the board, with a stretch goal to achieve an outstanding rating in the caring domain. The Board considers comprehensive work across our directorates to assess the baseline for that ambition and also reconsiders evidence in place in our well-led domain.

Our patients

2.1 Improvement work to address longstanding **delays and qualitative weaknesses in our complaints processes** is now largely complete. This means, in practice, that there is no longer a backlog of material from our PALs service, from Parliamentary representatives, nor direct into the complaints process. By the start of June, we expect to be up to date in all but one handful of concerns raised with us. This is very much a product of the restructure of Nursing and Facilities in late 2024, and intensive work over the last four months. The next milestone, in the improvement journey, is to document the lessons learned from complaints as a whole, and to return to services before the end of September an auditably test, whether changes promised during 2024/25 have, in fact, occurred. This is in the same spirit at the Board's work on Patient Safety Incident Investigations (PSII) on today's agenda.

2.2 The paper on serious incidents, before the Board today, reflects **a wider emphasis on improving patient safety and learning**. In June, the Clinical Leadership Executive, and the Learning/Education sub-group, will consider the learning model across the Trust and how it can be enhanced. If we are to achieve the leadership ambition we have set, we must be able to demonstrate "closing of the loop" of learning, from harm and from excellence, not only in services where these things are identified, but more generally. When we meet as a Board in July, we can explore the plan to make progress on this during 2025/26. PSIRF is a key enabler for this work: and building on work across the Board in December 2023, and reflecting review by clinical executives, myself and the chair of Quality Committee this winter, a revised PSIRF policy is presented at Annex 6 for the Board's sight, and, if acceptable, approval. Our draft internal audit programme for 2025/6, in quarter 2, reviews implementation since April.

2.3 In considering the submissions made by teams in respect of the core standards issued by the Care Quality Commission, the Board will recognise prior discussions that our key step is to ensure **personalised care planning** and up to date risk assessments are in place. Gaps within this are a longstanding concern, dating back to prior inspections, and apparent in peer reviews, as well as MHA visits. We need to identify what constitutes consistent success as a Trust, and then work to remove barriers to the application of that agreed approach. One critical element in that work will be our transition to using DIALOG+, as distinct from the Care Programme Approach (CPA). Training progress since 2024 remains strong, and Jude Graham has become the Senior Responsible Officer (SRO) for supporting teams to adopt this approach at scale and quality during the balance of the year. That year includes use of DIALOG+ in children and young peoples' services, which is not nationally mandated, but which we consider will be important in promoting meaningful transitional care arrangements between services, as well as offering wider benefits.

2.5 In autumn 2024, we received a **Prevention of future deaths (regulation 28) notice**, and work to change our all-age crisis pathway was immediate. The delivery review cycle will pick up an after-action review of the success of the changes, and we should consider too how this work is embedded into our clinical audit programme before the end of 2025/6. However, as the Board is aware, our other recent Reg 28 notice, in relation to 'disengagement', dating from December 2023, has seen less rapid change. The clinical

leadership executive has now approved the new Trust-wide Engagement Policy, which governs how we support patients to remain in contact with services, and how we will behave when that is not possible. Looking across enquiries into, in particular, adult mental health services, weaknesses in this area nationally, are a common thread. It will be important that we consider how we will know in Q4 2025/26 that our changes have been effective – and I have asked for that to be added to the action log of the Board such that the item is visible to all at the most senior level. Notwithstanding ICB-led assurance cycles in relation to the calibre of Assertive Outreach Services post-Nottingham, this wider work will be crucial to the Trust seeking to support patients better

2.6 **Our High Quality Therapeutic Care taskforce** has now met on four occasions, and we have also run 'ask me anything' sessions for staff about its work to improve inpatient mental healthcare at the Trust. A mobilisation plan is being finalised to describe the work being done between now and Q4 2025/6. We will circulate this later in June and create space for a discussion on it at the timeout of the Board. It is possible, by that point, that we will have a clearer indication of CQC feedback from their review, but we will also have undertaken the rapid improvement event with staff teams that seeks to select a 'preferred approach' to a variety of inconsistencies and points of variation of practice. Both the Culture of Care self-assessment work, now fed back to ward managers, and review work for the Chief Operating Officer, highlights this variation, and whilst action is needed beyond tackling that, it is a necessary condition for improvements in care experience and work to address iatrogenic harm.

2.7 In order to deliver our strategy, we know that **we need to become more systematic in our analysis of health inequalities data** – not only in planning service at a population level, but in scrutinising service delivery through the lens of protected characteristics. The significance of this issue is captured in our Strategic Delivery Risks (SDR/BAF) considered elsewhere on the Board's agenda. In practice, this requires us to take three steps, and we believe all can be achieved by July 2025, and our Board meeting. These steps are:

- Ensuring that (in addition to seeing data on Mental Health Act delivery by protected characteristic, as we have in 2024/5) we make sure that our in-year reporting keeps track of patterns of detention by comparison both to a) presenting demography and b) population demography.

- Analysing key IQPR data by a sub-set of protected characteristics in order to allow 'red flag' anomalies to be noticed and investigated rapidly. A prototype for this work is in hand and will be in place for July reporting.

- Routinely reporting into CLE, and its equity and inclusion sub-group, the agreed datasets associated with promises 6, 7, 8, 10, 11 and 12 – and from mid-year embedding those within the IQPR.

<u>Our people</u>

3.1 On May 6th, we held our first long service event since 2019. **The revised annual Distinguished Service Awards** were led by our chair, with the Mayor of Rotherham also attending. The new awards differ from past arrangements in being more generous,

extensive (10 years now honoured) and more immediate (at anniversary not retirement) than before. Catch-up arrangements for 2022 and 2023 are now place, culminating at our annual members meeting in July. Work to welcome new RdaSHians since October has been well received, and it is important that, as we look to sustain experience in our staff teams, we also pay attention to those who remain and who we retain, as a major strength in our culture.

3.2 The paper in our meeting on the staff survey understandably focuses attention on the broader responses to this material from over 2,000 people across the organisation. However, just as in 2023/4, the WRES data suggests a rise in active discrimination on the basis of ethnicity, or possibly religion, and our 2024/5 data should cause us to be concerned about **the experiences of those with disabilities or long-term conditions** – a reality we discussed in March. In responding to the survey before next autumn, we need to be clear how the Trust can become a positively promoted supporter of professionals and others with a disability – and move beyond our excellent work on reasonable adjustments using technology to ensure that attitudes and behaviours support work colleagues declaring a disability or LTC.

3.3 Quarter 1 (April to June) sees **major recruitment activities** for a number of exciting new service developments. Investment by Humber and North Yorkshire ICB has allowed us to create North Lincolnshire's Community Rehabilitation service. This includes investment in local authority teams. Meanwhile, initial investment from South Yorkshire ICB will support our High Dependency Unit from October 2025. Both will require multi-professional teams drawn from outside existing teams, as well as creating development opportunities for existing employees. We continue to explore the request to see how these developments can, from the outset, 'embody' all our promises and will provide detail of that idea in the next meeting of the Board.

3.4 The postgraduate deanery led an informal discussion **with Trust leaders about educational provision and its place in service planning and change**. This reflected some concerns felt by resident doctors arising from emergency changes in early 2025. The Trust remains highly rated by NHS England and placement quality remains good. Changes to our medical personnel function are bedding down and a survey of issues and improvements, that trainees would recommend, is being undertaken to ensure that we listen to the views of those in current and in the post August rotations. Investments in undergraduate and postgraduate medical education have been made since 2023, and the CMO is evaluating the value of such investments and how it is maximised and demonstrated over the coming year.

3.5 April saw **the second wave of our Leadership Development Offer**, led by Virginia Mason and PSC, with Mokita and New Local, going live. Later in Q1 the steering board for this work will need to cohere not only the initial evaluation framework for the LDO itself, but a clear description of how the impact of this investment on management performance will be considered. Board members have been introduced to the initial pilot of our first line managers programme, which needs to become a standard gateway before the end of 2025, and applications are opening now for the clinical leaders' programme.

3.6 The **Trust People Council** continues to develop its place as an influential body in our governance. Its connection to staff networks is increasingly evident, and we would hope

that we begin to strengthen links for other representational bodies into TPC. Further to the Board's consideration of the Promise 26 plan, that body has also explored what should be done. The recent health and wellbeing pitch for the year ahead was also revisited, and the general view was that there is more work do on ensuring 'hygiene' factors for good employment are consistently met – attention was drawn, for example, to proposals for a consultants' charter modelled on national work. Our investment in project timepiece outcomes represents an opportunity to apply practical change – as does our ambient speech pilot work (guidance about which is included in annex 3).

3.7 **Learning Half Days** will take place each month in the coming year. Take up remains strong and policy changes will support an expectation that individuals attend 80% of the time – while a pilot for services, whose acute nature makes attendance difficult, will take place during Q2. LHDs remain a key differentiator for the Trust in a challenging employment market and reflect the Board's intention that we develop as a learning organisation. We are into our second PDSA cycle now and want to think through how best to sustain initial momentum and move decisively beyond a focus on mandatory training.

3.8 **Budget sign off** is included within this section of the report, notwithstanding the critical importance of finance to patient-facing care: in the year ending in March 2025, we appear to have moved to spending 69p in each pound on patient facing care, a movement from 64p in May 2023. All 23 directorates have achieved sign off, which indicates not only that cost improvement programme plans have met target, but that the wider financial framework, we established, has been met. It is important to recall that the localised plans for 2025/26 maintain our agency eradication work, reduce reliance on bank roles, and include a bias to reduce corporate service scale. At the last Board meeting, we discussed 'think directorate' our post 2023 transition plan to deepen operational management skills and incorporate more clinicians into management; for the first time in 2025 budgets have been set at directorate level throughout the Trust. Automated de-delegation of budgets will take place, on a quarterly basis, if teams are unable to achieve the phased budget plan.

<u>Our population and partners</u>

4.1 During Q2 this year, we will initiate **our 'shadow' CLE** (in this case our *community* leadership executive). This work will continue promise 5 activities undertaken across 2024/25, which sought to put patient voices into the heart of our decision making. This has been further amplified by success in filling, with activists, our governor roles from the local community. Review of the views and experiences has, of those contributing to our leadership spaces, and within our LDO, been undertaken – and Glyn Butcher, supported by Jude Graham, is now studying some of the more practical barriers to impact and influence, which we need to overcome.

4.3 Annual health checks, despite their removal from QOF models in the revised GP contract, remain a focus of effort and improvement. Consistent with the Board's intervention in November 2024, we have **accelerated work led by Richard Chillery to align our registers, especially for serious mental illness**, with those held by local general practice. Cross Trust work, to improve take up and to standardise our approach, has taken place, and a Q2 LHD event to further support that, alongside local GPs, is planned. The equity and inclusion group is supporting parallel work on learning disability registers, mindful of our promise 8 commitment to address ethnic access inequalities, as part of

broader work to tackle premature mortality among black and minority ethnic residents with learning disabilities.

4.4 At the start of June, **our "in plain sight" reports from the 2024/25 poverty proofing work** will be published on our website and widely advertised. This work builds on pilots discussed within the Board and our committees, and augments this year's adoption of the Real Living Wage, extension of our period poverty investment, and work on food banks and cupboards – which we will be considering consistently within the Trust People Council as a practical demonstration of the Trust's values. Investment to address disparities of transport access were part of our 2025/26 Investment Fund approved at the last Board meeting.

4.5 We have now **'gone live' with our first housing venture of recent years**, taking responsibility for a residential lease programme in collaboration with the South Yorkshire Housing Association in Rotherham. Similar projects are intended for the coming months in our other places. This work compliments the engagement of the Pathway organisation to develop our homeless health team this summer, work to consider an employment scheme modelled on work at Sandwell and West Birmingham NHS Trust, the research and development work on Poverty Truth Commissions locally, and the creation of benefits and debt advice services in each of our places. Take up, and in particular, de-stigmatising mainstreaming of this last offer, is a key step in support of our wider efforts, and close attention to the impact of this work will be governed and overseen through our Public Health, Patient Involvement and Partnerships Committee.

Toby Lewis, Chief Executive
May 20th 2025

Annex 1

Clinical leadership executive – April 2025 and May 2025

There has been only one meeting of this body since the Board last met. That is because the April meeting was stood down to reflect the immense workload, and national holiday pattern of the month.

CLE meetings routinely consider – the IQPR and sub-group outbriefs. The key or non-standard agenda 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.

April	May
Meeting cancelled – routine papers circulated to consider by exception, including outbriefs and IQPR	MHA review of 24/25
	PSIRF policy (including adverse events SOP for resident doctors)
	Out of area placements approach and detail
	Engagement policy
	IPS services Trustwide
	Housing programme – phase one, Rotherham

In terms of decisions made, in May we discussed the engagement policy referenced in the CEO report – as well as the PSIRF policy due for Board approval in this meeting.

There are no specific matters to escalate to the Board, but the CLE meeting informs the report to Board, for which this is an annex.

Over the next two meetings (June/July) we will consider, in particular:

- The segment 3 priorities among our promises
- The trajectories for wait time improvements during 2025,
- How we support our work to meet core CQC standards,
- Our policy and practice approach to both remote working and remodelling PDRs

Toby Lewis, Chief Executive
21 May 2025

Annex 2

Current vacancy summary at 1st May 2025

The current vacancy rate is 3.56%. The figures shown in the Offered and Start Date Given columns are external candidates joining the Trust, there are also 38.68 wte internal movers. Of the 35.26 wte candidates with a start date, 27.46 wte are starting in late May and June. There are currently 20.57 wte leavers in May who are not accounted for on this table.

Org L4	FTE Budgeted	FTE Actual	FTE Variance	RECRUITMENT	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	Offered	Start Date Given	Total
376 CCG Management	25.43	24.85	-0.58								
376 CCG Mental Health	324.33	314.61	-9.72		3.00	5.80		1.00	7.00	8.25	25.05
376 CCG Physical Health	300.25	281.82	-18.43			2.50			1.00	4.27	7.77
376 DMHLD Acute Services	228.61	197.58	-31.03			1.60	4.16		7.00	2.00	14.76
376 DMHLD Community Services	338.76	327.73	-11.03		1.00			2.00	2.00	3.20	8.20
376 DMHLD Learning Disabilities & Forensics	188.70	180.83	-7.87			1.00	1.00		1.00	2.60	5.60
376 DMHLD Management	10.20	8.80	-1.40								
376 NLCG NHS Talking Therapies	182.67	189.49	6.82			1.00		0.40	0.60	2.54	4.54
376 NLCG Acute Care Services	133.31	119.51	-13.80			1.40		1.80	6.00	1.60	11.80
376 NLCG Community Care Services	139.81	108.68	-31.13		2.60	7.28	4.04	4.65			18.57
376 NLCG Management	25.01	27.84	2.83				1.00	1.05			2.05
376 PHND Community & Long-Term Conditions	398.02	396.73	-1.29			4.00		1.00	7.40	3.00	15.40
376 PHND Rehabilitation	323.63	305.72	-17.91			1.60	1.00	4.23	5.44	2.00	14.27
376 PHND Management	10.20	9.85	-0.35								
376 PHND Neurodiversity	41.70	40.79	-0.91						3.00	1.00	4.00
376 RCG Acute Services	213.92	227.37	13.45		1.80	7.00		0.70			9.50
376 RCG Community Services	236.68	233.84	-2.84			3.80		0.60		1.00	5.40
376 RCG Management	17.00	14.01	-2.99			1.00					1.00
376 Corporate Assurance	29.69	27.56	-2.13		1.00						1.00
376 Estates	42.18	40.17	-2.01		1.00				1.00	1.00	3.00
376 Finance & Procurement	44.99	38.99	-6.00				1.00			0.80	1.80
376 Health Informatics	74.46	74.36	-0.10					1.00			1.00
376 Medical, Pharmacy & Research	35.98	53.39	17.41				1.00				1.00
376 Nursing & Facilities	172.99	168.94	-4.05			0.53	1.64	1.50		2.00	5.67
376 Operations	52.08	49.00	-3.08			1.00		1.00			2.00
376 People & Organisational Development	90.25	86.25	-4.00			1.00	2.00				3.00
376 Strategic Development	20.38	20.56	0.18			1.00					1.00
376 Psychological Professionals and Therapies	5.00	5.00	0.00			1.00					1.00
Total	**3,706.23**	**3,574.27**	**-131.96**		**10.40**	**42.51**	**16.84**	**20.93**	**41.44**	**35.26**	**168.38**

Annex 3:

National publications/guidance summary – April 2025/May 2025

Working together in 2025/26 to lay the foundations for reform
(*NHS England, 01/04/2025)*

Letter from Sir James Mackey.
https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/

Model ICB Blueprint
(*NHS Providers, 08/05/2025)*

This briefing provides a summary of the blueprint document, highlighting the aspects most relevant to trusts, and includes NHS Providers' view.
https://nhsproviders.org/resources/model-icb-blueprint

Impacts and benefits of provider collaboration at scale
(NHS Providers, 31/03/2025)

This case study report brings together examples of what provider collaboratives are achieving together, from reducing waiting lists, to creating shared services that go further.
https://nhsproviders.org/resources/impacts-and-benefits-of-provider-collaboration-at-scale

Board member appraisal guidance
(*NHS England, 01/04/2024)*

The guidance outlines NHS England's expectations and recommendations in the completion of board member appraisals. It has been developed in service of board effectiveness and to ensure a consistent and standard approach to appraisal, recognising that there will be a requirement to adapt depending on the type of organisation and whether the appraisee is an executive or non-executive director.
https://www.england.nhs.uk/publication/board-member-appraisal-guidance/

Consultation on the draft NHS Performance Assessment Framework
(NHS England, 12/05/2025)

NHS England is consulting on the draft NHS Performance Assessment Framework, focussed on the proposed approach and methodology for assessing the performance of integrated care boards and NHS trusts and foundation trusts. The consultation will run until **30 May 2025** and feedback will help refine the framework's approach to oversight across the NHS ahead of publication and implementation later this year.
https://www.england.nhs.uk/publication/consultation-on-the-draft-nhs-performance-and-assessment-framework/

NHS very senior managers pay framework
(*NHS England, 15/05/2025)*

The framework applies to all integrated care boards (ICBs) and NHS provider trusts and seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles. The VSM pay framework has

been jointly produced by NHS England and the Department of Health and Social Care (DHSC), with the policy owned by DHSC as instructed by the Secretary of State for Health and Social Care.
https://www.england.nhs.uk/publication/nhs-very-senior-managers-pay-framework/

2025/26 NHS Standard Contract – Model system collaboration and financial management agreement
(*NHS England, 03/04/2025)*

The model system collaboration and financial management agreement is a framework document which an integrated care board and its local partner trusts can choose to use locally, to set out how they will work together to manage NHS system finances and in-year financial risks. It is not a mandatory template; local systems are encouraged to use it as a starting point.
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2025%2F04%2F038-nhssc-2526-scfma.docx&wdOrigin=BROWSELINK

Enhanced therapeutic observation and care: A guide to improving data collection and reporting
(*NHS England, 04/04/2025)*

This publication is designed to support organisations in improving how enhanced therapeutic observations and care (ETOC) is provided and managed. It focuses on how to use ETOC data to understand current provision, improve workforce deployment and enhance patient safety. As part of this, the guide outlines 10 core ETOC metrics.
https://www.england.nhs.uk/long-read/etoc-guide-improving-data-collection-reporting/

Staying safe from suicide: Best practice guidance for safety assessment, formulation and management
(*NHS England 04/04/2025)*

Guidance supporting the government's work to reduce suicide and improve mental health services.
https://www.england.nhs.uk/long-read/staying-safe-from-suicide/

National mandatory learning people policy framework (*NHS England, 07/04/2025)*

This policy is for NHS organisations to adopt and adapt to help them meet their statutory obligation to ensure a safe and inclusive work environment. It is intended to reduce or prevent incidents, near misses, risks and connected loss of productivity. It also aims to increase efficiency by ensuring learners do not need to repeat learning unnecessarily.
https://www.england.nhs.uk/publication/national-mandatory-learning-people-policy-framework/

Wheelchair quality framework (*NHS England 09/04/2025)*

This framework will assist integrated care boards and NHS wheelchair service providers in delivering high-quality provision that offers improved access, outcomes and experience.
https://www.england.nhs.uk/long-read/wheelchair-quality-framework/

Investment priorities for mental health 2025
(*NHS Confederation, 07/05/2025)*

Commissioned by the NHS Confederation's Mental Health Network as part of the Mental Health Economics Collaborative (MHEC), this report draws on existing evidence about six investment priorities that would support better mental health and represent good value for money.
https://www.nhsconfed.org/publications/investment-priorities-mental-health-2025

Climate adaptation resources
(*NHS England, 08/05/2025)*

The NHS Climate Change Risk Assessment (CCRA) Tool and the NHS Climate Change Adaptation Framework has been developed to support NHS organisations to adapt to climate change.
https://www.england.nhs.uk/publication/climate-adaptation-resources/

Psychological professions national workforce census
(*NHS England, 08/05/2025)*

This document's aim is to provide a more comprehensive overview of the psychological professions' workforce in England, to understand the size and scale of the workforce and highlight progress and challenges.
https://www.england.nhs.uk/publication/psychological-professions-workforce-census/

Being fair tool: Supporting staff following a patient safety incident
(NHS England, 09/05/2025)

The being fair tool will support decision-making for patient safety incidents referred to workforce, and to ensure that staff are not treated unfairly after a patient safety incident. In rare circumstances, a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances that the being fair decision-making tool can help decide what next steps to take.
https://www.england.nhs.uk/publication/being-fair-tool/

Patient safety healthcare inequalities reduction framework
(*NHS England, 15/05/2025)*

This framework sets out five key principles to reduce patient safety healthcare inequalities across the NHS. It outlines opportunities that local teams and integrated care boards (ICBs) can implement, as well as the work NHS England is taking nationally to support and enable this.
https://www.england.nhs.uk/publication/patient-safety-healthcare-inequalities-reduction-framework/

Leading for all: supporting trans and non-binary healthcare staff
(NHS Confederation, 16/05/2025)

Supporting leaders to understand the needs of transgender and non-binary colleagues so they can perform their duties and provide high-quality allyship.
https://www.nhsconfed.org/publications/leading-all-supporting-trans-and-non-binary-healthcare-staff

The digital road to preventative care
(NHS Providers, 20/05/2025)

Blog by Chris Fleming, health and care lead at Public Digital. *The subject of health, in its broadest sense, involves not only medical services but all those environmental factors- good housing, sanitation, conditions in school and at work, diet and nutrition, economic security, and so on-which create the conditions of health and prepare the ground for it.*
https://nhsproviders.org/resources/the-digital-road-to-preventative-care

Freedom to speak up
(NHS England, 21/05/2025)

Freedom to Speak Up (FTSU) is about encouraging a positive culture where people feel they can speak up, their voices are heard, and their concerns acted upon. This guidance helps patients and staff of NHS organisations understand the FTSU process and FTSU guardians and information governance professionals to manage information raised in a safe and appropriate way.
https://www.england.nhs.uk/long-read/freedom-to-speak-up/

Providers Deliver: putting young people at the heart of care
(*NHS Providers, 21/05/2025)*

The report features four case studies demonstrating how trusts are successfully improving services for children and young people across a variety of sectors. One of the case studies features Humber Teaching NHS Foundation Trust, who has developed a number of initiatives to support children and young people in the community.
https://nhsproviders.org/resources/providers-deliver-putting-young-people-at-the-heart-of-care/introduction

Annex 4: South Yorkshire MHLDA papers – March and May 2025

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 12 March 2025

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 12 March 2025. The main areas of discussion and subsequent action are outlined below.

Managing Director Report

The Board received an overview on national planning guidance for MHLDA. System level commissioning intentions were also discussed with an agreement that the Collaborative would work with the ICB to provide clarity on the responsibilities of the Collaborative for delivery and the associated reporting mechanisms.

It was noted that the Collaborative coordinated a system response to the recent opportunity to bid for national capital funding and outcomes of the bids will be fed back to Board.

Managing Medical Emergencies in Eating Disorders (MEED)

Further to previous papers on MEED, a final proposal was presented which sets out an intention to transform the eating disorders service over a two-year landscape.

The model was supported, and the Collaborative will now seek to reach a financial agreement for implementation with the ICB either as part of the Mental Health Investment Standard or by considering this as part of a longer-term financial plan where savings from the Collaborative programmes can be reinvested.

Planning 2025/26

The Board was provided with an overview of the agreed priorities for 2025/26 and the associated supporting documentation.

The proposed workplan comprises four types of work: programmes, peer review and challenge, sharing success and advocacy and the three-year plan development, underpinned by financial assumptions.

Existing programmes have been reviewed and the Health Based Place of Safety project has been closed with oversight recommended. The Out of Area Placement programme, which currently focusses on complex placements, will be widened to incorporate all out of area placements.

Newly included are three key clinical areas to undertake the work programmes commenced with Akeso: Child & Adolescent Mental Health, Community Mental Health Teams, Older

People's Inpatient and Community Models and an additional supporting Information Improvement Programme. The Chief Executives have agreed to each lead a workstream given the focus required.

The plan was fully supported by members of the Board.

Work on a performance scorecard was presented as a separate paper. It was noted that this would need to be adapted to also include the measures from the new programmes and would need to incorporate the revised national priorities for 25/26.

Progress against the national targets was discussed and the potential impact of revised national measures for 25/26. The Board noted that the performance report needed to continue to develop to clearly illustrate the impact of the Collaborative improvement work.

Health Based place of Safety (HBPOS) – Closure Report

Structurally the HBPOS programme is complete and a lessons learnt exercise has been undertaken.

The six suites are up and running and starting to have a positive impact. There is robust data on length of stay in the suites and the use of the Emergency department as a HBPOS when a suite is unavailable.

Autism and ADHD Programme Deep Dive

A review of this programme was undertaken by the new Senior Responsible Officer, and this was presented to the Board. Good progress had been made with the five-point plan that had previously been agreed.

The Board noted the work to date and agreed, alongside the ICB, to consider the role of the Collaborative with regards the right to choose workstream and agreed to support work on baseline costs and current productivity.

Specialised Commissioning Update

The Board received the routine report from the SYB Specialised Commissioning Provider Collaborative Partnership Steering Group and brought to the attention of the Board items for escalation and risk to the system.

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 14 May 2025

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 14 May 2025. The main areas of discussion and subsequent action are outlined below.

Managing Director Report

The Board received an overview of the national changes to Integrated Care Boards (ICBs) and NHS England and noted the potential implications of the on Provider Collaboratives in terms of funding and engagement. Focus remains on continuing to implement and deliver the agreed priorities, whilst working with system leaders to consider future options.

Service Development Funding (SDF) and the Mental Health Investment Standard (MHIS)

Service Development Funding (SDF) for 2025/26

The Executive Place Director Rotherham & Deputy Chief Executive of the ICB provided the Board with an update on the plan for the Service Development Funding for 2025/26.

The high-level message was that funding had been applied differently this year and there has been a 7% reduction nationally compared with 24/25. As part of the South Yorkshire planning approach additional reductions have also been made from the SDF envelope, impacting mental health services.

Whilst funding for core NHS services and committed funding for developments has continued, funding that has been earmarked but not committed will be withdraw and this impacts funding of several service developments.

The delay in implementing previous plans for mental health support teams in schools was discussed and the potential long term impact of reducing other mental health services, especially those that are preventative. Members of the Board requested more detail on the impact assessment process, including what it covers, decisions made, and outcomes.

It was also agreed that there needs to a MHLDA specific space for ongoing SDF oversight and discussion, and regular updates on SDF funding and planning will come back to the Collaborative Board.

Mental Health Investment Standard

The MHIS applies to Integrated Care Boards (ICBs) and will continue to be subject to an independent review. For 2025/26, the MHIS requires ICBs to increase spending on mental health services in line with the growth of the ICB programme allocation base.

A colleague from the Integrated Care board (ICB) finance team attended the meeting to discuss the process for calculating and forecasting the MHIS. This calculation suggested that there was likely to be a spending increase of more than the amount required by this MHIS over 25/26. There were several questions on the methodology and consistency of approach. ICB and Trust colleagues will meet to resolve this prior to the next Board meeting.

A paper on Financial Planning followed, updating the Board on the development of a three year plan for the South Yorkshire MHLDA Providers which is being developed by the Directors of Finance and Chief Executives.

Delivering Our Work programme

The Board was provided with an overview of progress against existing programmes and the recently agreed priorities for 2025/26 which are the Information and productivity programmes. The current delivery status will be reviewed with Senior Responsible Officers for the programmes to ensure rigour in the approach.

Work on a performance scorecard was presented as a separate paper. This included draft measures for the new programmes and updated detail on the revised national priorities for 25/26. Trust teams are working together to develop a shared dataset that reflects shared performance measures associated with the Collaborative priorities for 2025/26.

Out of Area Placements (OAP)

A deep dive into the OAP programme identified current challenges and highlighted opportunities to further develop services closer to home. Progress has already been made across the Trusts with further work planned in 2025/26. Following further Chief Executive discussion, proposals will be finalised and presented to the ICB Board to agree next steps at a system level.

Specialised Commissioning Update

The Board received the routine report from the SYB Specialised Commissioning Provider Collaborative Partnership Steering Group and brought to the attention of the Board items for escalation and risk to the system.

Board Assurance Framework

An updated BAF was presented, and the Board requested further review to include the changing funding landscape and a review of the scoring.

Terms of Reference

The Board agreed the following minor changes to the Terms of Reference (ToR) and Joint Working agreement (JWA)

- The ToR and JWA to be amended to clarify that meetings are held in private to reflect current practice, but there was an undertaking to consider this as part of the strategic development session in August.
- ToR revised to confirm that reporting from the Collaborative Board into Trust Boards will be in the form of a summary report to reflect current practice
- A small number of minor amendments to names and job titles

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

Annex 5: April RIDDOR report

Further to work championed by the Board's People and OD committee, the Board of Directors considered an assurance report on RIDDOR when it met in March 2025. Given modest confidence in processes and impact, we agreed that for the duration of 2025/26, the chief executive would present a routine RIDDOR report at each meeting to the full Board.

RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These regulations require employers, the self-employed and those in control of premises to report specified workplace incidents to the Health and Safety Executive (HSE).

April 2025 there have been 3 RIDDOR reportable incidents resulting in employee injury.

Incident date	Cause	Location	RIDDOR reason
03/04/2025	An employee slipped on a wet floor in the hub area and suffered a knee injury.	Brodsworth Ward (Doncaster Acute Directorate)	Over 7-day absence
22/04/2025	A Community Healthcare Assistant suffered shoulder pain and a trapped nerve after applying compression bandages to a bariatric patient's legs.	Community Long-Term Conditions	Over 7-day absence
30/04/2025	A Community Partner (volunteer) suffered a hip fracture after falling up steps at an offsite Trust event.	AES Seal New York Stadium	Member of the public taken to hospital

Annex 6 – revised PSIRF policy

Rotherham Doncaster and South Humber NHS Foundation Trust

Patient Safety Incident Response Approach / Policy

DOCUMENT CONTROL:	
Version:	1
Approved by:	To be agreed with Board of Directors – May 2025
Date approved:	
Document developed in consultation with:	
Name of responsible individual(s):	CNO
Unique Reference number:	
Date issued:	
Review date:	April 2026
Target Audience	All staff, patients, learners and visitors.

Contents

Introduction

The Patient Safety Incident Response Framework (PSIRF) is not an investigation framework: it does not mandate investigation as the only method for learning from patient safety incidents or prescribe what to investigate. It is a framework that supports the development and maintenance of an effective patient safety incident response system with four key aims;

1. compassionate engagement and involvement of those affected by patient safety incidents
2. application of a range of system-based approaches to learning from patient safety incidents
3. considered and proportionate responses to patient safety incidents
4. supportive oversight focused on strengthening response system functioning and improvement.

This patient safety incident response approach sets out how Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) intends to respond to patient safety incidents over a period of 12 to 18 months. The approach sets out the areas we will focus on, to gain a deeper understanding of the problem and how we will make improvements.

The approach is not a permanent rule that cannot be changed. It will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

We operate services in more than 100 locations across Rotherham, Doncaster and North Lincolnshire.

We employ over 3,700 staff and have more than 250 committed volunteers. Our services are organised by geographical location and include:

- Adult Mental Health Services
- Older Peoples Mental Health Services
- NHS Talking Therapies
- Drug and Alcohol Services for Adults (Doncaster)
- Forensic Services (Doncaster)
- Adult Physical Health Community Services
- St Johns Hospice
- Learning Disability Services
- Children and Young Peoples Mental Health Services
- Children Young People and Families

You can find out more about our trust and the services we provide on our trust website https://www.rdash.nhs.uk/.

Defining our patient safety incident profile

To define our profile, we used information provided by our key stakeholders (patient and carers, staff). We found that information through

- Incidents reported
- Complaints
- PALS feedback
- Serious Incidents & Patient Safety Incident Investigations
- Safeguarding data
- Medicines Management data
- Freedom to speak up reports.
- Human Resources
- Clinical Negligence Claims
- Inquests
- Care Group Service Improvement Plan and Risk Registers
- Key themes identified from the Quality Committee and supporting subgroups.
- Data from quality surveillance processes: Falls, tissue viability and mortality
- The trust's Clinical and Organisational Strategy 2023-2028 & 28 promises
- Half day learning sessions on PSIRF

We put this data together and looked for the greatest opportunities for learning. We used this along with national guidance to develop our patient safety priorities.

Our patient safety incident response plan: national requirements

	National Priority patient safety incident types	**Required response**
1.	Incidents meeting the Never Events criteria 2018, updated in 2021.	PSII locally led by RDASH Patient safety and investigations team.
2.	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	PSII locally led by RDASH Patient safety and investigations team.
3.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	PSII
4.	Mental health-related homicides	Referral to NHS England Regional Independent Investigation Team (RIIT) for consideration of an independent PSII Locally-led PSII may be required
5.	Deaths under the state or in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations

6.	Deaths of persons with learning disabilities	Learning Disability Mortality Structure Judgement Review in line with RDaSH learning from deaths policy LeDeR referral process
7.	Child death	Child Death overview process Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
8.	Domestic Homicide (DH)	Domestic Homicide Related Death Review (formerly DHR) The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs
9.	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	To be referred to RDASH safeguarding Team. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards

Our patient safety incident response plan: local focus

In line with our strategic objectives as a trust, we want to understand and resolve the issues which result in delay. This links to objective 3 and promise 14 of our clinical and organisational strategy.

Waiting for care to start can add additional stress and deterioration in health for people. Delays can cause difficulties in the wider care system and result in people not receiving the right care at the right time in the right place. To guide our understanding and our improvement work in this area, where we don't already understand the contributing factors, we will respond to the following patient safety incidents with a PSII:

- Suspected suicide of a person waiting for an assessment longer than planned
- Community Suspected Suicide where there have been three failed contacts with services
- Incident involving a patient who has been identified as requiring a mental health admission and is awaiting a bed. Where the incident is likely directly linked to the mental health problem.

Inpatient services and alternatives to hospital admission

Our inpatient services are a critical but limited resource. Inpatient admissions and alternatives to inpatient services are used to support people when they are experiencing some of their most difficult times. We recognise there is pressure to move people through the service, due to the limited resources and high demand. It is imperative that we are providing evidence based safe and therapeutic care.

This is particularly important at points of transfer and discharge. Unsafe discharges potentially lead to poorer outcomes for people using our service and discharged patients are 32 times more likely than the general population to die by suicide.[1]

To guide our understanding and our improvement work in this area, where we don't already understand the contributory factors involved, we will respond to the following patient safety incidents with a PSII:

- Suspected suicide of an inpatient, including if the person is on leave
- Suspected suicide of patient under the crisis home treatment and liaison service

This will include people who have been discharged from an inpatient or alternative to admission, within 30 days.

Our PSIRF Implementation Guide

We will be flexible and proportionate where required to find the most suitable learning response. To assist in discussions around choosing the most appropriate learning response, we have developed a 'PSIRF Policy Summary and Decision Guide' – please see Appendix 1.

Where incidents involve care given by several agencies or trusts, and where system partners agree this is most appropriate, RDaSH will work collaboratively and undertake joint learning responses. Each party will follow their own sign off processes in the production of a single learning response and will work together with service users, their carers, families and advocates in a compassionate, engaging and joined up way.

Our approach to compassionate engagement with patients and their families.

We always want to be open and honest with the people who use our service, their families and carers, if something in our care has not gone the way we had planned it to. As a trust we strive to be compassionate in the way that we engage with people, particularly if something has gone wrong. It is important that we always tell the people affected and say sorry where needed, if something has not gone as planned.

If there has been a problem in care where we have made a mistake, it is especially important that we say sorry and that we engage with the people affected. If someone has been significantly harmed or there was a potential that they could have been, then we have a legal duty to be open and honest with patients. This is called *duty of candour.*

[1] https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/fourth-investigation-report/#1-background-and-context

Our approach to compassionate engagement with our staff - Just culture

We recognise that our work is complex and that there is inherent risk in everything we do. Sometime things go wrong.

'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. Generally, in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts[2]'.

We aim to achieve a culture where the people doing the work feel able to talk freely about what happened without fear. This goes beyond "incidents" and is about our day-to-day work. Those closest to the work are uniquely placed to provide knowledge and information about the challenges of providing the care we aspire to. If we can create a just culture, where our workforce understands that when things go wrong, they will be treated fairly, then this will drive a strong reporting culture and a strong learning culture within RDaSH.

RDaSH aims to ensure everyone working within the trust feels safe and confident to speak up. We encourage our leaders to take the opportunity to learn and improve from those who speak up.

We want everyone working in the trust to feel safe and confident to speak up and all leaders to welcome this opportunity to learn and improve.

To support developing a 'Just Culture', RDaSH has invested in specific 'Just Culture' training for managers, clinical leaders, safety experts, staff side agencies and workforce support teams. This training was facilitated by Mersey Care, who are acknowledged as national experts in this field.

As a Trust we also have an active Freedom to Speak Up Guardian & champions service, who all work together in support of 'just culture principles'. Please refer to our Trust Freedom To Speak Up processes in relation to this service:
https://intranet.rdash.nhs.uk/wp-content/uploads/2024/05/FTSU-national-insert-Policy.pdf

Recording & Reporting Incidents and Learning

The recording of patient safety events is vital in supporting patient safety by providing opportunities for learning and improvement. Where we have a strong culture of reporting this underpins our ability to learn and make improvements.

From May 2025, RDaSH embedded a new electronic system, designed to support healthcare organisations create a safer patient experience, through:

[2] https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/

- Timely reporting of incidents and complaints
- Tracking progress of investigation
- Consolidate learning response data and analysis of this data to create information
- Highlighting trends and key areas for improvement
- Enabling learning in how to prevent incidents and improve future outcomes through continuous improvements.

Incident Response

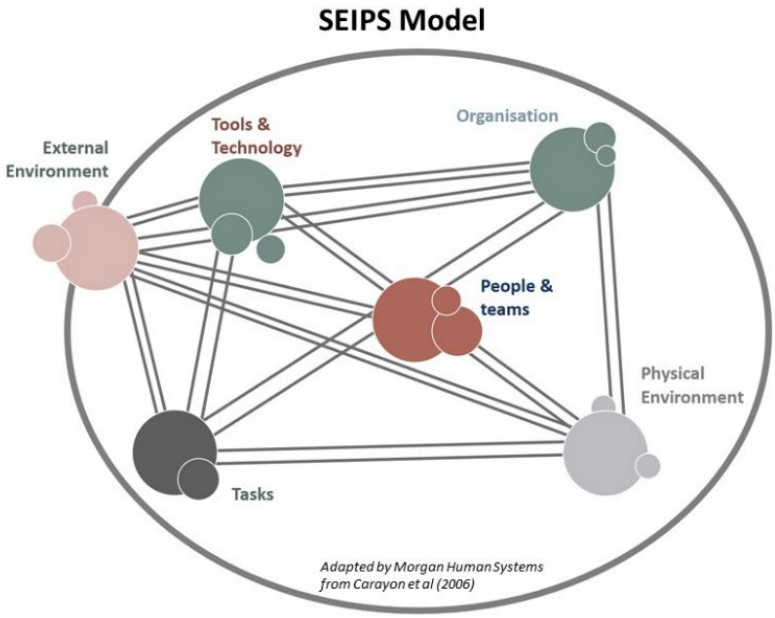
There are a variety of approaches suggested for how we can learn from when patient safety incidents occur, RDASH intends to use all the available tools, and choose the most appropriate one for the incident concerned

Swarm Huddle	This learning response pulls everyone together quickly to support and identify any immediate learning. A is a good response when the incident is localised and the learning best drawn out by meeting with those immediately involved with the events. The SEIPS methodology must be used to review the events and describe the systemic factors at play.
After Action Review (AAR)	A structured gathering of those involved in the incident together in a safe space to look at what happened, what should have happened, why there may have been a difference, and is there any learning. This should be carried out soon after the event and have the right people there to ensure the right people are involved in this wider meeting
MDT Review including **Thematic analysis**	A structured gathering with input from different disciplines, a similar process to that of a Swarm, however thoroughness is prioritised over speed. It may take some time to get everyone needed round the table, however in doing so a deeper dive into the system can be achieved. Useful where there are several teams involved or different agencies. Analysing a patient safety theme or perceived pattern to identify issues and learning from multiple patient safety incidents. A few learning responses can be used to try to spot themes and trends.
PSII	A full review. This is reserved for topics which are a priority as identified in the PSIRP. A national template must be used and the PSII must be undertaken by a person with the relevant level of PSIRF training. The SEIPS methodology is utilised to assist describing the system of work.
Structured Judgement Review (SJR)	A Structured Judgement Review (SJR) involves trained reviewers looking at the clinical record in a critical manner and commenting on specific phases of clinical care. The SJR approach can be used for any patient pathway that has a defined endpoint or characteristic, eg death, pressure sore or a fall. It is a component to the RDASH PSIRF approach, rather than a point of duplication.

Systems Engineering Initiative for Patient Safety (SEIPS)

Traditionally serious incident investigation and root cause analysis has focused on the actions or inactions of individuals. Whilst other elements of system learning may have been included, it has not been a central part of the approach.

To ensure that our learning is systems based under PSIRF, the trust will ensure that the SEIPS model is used, to help us make sense and describe our system of work. Using this model will ensure that all the system elements are considered within the learning responses and how they interact mapped out as the below diagram shows.



Learning from deaths

If someone who is using our services dies, there are reliable processes in place to review our care and treatment for that person. Nationally this work is called learning from deaths in the NHS.

As part of our process we have a medical examiner, who is senior medical doctor. They provide an independent scrutiny of what caused the death of the deceased and decide if the persons care before they died was appropriate. They will also decide if the coroner needs to be notified of the death. often this will be the end of the process.

If as part of this review we identify that the deceased person had a diagnosis of psychosis or an eating disorder at the time of their death, then we will do a more in-depth review. This is called a structured judgement review and involves a senior clinician reviewing the clinical records of the deceased person. The senior clinician will make judgements on the quality of the care and give appropriate feedback to services, which allows them to make improvements where required.

If a significant problem in someone's care is identified then further learning will take place to understand the issues more fully. If the problems identified are thought to have contributed to the person's death, then a PSII will be completed.

Timeframes for investigations

We aim to engage with those affected by incidents at the earliest opportunity, in order to discuss and agree how long our investigation will take. In all cases investigations should be completed within 50 working days.

Core Governance

The trust has a process in place where incidents are reviewed with the patient safety team, to ensure that there is oversight with the opportunity to escalate where required,

and monitoring to ensure learning responses are being completed (see Appendix 2 and 3).

There are patient safety huddles twice per week where care services can raise issues with learning responses and seek guidance and assistance.

The main group to oversee patient safety at an operational level within the organisation is the Patient Safety Operational Group (PSOG), which meets monthly. This is both an oversight and learning group, which receives escalations from care groups and connects ward to board from a patient safety perspective. The learning from each care group's learning responses will be presented at PSOG. Any issues with learning responses, or significant exceptions to the expected learning responses will also be raised and monitored through this group.

There will be an out brief from PSOG to the quality and safety group and the learning will be included in the patient safety report which is overseen by the Board Quality Committee bimonthly.

To Note:

*All Terms of Reference for a PSII will be signed off by CMO and or CNO without exception

**There is a specific requirement in terms of medical training and reporting to the Directors of Medical Education and associated deaneries. The RDaSH process for this is summarised in Appendix 4 of this document.

Appendix 1 – PSIRF Policy summary – guide to decision making

(This matrix is not designed to be restrictive and cannot provide an exhaustive list of directions. It is instead to provide guidance on a suitable response. If the considered opinion is that a different response from the one above would be more suitable, then deviation from the above is permissible. In some limited cases the system issues may be so poorly understood that a PSII may be the most suitable approach. Some incidents will directly affect RDaSH, but will not be our incidents, for example transfer of a patient into RDaSH services with incorrect medicines. In these cases, the service-to-service processes should be used, where we assist other organisations with their learning)

RADAR Risk Rating Chart -

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Injury (Physical & Mental) to anyone	Minor injury (not requiring first aid)	Minor injury or illness (first aid treatment needed)	Reportable to external agencies/statutory bodies (e.g. RIDDOR, HSE, NPSA, Police, MHRA Contractor, CQC)	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience no injury	Unsatisfactory patient experience and or involving first aid treatment readily resolvable	Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover (breach of working practices)	Serious mismanagement of patient care (major permanent harm) (breach of working practices)	Totally unsatisfactory patient care (breach of working practices)
Complaint / Claim Potential	Locally resolved complaint	Justifiable complaint peripheral to clinical care / management	Justifiable complaint involving lack of appropriate care / management. Claim below excess	Multiple justifiable complaints. Claim above excess	Multiple claims or single major claim
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage. Minor reduction in quality or scope	5 - 10% over budget / schedule slippage. Reduction in scope or quality requiring client approval	10 - 25% over budget / schedule slippage. Does not meet secondary objective(s)	> 25% over budget / schedule slippage. Does not meet primary objective(s)
Service / Business Interruption	Loss / interruption < 1 hour	Loss / interruption >1 hour and < 8 hours	Loss / interruption > 8 hours and < 24 hours	Loss / interruption > 24 hours and < 1 week	Loss / interruption > 1 week
Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality < 1 day	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training
Financial	Small loss < £100	Loss > 0.1% of budget or > £100 and < £1,000	Loss > 0.25% of budget or > £1,000 and < £5,000	Loss > 0.5% of budget or > £5,000 and < £10,000	Loss > 1% of budget or > £10,000

Likelihood Score *

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probablility	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

PSIRF response to Death (this is a suggested matrix; however any complicating factors may increase the type of response needed, therefore this should be considered as a minimum)

SWARM	After Action Review (AAR)	MDT Review	PSII - internal	PSII - external	Structured Judgement Review

Incident type	Area (typical not restricted to)	SWARM	After Action Review	MDT Review	PSII Internal	PSII External	Structured Judgement Review (SJR)	Agencies to brief	Other Comments
Expected Death – in expected time	Hospice &/or Older Peoples Service	X							Mortality form and review at MOG & by medical examiner – for all of these incident types Please also note that this process is neutral to coroner or police process, who may have their own investigation which we may be involved with but wouldn't change or delay our internal process
Expected death with unexpected factors	Hospice &/or Older Peoples Service		X					If Inpatient CQC	
Stillbirth or pregnancy loss	Community or inpatient	X							
Death of a person with LD	Community or inpatient				X			LeDeR	
Unexpected death of a Child in community	Community – no inpatient				X			Safeguarding	
Death with drug/ alcohol comorbidity	Community or Inpatient				X			If Inpatient CQC	
Suspected Suicide	Community or Inpatient	X (For community suspected suicide - if system factors are not well understood then any of these responses would be appropriate)			X (if it is death of an inpatient or 3+ failed contacts with services)			If Inpatient CQC & ICB	
Unexpected Inpatient Death	All RDaSH inpatient areas				X			CQC, ICB	
Unexpected community Death	Any community			X					
Inpatient Homicide	Any Inpatient setting					X			
Community Homicide	Community service				X				
Death related to medication error	Inpatient or community				X				

Example Scenarios: - (this is a suggested matrix with examples; it is not exhaustive AND, any complicating factors may increase the type of response needed, therefore should be considered as a minimum only)

		Physical Harm (examples)				Psychological Harm (examples)			Comments / persons involved
Inappropriate Behaviour									
Sexual Safety	Verbal	Sexual threat & Touch	Sexual Assault	Rape	See table above	Harassment	Threat and behaviours such as exposure	Persistent Threat	Criminal Investigation, RIDDOR, POD Team

Violence and Aggression	Verbal	Physical assault with minimal injury, requiring first aid	Physical Assault requiring hospital treatment. Injury is non-permanent	Attempted homicide or injury resulting in permanent damage/injury		Harassment	Threat of harm	Persistent Threat accompanied with behaviours such as stalking / following	Criminal Investigation, RIDDOR, Health and Safety Team
Other inappropriate behaviours	Discriminatory Language/Racism	Vandalising/Throwing and / or damaging equipment	Significant damage to personal or Trust property						Police contact, Health and Safety Team involvement
	Examples	Physical Harm (examples)				Psychological Harm (examples)			Comments / persons involved
Medication Errors									
Prescribing	Recording error	Dose error (form, dose, rate, timing) – too low/high – minimal side effect	Dose error – moderate side effects experienced requiring treatment	Dose error severe side effects / permanent	See table above	Side effects			Reporting via the 'Yellow Card' BNF/NICE scheme – includes VAPE
Administration	Wrong time administered or medication given with out current prescription	Drug administered to wrong patient – low harm	Drug administered to wrong patient – moderate harm	Dose error severe side effects / permanent					Please note specific trust process for reporting insulin errors
Other medication	Medication theft	Needlestick (injury may vary)	Adverse drug reactions	Overdose or non-prescribed medication		Unable to gain medication			MHRA Reporting "Yellow Card"
Missing Person									
Patient (informal)	Leave ward without discussion	Leave ward, resulting in self-injury			See Table above				Family/ significant other notification
Patient (detained)	Returned – had leave but the leave breeched the prescribed S17 time	Absconding from inpatient ward – may be connected to any of these harm categories and MDT review should follow including family							Mental Health Act reporting & family notification
Staff	Not returned at time agreed from visit								Counter fraud may be a consideration
Patient Care and treatment									
Pressure Sore (inpatients only)	Risk identified without the ability to adhere to safety advice	Reddening to the skin, physical assessment & mobility assessment	(Grade 3+) Moderate to severe Pressure Sores concerning inpatients are subject to an SJR process		See above tables	There may be a number of psychological side effects related to a pressure sore (i.e. social isolation, embarrassment related to odour); these should be assessed on an individual basis.			SJR if an inpatient – not in the community
Falls (inpatient only)	Slip or trip with no injury	Slip or trip with no significant injury	Moderate to severe falls concerning inpatients are subject to an SJR process			There may be several psychological side effects related to a fall; (i.e. shame, PTSD) these should be assessed on an individual basis.			NAIF report and SJR – if an inpatient

VTE	Assessment identifies issues but no physical need	Assessment identifies issues, but physical complications seen due to lack of adherence to guidance re proactive intervention, may fall into any of these harm categories. Also, may be suitable for AAR, MDT Review or SWARM dependant on level of harm and context.			Consider specific VTE policy and assessment requirements
Other Examples					
Data Breech	Information governance will advice upon the questions in SWARM		See table above	There may be a number of psychological side effects related to a data breech (i.e. fear of sensitive information been known; safeguarding issues etc); these should be assessed on an individual basis.	Data Protection; Information Commissioner
Mental Health Act Breech	i.e. second opinion not completed in time frame				Mental Health Act Office, CQC in some circumstance
Infection control – hospital acquired infection or outbreak	See related policy / process within the infection control manual				Infection control team, Health and Safety. National reporting.

Appendix 2 - PSII - Process Flow Process

The process below provides a guided timeline for Patient Safety Incident Investigations (PSII).

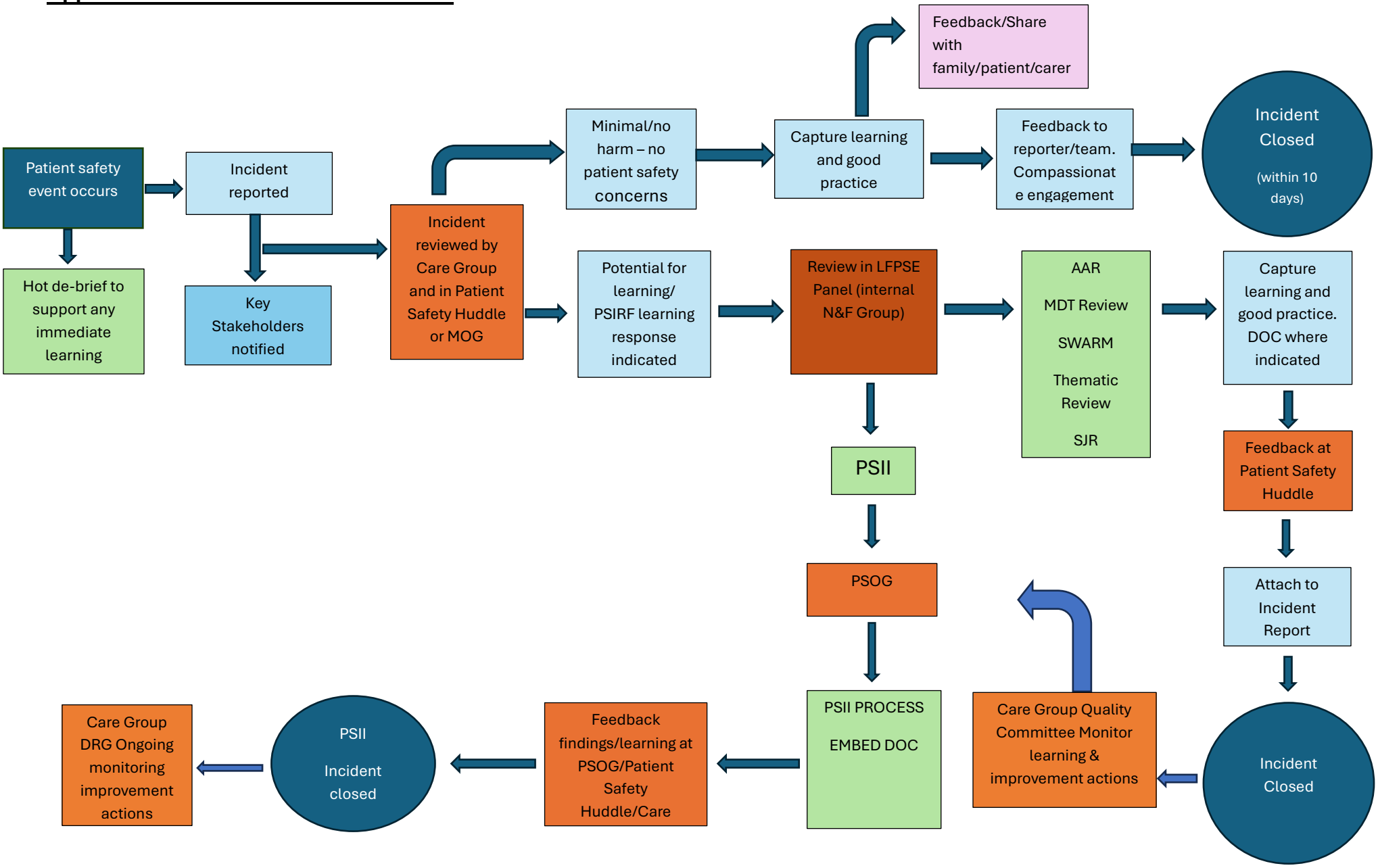
Day 0 is the day the event is declared a PSII, either by the nature of the incident and being one of the trusts priorities or following review at the LFPSE group.

Timescales are in working days excluding weekends and public holidays. Timescales may be broad due to the differing length of time it may take to investigate.

There may be some investigations that take longer than outlined below depending on the preferences and wishes of the family/patient.

Investigation Timeframe	In Working Days
A PSII is indicated as meeting criteria outlined in PSIRF plan/agreed at LFPSE Panel	Day 0
The PSCCT to allocate a lead investigator.	Day 0
The PSCCT notify the care group SLT This will include the identified lead investigator contact that will work with the care group.	Day 0-1
The lead investigator will contact the family/patient to introduce self and talk through the process and arrange first face to face (or preferred option) meeting to agree timescales and preferences. Share the learning together guide *(Family/carer involvement will be threaded throughout the process according to their wishes and preferences)*	Day 1-4
The lead investigator will scope the incident time window & review the patient record	Day 1-4
The lead investigator will hold a meeting with the care group identified team to establish terms of reference and scope of investigation. *(to be determined with care group)* The PSCCT will coordinate and arrange the required meetings within the PSII process at this point with relevant professionals – this to avoid any delays in meeting schedules. Key elements with application of the SEIPS methodology to review findings, key learning points and improvement planning.	Day 4-8
ToR with IR1 to be approved at LFPSE panel (but MUST also have CMO and CNO sign off)	By day 10
Establish an interview schedule for the investigation ensuring family/patient are first to be involved. Interview schedule to be shared with PSCCT lead and team	By day 10
The Lead Investigator conducts interviews and present **version 1** draft report and share with PSCCT lead. *(version 1 needs to have been edited and formatted appropriately)*	By day 20
The PSCCT lead will review, edit and feedback on **version 1**.	By day 25
The lead investigator will send **version 1** draft to the clinical services involved for comment and will then work with the care group representatives and relevant clinicians/specialist services to formulate/review the key findings/learning/improvement planning *(Expected return within 5 days)*	By day 30
The Lead Investigator will complete draft **version 2**, with improvement plan and send to the PSCCT lead for sign off. *(Expected return within 2 working days)*	By day 32
The PSCCT lead will send draft **version 3** to the Care Group SLT for review/sign off. *(Expected return within 5 working days).*	By day 37
The PSCCT lead and Head of Quality and Promises to QA **version 4** *(Expected return within 3 working days)*	By day 40
The Head of Quality and Promises/PSCCT lead will send draft **version 4** to LFPSE Panel for sign off *(Expected return within 5 working days)*	By day 40
Nominated appropriate person(s) (depending on the individual case) will meet with family/patient/carer to go through the report for further input and family/patient/sign off.	By day 45
The Deputy Director of Nursing will send draft **version 5** to the Chief Nursing Officer and/or the Chief Medical Officer for Trust sign off. Any PSII of a ***never event*** is to be signed off by the CEO *(Expected return within 5 working days).*	By day 50
The PSII and the learning will be presented at the PSOG meeting by the Care Group.	At the next available PSOG.
The final report **(ONE VERSION)** will be shared with family, Care Groups (to circulate with focus on learning/improvements), Coroners (if required), MOG.	Following PSOG.

Appendix 3 - PSIRF Incident Flow Chart



PROCESS FOR IDENTIFYING PGDiT INVOLVEMENT IN SIGNIFICANT EVENT TO PGME TEAM

PSIRF Response

If a PGDiT is involved in a PSIRF learning response such as SWARM, MDT, AAR, SJR or Thematic Review then this should be discussed with the Clinical Supervisor during supervision.

Unless event identified as meeting threshold via one of the established routes it will not result in an exception report being necessary.

HM Coroners' requests

Any requests from HM Coroner for statements/witnesses from a PGDiT will be forwarded to the PGME team.

The PGDiT will be expected to discuss any Coroner requests in supervision with their Clinical Supervisor.

CLS will update PGME Team of inquest dates.

Final Coroners outcome (if known, or confirmation of no learning identified if inquest passes without further request) to be shared with the PGME Team by CLS to enable Revalidation Exit Exception Report submission.

Complaints

The PSCC Investigator will use the list of PGDiTs to identify any PGDiT involvement in the investigation.

The PGDiT is expected to discuss any complaints they are named in during supervision with their Clinical Supervisor who will determine if the threshold for exception reporting being met.

Final complaint response to be shared with PGME Team by the PSCC Investigator to enable Revalidation Exit Exception Report submission.

PGME Team to follow the Revalidation Exception Reporting processes.

Incidents

Any incident involving a PGDiT should be brought to supervision with their Clinical Supervisor by the PGDiT.

Unless incident gives rise to conduct or capability concerns or needs to be managed under another route this does not require escalation to PGME.

Patient Safety Incident Investigation

At the point of an incident being identified as a PSII the PSCC Investigator will identify any Senior Psychiatrist (Cons or SAS) within the team. PSCC will notify the Consultant Psychiatrist and PGME Team of the PSII being commenced.

The Senior Psychiatrist and PGME Team will determine whether a PGDiT has been involved in the patient's episode of care.

PGME Team follows Revalidation Exception Reporting processes.

Final PSII Report to be shared with the PGME Team by the PSCC Investigator to enable Revalidation Exit Exception Report submission.

Key
PGME Team - Postgraduate Medical Education Team
PSCC - Patient Safety, Carer and Community
PGDiT – Post Graduate Doctor in training **CGMD** – Care Group Medical Director
CLS – Coroner Liaison Services **PSII** – Patient Safety Incident Investigation
MOG – Mortality Operational Group **NFA** – No further action

- The matrix of training posts and residents placed within RDASH will be shared with the Patient Safety, Carer and Community Team and Coroner Liaison Services. The lists will be updated whenever changes occur to ensure information is accurate.
- Actions following identifying PGDiT involvement in a significant event to ensure compliance with requirements of NHSE Y&H requirements and support for PGDiT throughout this process are set out in accompanying 'Actions on PGDiT Involvement in Significant Event' SOP.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Staff Survey – Areas of Focus	**Agenda Item**	Paper L
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	**Date**	29 May 2025

Suggested discussion points

In March 2025 the Board received the staff survey results, this paper suggests our areas of focus for the next three years to further improve our staff survey results, our working environments for colleagues and ultimately the care which we deliver to our patients. The three-year timescales, to 2028 coincides with the Organisational Strategy and the delivery of our 28 Promises. The focus being on changes as Directorate level which will of course influence the Trust wide results

As a minimum (our floor) we expect our staff survey results to be rated as above average against our comparator group, or where the result is already rated as above average to not deteriorate for the nine areas by 2028.

Two areas have then been identified as where we should aim to be rated as the best in class specifically People Promise 1 – We are Compassionate and Inclusive and People Promise 5 – We are Always Learning, as we have dedicated significant resource and time across the Trust in these areas and they are directly linked to our Strategy and Promises.

In addition, whilst our staff engagement score of 7 is recognised as good we are rated as below average against our comparator group, we should aim higher, our colleagues deserve better. The three broad measures within staff engagement are key to the Trust and the delivery of our aspirations, the staff FFT questions are also included in this category – recommending the Trust as a place to work and to receive care. It is recommended that we look to exceed the average score for this area – average is not good enough.

Alignment to strategic objectives	
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Business as usual	X

Previous consideration

Board of Directors – March 2025 CEO Report

Recommendation

The Board of Directors is asked to:

	NOTE the staff survey results and the suggested areas of focus
	CONSIDER the nine staff survey areas and whether we should focus our attention on other areas to those suggested, whether we should increase the areas of focus and whether we should be more ambitious
	RECOGNISE the work and commitment required to facilitate the suggested improvements
	DELEGATE the development and subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council. In addition, delegate to the People and Organisational Development Committee the review and submission of the 2024 WRES and WDES data.

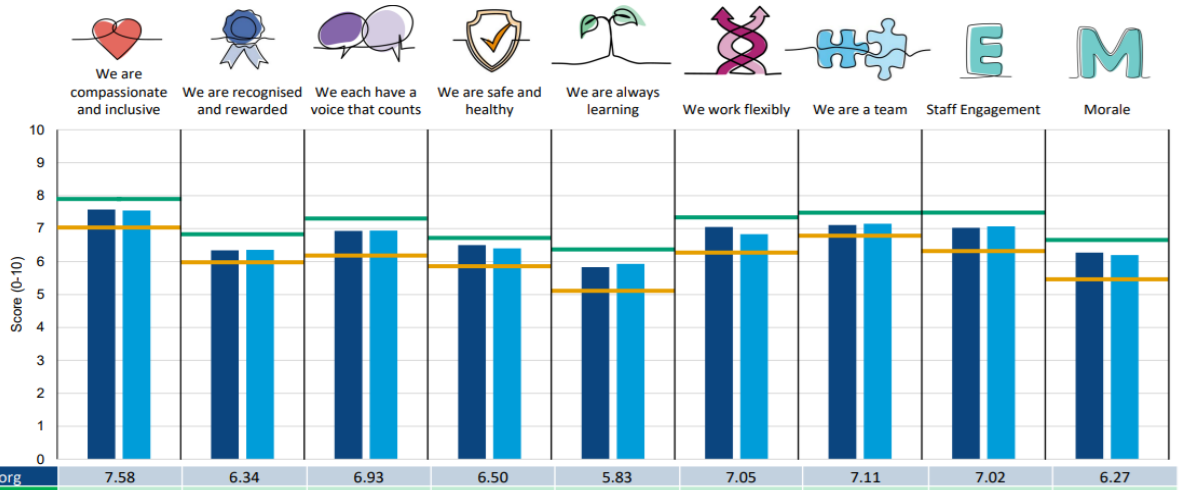
Impact								
Trust Risk Register								
Strategic Delivery Risks	X	SO2, SO4, SO5						
System / Place impact								
Equality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Appendix								
Annex One – Staff Survey analysis all area Annex Two – People Promise 1 and 5 analysis								

1.0 Staff Survey – Areas of Focus

1.1 Our 20024 results were detailed in the March CEO report and the purpose of this paper is not to repeat those results and analysis, but to detail our suggested areas of focus for the next three years, linked to the Organisational Strategy, our vision and our 28 Promises.

1.2 We strive to foster a culture where colleagues are able to thrive in the workplace, colleagues want to come to work at RDaSH and our turnover remains at a healthy level. In 20024/25 we made significant progress in filling our vacancies, reducing our turnover levels and provided increased training/development opportunities to our colleagues, but our staff survey results highlighted areas for improvement. The annual staff survey provides a detailed set of results across the Trust and more importantly broken down to our Directorates to understand the areas of success and the areas of focus. The 2024 staff survey results are the first results which we have received at Directorate level.

1.3 As a reminder, the staff survey comprises the 7 People Promise themes plus staff engagement and morale – providing nine areas in total. The following infographic summaries our results for the 2024 survey across all 9 areas.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.58	6.34	6.93	6.50	5.83	7.05	7.11	7.02	6.27
Best result	7.90	6.83	7.31	6.72	6.37	7.34	7.48	7.49	6.66
Average result	7.55	6.35	6.94	6.40	5.93	6.83	7.15	7.07	6.20
Worst result	7.03	5.98	6.18	5.86	5.11	6.27	6.78	6.32	5.46
Responses	2205	2205	2183	2185	2104	2193	2204	2211	2208

Key: *Our results - Navy blue bar, Best result – Green line, Average result – Light blue bar, Worst result – orange line*

1.4 Overall, the Trust has seen a decrease in results against each of the people promise themes when compared against the 2023 scores. All 2024 people promise theme scores remain aligned with the average comparator scores, with 4 scoring slightly above and 5 slightly below the comparator average (between 0.1 and 0.01 lower). To provide context, nationally within our benchmarking group the average score has reduced for 7 of the areas, stayed the same for one and slightly improved for one, therefore the Trust results are not an outlier.

1.5 As part of the results, two areas of change were statistically significant, specifically we each have a voice that counts and staff engagement.

1.6 Whilst the Trust results remain positive in the main, with no areas categorised as the worst and most of the results are in the average category but we are keen to further improve. When we compare the Trust performance across all provides (210 providers) our lowest ranking is People Promise 5 – We are always learning (81st out of 210) followed by engagement (77th out of 210). When comparing our performance to other Mental Health, Learning Disability and Community Trusts, our peer group, our lowest ranking areas are People Promise 5 – We are always learning and People Promise 7 – We are a team (both 32nd out of 50). Our best performing area against all Trusts and our peer group is People Promise 6 – We Work Flexibly, (14th for all and 10th for our peer group). But it should be recognised that we have pockets in the Trust where our scores are very low in this area and our high performance is not replicated across all areas such as the Acute Directorates.

2.0 What should we and more importantly our colleagues expect?

2.1 Historically we have focussed on the Trust staff survey results or the group levels results, but recognising our Trust structure we have started to **focus on the Directorate level results (23)** and then in future years the teams within the Directorates. Whilst we will have some areas of focus from a Trust level perspective and for 2025 we have identified three areas (Appraisals, Disability Discrimination and Learning) to ensure we meet the needs of colleagues/teams and Directorates we are focussing on the Directorate/team results and the identified levels of focus in these areas.

2.2 In addition, our junior and middle managers have significant influence within our teams and therefore we need their commitment to drive forward the agreed areas of focus for each of the teams – hence their involvement in the wider engagement piece this year and our focus to understand the engagement which teams have undertaken and what colleagues have identified as their areas of focus rather than the previous approach which focussed on have we agreed areas of focus, which was management driven in the main. We are confident with the 'buy in' of colleagues we are more likely to achieve progress in the agreed areas and colleagues will hold each other to account, alongside the wider Trust monitoring.

2.3 As a **minimum** we should expect our staff survey scores, across all of our 23 Directorates **to be above average for all of the 9 areas,** we recognise that the Trusts Organisational Strategy is stretching alongside the delivery of the 28 promises and as such we need a highly motivated and skilled workforce to deliver on our commitments.

2.4 When applying this to the Trust results at a Directorate level, recognising we have 23 Directorate, **18 Directorates require attention to achieve the Trust average** in the first instance and then move to above the peer group average. Only **5 of our Directorates currently rate equal to or above the Trust average in all of the 9 staff survey measures**. The work associated with this should not be underestimated, Annex One details the Directorate and Group level results and this requires the focussed attention across all 23 Directorates. Whilst it's great that 5 Directorates are currently rated equal to or above the Trust average we need others to move towards the average rating for our peer group if currently below and then for some areas towards the best in class. The **size and scale of the ask differs** across the directorates – but all directorates require work.

2.5 There are two areas suggested where we should aim to be **best in class** linked to our Organisational Strategy and Promises

- People Promise 1 – We are compassionate and inclusive
- People Promise 5 – We are always learning

3.0 People Promise 1 – We are compassionate and inclusive

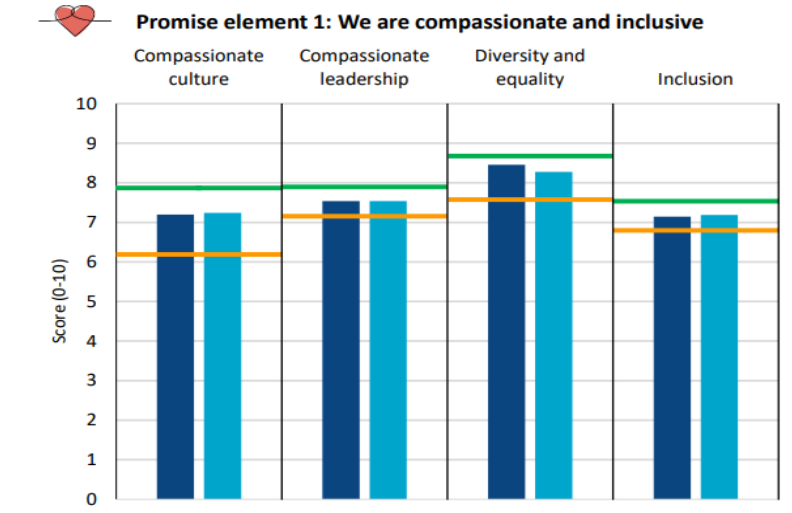
3.1 Whilst our scores in we are compassionate and inclusive are above average, given our commitment to becoming an anti racist organisation and our investment in leadership we should **strive to be close to the best result or the best**. Our score is currently 7.58 with the best being 7.90

We are compassionate and inclusive

This People Promise contains 4 areas of focus – compassionate culture, compassionate leadership, diversity and equality and Inclusion

3.2 When reviewing our Directorate level data, **10 Directorates are currently rated as above the peer group average** and the largest gap between the Directorate score and the best in class core is 1.34 (Estates).

3.3 When reviewing the four areas in detail, the two areas which will have the largest impact is **compassionate culture** (0.68) and **inclusion** (0.39) both of which are currently below the peer group average score. The detailed analysis is available at Annex Two.



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.19	7.54	8.45	7.14
Best result	7.87	7.90	8.68	7.53
Average result	7.24	7.54	8.28	7.19
Worst result	6.19	7.16	7.58	6.80
Responses	2200	2205	2199	2193

Within compassionate culture our score **deteriorated** last year and this is more noticeable as the peer group average score stayed the same. Whereas our inclusion score slightly increased last year by 0.01, and whilst the peer group average and best result reduced, our score remains below the peer group average.

3.4 As part of our wider analysis work we will explore with the top 5 ranked Trusts in this category to understand their work and actions to date, to identify whether any of the approaches are relevant and applicable to RDaSH. The top 5 ranked Trusts in this category are

- Cambridgeshire Community Services NHS Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust

- Kent Community Health NHS Foundation Trust

With Lincolnshire being a local Trust and also a peer group Trust.

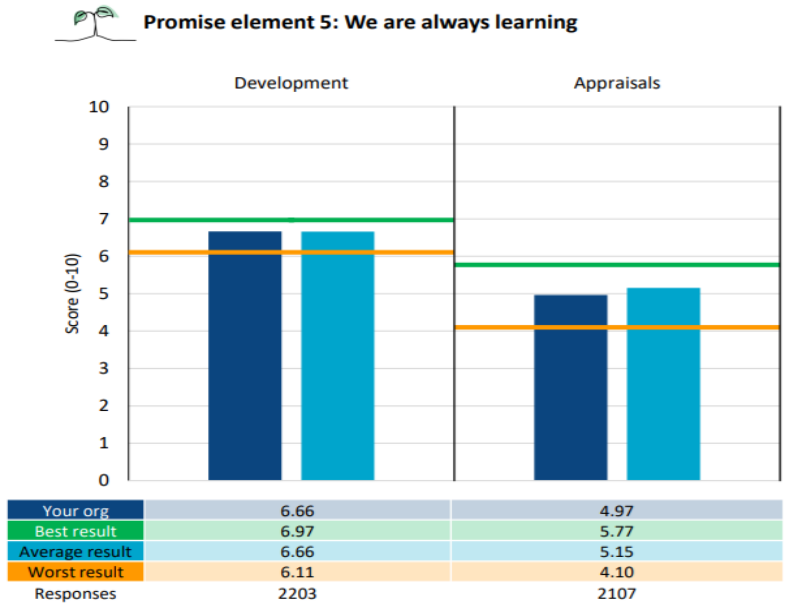
4.0 People Promise 5- We are always learning

4.1 Our scores in we are always learning are currently rated as **below the peer group average,** given our commitment to the ringfenced training budget, the apprenticeship levy, leadership development programmes and other development opportunitirs we should strive to be **close to the best result or the best**. Our score is currently 5.83 with the best being 6.37

This people promise is made of 2 elements; development and appraisals and has seen a slight decline in results from 5.93 in 2023 to 5.83 in 2024.

4.2 When reviewing our Directorate level data, **8 Directorates are currently rated as above the peer group average** and the largest gap between the Directorate score and the best in class core is 1.75 (Estates). The detailed analysis is available at Annex Two.

4.3 The following inforgraphic sumamrises the two areas and whilst development is categorised as the same as the peer average, appraisals are much lower. We are already working on a new appraisal scheme, soft launch planned for 2025/26 and implementation in 2026/27 which should improve the appraisal experience for colleagues and the reporting functunality, but there is a risk that with a new appraisal scheme the score may reduce in the first year.



	Development	Appraisals
Your org	6.66	4.97
Best result	6.97	5.77
Average result	6.66	5.15
Worst result	6.11	4.10
Responses	2203	2107

In relation to appraisals, the Trust scored lower than our peer group average, with a reduction in staff **feeling that their work is valued** by the organisation. The number of colleagues reporting having had an appraisal in the last 12 months remains high at 89.4%, which indicates that whilst appraisals are taking place, their value is not being recognised.

4.4 Work is required to support managers to provide a meaningful appraisal process, where career development is discussed and encouraged. The introduction of the First Line Manager Development Programme should support in equipping line managers with the skills required to conduct a meaningful appraisal process and support individual and team development. Additionally, the new appraisal system will be supported by a training programme for our

appraisers and the opportunity for colleagues to provide feedback on the quality of the appraisal outside of the annual staff survey.

4.5 As part of our wider analysis work we will explore with the top 5 ranked Trusts in this category to understand their work and actions to date, to identify whether any of the approaches are relevant and applicable to RDaSH. The top 5 ranked Trusts in this category are

- Midlands Partnership University NHS Foundation Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Humber Teaching NHS Foundation Trust

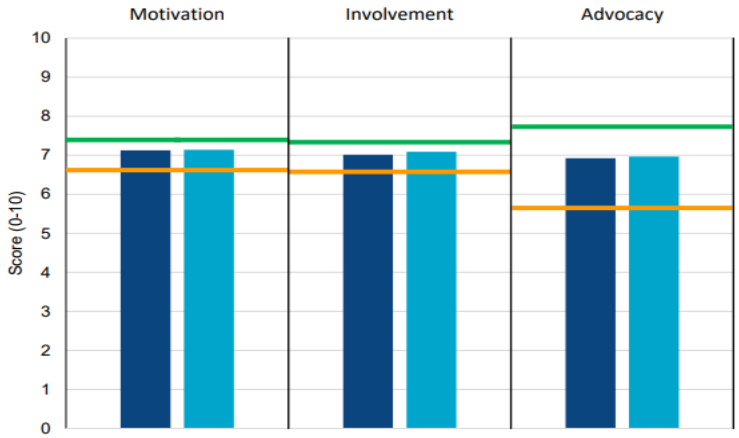
All of the Trusts, with the exception of Liverpool are within our comparator peer group so there is a wealth of learning and support which we can access.

5.0 Engagement

Whilst the Trust engagement **score of 7 remains a good score**, we should expect a higher score for our colleagues and therefore as part of our Trust wide staff survey plan we should aim to be rated as above average in this area and be on a journey towards the best.

5.1 The staff engagement score consists **of three categories** as detailed below, with our results close to being rated as average within our peer group but the largest differential is within the **advocacy** element. Whilst the peer group average score slightly increased last year (0.01) our score reduced by 0.20. Within the advocacy section this contains the **staff friends and family questions** – recommending the organisation as a place to work and to receive treatment alongside the question whether care of patients and service users is the Trusts top priority. All of these three questions declined nationally last year, but our decline was more significant than the national reductions, with the largest reduction being in care of patients/service users is the Trusts top priority.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.13	7.01	6.92
Best result	7.39	7.34	7.73
Average result	7.14	7.09	6.96
Worst result	6.62	6.58	5.65
Responses	2195	2207	2199

6.0 Next Steps

6.1 The staff survey results have been shared with all Directors and the engagement commenced with colleagues. Each Directorate has been asked to identify a small number (two or three) actions which they wish to focus on this year.

6.2 If the areas of focus are supported from a Board perspective, then the refinement of these areas, the scrutiny of the questions and the agreed plans will be developed and monitored via People and Organisational Committee and the Trust People Council, as again engagement is key to ensuring success.

6.3 The WRES and WDES data and the associated national submissions will be reviewed by the People and Organisational Development Committee in August, in advance of the national reporting deadline in October 2025.

7.0 Recommendations

7.1 The Board of Directors are asked to:

1. Consider the suggested areas of focus which will be complemented by the Directorate and Trust wide action areas which are agreed each year.

2. Recognise the need for the Directorates to undertake the engagement and associated work.

3. As in 2024 to delegate the review and submission of the 2024 WRES and WDES data to the People and Organisational Development Committee.

4. Agree the development and subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council.

Carlene Holden
Director of People and Organisational Development
May 2025

Annex One

Staff Survey – All Areas

Group / Directorate	We are compassionate and inclusive 	We are recognised and rewarded 	We each have a voice that counts 	We are safe and healthy 	We are always learning 	We work flexibly 	We are a team 	Staff engagement 	Morale 
Backbone	✗	✗	✗	✓	✗	✓	✗	✗	✗
Corporate Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates	✗	✗	✗	✗	✗	✗	✗	✗	✗
Finance and Procurement	✗	✓	✗	✓	✓	✓	✓	✗	✓
Health Informatics	✗	✓	✓	✓	✓	✓	✓	✗	✓
Medical, Pharmacy & research	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing & Facilities	✗	✗	✗	✓	✗	✗	✗	✗	✗
Operations	✓	✓	✗	✓	✗	✓	✓	✓	✓
People and Organisational Development	✗	✗	✗	✗	✗	✓	✗	✗	✗
Strategic Development	✗	✗	✗	✗	✗	✓	✓	✗	✗

Children's	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health	✓	✓	✗	✓	✓	✓	✓	✓	✓
Physical Health	✓	✓	✓	✓	✓	✓	✓	✓	✓
Doncaster Mental Health and Learning Disabilities	✓	✓	✓	✓	✓	✗	✓	✓	✓
Acute Services	✗	✗	✗	✗	✗	✗	✗	✗	✗
Community Services	✓	✓	✓	✓	✓	✓	✓	✓	✓
Learning Disabilities and Forensics	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Lincs Adult Mental Health & Talking Therapies	✗	✗	✗	✗	✗	✗	✗	✗	✗
Acute Services	✗	✗	✗	✗	✗	✗	✗	✗	✗
Community Services	✗	✗	✗	✗	✗	✗	✗	✗	✗
Talking Therapies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Health and Neurodiversity	✓	✗	✓	✗	✓	✗	✓	✓	✓
Community & Long Term Conditions	✓	✗	✓	✗	✓	✗	✓	✓	✓
Neurodiversity	✓	✓	✓	✗	✓	✓	✓	✓	✗
Rehabilitation	✗	✗	✗	✗	✗	✓	✗	✗	✗

Rotherham Adult Mental Health	✗	✗	✗	✗	✗	✗	✓	✗	✗
Acute Services	✗	✗	✗	✗	✗	✗	✗	✗	✗
Community Services	✗	✓	✗	✗	↔	✓	✓	✗	✗

Key ✗ - below Trust average, ✓ - above Trust average, ↔ same as Trust average

Annex Two - Staff Survey

People Promise 1 – We are Compassionate and Inclusive and People Promise 5 – We are always learning

Group / Directorate	We are compassionate and inclusive	We are compassionate and inclusive	We are always learning	We are always learning
	Above Trust Average (7.58)	Above Peer Group Average (7.55)	Above Trust Average (5.83)	Above Peer Group Average (5.93)
Backbone	✗	✗	✗	✗
Corporate Assurance	✓	✓	✓	✓
Estates	✗	✗	✗	✗
Finance and Procurement	✗	✗	✓	✓
Health Informatics	✗	✗	✓	✓
Medical, Pharmacy & research	✓	✓	✓	✗
Nursing & Facilities	✗	✗	✗	✗
Operations	✓	✓	✗	✗
People and Organisational Development	✗	✗	✗	✗
Strategic Development	✗	✗	✗	✗

Children's	✓	✓	✓	✓
Mental Health	✓	✓	✓	✗
Physical Health	✓	✓	✓	✓
Doncaster Mental Health and Learning Disabilities	✓	✓	✓	✗
Acute Services	✗	✗	✗	✗
Community Services	✓	✓	✓	✓
Learning Disabilities and Forensics	✓	✓	✓	✗
North Lincs Adult Mental Health & Talking Therapies	✗	✗	✗	✗
Acute Services	✗	✗	✗	✗
Community Services	✗	✗	✗	✗
Talking Therapies	✓	✓	✓	✓
Physical Health and Neurodiversity	✓	✓	✓	✓
Community & Long Term Conditions	✓	✓	✓	✓
Neurodiversity	✓	✓	✓	✓
Rehabilitation	✗	✗	✗	✗

Rotherham Adult Mental Health	✗	✗	✗	✗
Acute Services	✗	✗	✗	✗
Community Services	✗	✗	↔	✗

Key ✗ - below Trust average, ✓ - above Trust/Peer Group average, ↔ same as Trust/Peer Group average

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	RDaSH CQC Readiness: Safe, Effective, Caring and Responsive	**Agenda Item**	Paper M
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Jim Cooper, Deputy Chief Nursing Officer		
Meeting	Board of Directors	**Date**	29 May 2025

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

This paper follows the tetralogy of papers in 2023/24 from the then Nursing and Quality Directorate. The Board are reminded of the four domain submissions that were discussed up until the end of Q4 in 23/24, this serves as an important reflection, as the intent behind those papers is mirrored here, highlighting an improved, methodology and robust approach in 2025/26.Each domain has been self-assessed within each care group, by each clinical directorate, all 13 have had independent scrutiny via the internal governance framework within the CLE reporting structure. Importantly this has included multi professional leadership, practitioners and most importantly, promises 4 & 5 – as our objective review panel had key members from our patient partners.

Although the paper is labelled as "CQC" self-assessment, this is an internal document in which we are using their standards as a key part of our quality and safety plan. That means that, at Board level, we need to form a view on this baseline assessment.

The paper here is for Board colleagues to identify evidence gaps that they see in our process, interrogate the self-rating and scrutiny oversight which has been robustly provided by peers, independent and backbone panel members. For example, are the judgements sufficiently data informed and triangulated, including from information held outside N&F or outside care groups. When the paper returns to July Board, we will have a detailed improvement plan for RI rated areas, together with deployment detail for the improvement of Trust personalised care planning.

The Board should use this report to debate as to whether they ratify the methodology which the Chief Nurse has used and secondly, the proposed self-assessments. The report will, if approved form a baseline for ongoing improvement works across the organisation into Q2-Q4, inevitably this will subsume into the HQTC work (adult MH acute) and more broadly the Quality & Safety plan.

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 addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Business as usual	X

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

Quality Committee (21 May 2025) discussion around the process and scrutiny.
CQC Readiness Group

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

The Board of Directors is asked to:

X	**RECEIVE** this report and **NOTE** the update and status report in respect of the Safe, Effective, Caring and Responsive questions
X	**COMMENT** on the status currently assigned of each of the statements and with specific reference to the examples of key sources of evidence

Appendix (please list)

Appendix One – Triangulated Breakdown into Quality Statements
Appendix Two – Untriangulated Self Assessments by Directorate

1. Introduction

The Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) underwent a full formal assessment (formerly known as inspection) by the Care Quality Commission (CQC) 8 Oct to 12 Nov 2019, with the report published February 2020. A CQC action plan was last presented to the Quality Committee in May and July 2022 and subsequently, a review was undertaken by 360-assurance against the CQC action plan from June 2023. The ratings from the 2020 inspection are listed in table one of this document.

This paper follows the tetralogy of papers in 2023/24 from the Nursing and Quality Directorate. The Board are reminded of the four domain submissions that were discussed up until the end of Q4 in 23/24, this serves as an important reflection, as the intent behind those papers is mirrored here, highlighting an improved, methodology and robust approach in 2025/26. This paper focuses on the Safe, Caring, Responsive and Effectiveness key questions, a part of the overall CQC's single assessment framework.

It stressed the importance of recognising the Well-Led key question (being posed via separate paper) as one of the five key questions (alongside Caring, Safe, Responsive and Effective), also appreciating the interdependency across the other key questions, with them each, also considering well-led related matters.

It presents an initial assessment from which further work will be undertaken in readiness of any regulatory inspection, but primarily, intends to provide the Board with an overview of the key questions safe, caring, responsive and effective, and whether the services provided by the organisation would be self-rated as inadequate, requires improvement, good or outstanding.

Whilst the trust embarks on a CQC readiness process, this paper aims to be the first of many to provide the board an overview of the self-assessments along with a triangulated view. This triangulated rating is based on internal data and intelligence from quality and safety reporting, including incidents, complaints & peer reviews and associated action plans.

2. Self-Assessment Process

The Trust has developed a framework using CQC guidance and gathered information from diverse sources to provide a basis for a continuous, developmental self-assessment against the CQC quality statements for safe, caring, effective and responsive.

The quality statements have been considered by each of the 13 clinical directorates, and they have undertaken a self-assessment of their current position. On 24 April 2025, the directorates presented this self-assessment back to the CQC readiness group (**see photo below – standing room only**) and subsequently submitted this as part of the overall self-assessment process. There was then a period of triangulation undertaken in May 2025 to ratify the self-assessments for each directorate, where there is a disparity between the directorate rating and the triangulated rating, this independent review process to triangulate the scores included patient representation.

*Pictured in attendance at the CQC challenge and scrutiny meeting as above:
Rachel Millard Chair Nurse Director Backbone (Interim),Laura Powell Compliance Officer, Sam Butcher Nurse Director, Physical Health and Neurodiversity Care Group, Jo Dakin Nurse Director, Doncaster Care Group, Megan McNaney Nurse Director, Rotherham Care Group, Vicky Clare Nurse Director, North Lincs & Talking Therapies Care Group, Dawn Talabi Social Work Practice Lead, Rachael Deakin Matron Learning Disabilities & Forensic Directorate, Helen Moran MHA Manager, Mark Swift Head of Estates and Development, Laura People Focus Group
Sarah Benson Matron Acute Pathway, Doncaster, Natalie Lowe Community Matron, Kate Jones Nurse Director Children's Care Group, Angie Nisbet Interim Associate Director of Governance, Chris Pym Matron and Practice Development for RRI, Rose Robinson-Smith Matron Rehabilitation Directorate in PH&ND Care Group, and Kathryn Bebb Matron – Community & Long Term Conditions, PH&ND Care Group.

The intent is to use this framework and specifically this assessment to drive actions throughout our organisation. Identifying areas of best practice, innovation, learning, and sharing information across each of the key questions. Ultimately this will allow us to achieve our goal of becoming an organisation that meets the criteria that the CQC would consider issuing a 'Good' rating to.
The following themes and deliverables were agreed at the above CQC readiness meeting and will be progressed and reported to Board, July 2025. Leadership for the key deliverables will be by the Care Group Nurse Directors & supported by Backbone services

A further CQC readiness meeting took place on 13 May 2025, with a *'time to show'* session scheduled for 20 June 2025. This session will enable directorates to showcase their improvement work, share this across the organisation and provide evidence for their self-assessment rating, where assessing themselves as 'good'.

3. CQC Inspections and Ratings

Table one details the previous trust rating following the previous full CQC inspection in Feb 2020. The CQC undertook a partial assessment of the trust 6-7 May 2025. This assessment was undertaken in the CQC core service, acute wards for adults of working age and psychiatric intensive care units. In attendance were two teams of 6 CQC reviewers.

The review team did not identify or raise any immediate concerns with the Trust during the on-site assessment. The team advised that the scope of the assessment was all 5 CQC domains, focusing on a range of themes within these domains, e.g. medicines management, safeguarding, benchmarking, governance, ligature risk management, health and safety, infection prevention control, and MAST. Formal feedback is awaited at the time of writing this paper.

Table One Last CQC Rating Feb 2020				
	Safe	**Effective**	**Caring**	**Responsive**
Trust Wide	RI	RI	Good	Good
Community Health Services for Adults	RI	RI	Good	Good
Community Health Services for Children and Young People	Good	Good	Good	Outstanding
Community health inpatient services	Good	Good	Good	Good
Community end of life care	Good	Good	Good	Good
Hospice services for adults	Good	Good	Good	Good
Acute Wards for adults of working age and psychiatric intensive care units	RI	Good	Good	Good
Long-Stay or rehabilitation mental health wards for working age adults	RI	RI	Good	Good
Forensic inpatient or secure wards	RI	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good
Community-based mental health services for adults of working age	RI	RI	Good	Good
Mental health crisis services and health-based places of safety	Good	Outstanding	Good	Outstanding
Specialist community mental health services for children and young people	Good	RI	Good	Good
Community-based mental health services for older people	Good	Good	Outstanding	Good
Community-based mental health services for people with a learning disability or autism	Good	Good	Good	Good
Substance misuse services	Good	Good	Good	Good

* Please note that after the May 2025 inspection Acute MH ward ratings may change

4. **Rationale for rating change between the care group directorate and the triangulated assessment of the scrutiny and challenge process held April 2025.**

NL +TT – Acute: Changed from Good to RI: Mulberry ward had 91 incidents during 2024/25 that related to violence and aggression noting staff morale has needed additional support, and this has been provided with ongoing external support from BRAP. The ward has had changes in leadership through the year, which does create instability and flux, consistent leadership is essential for culture setting and performing for all the reasons that have been well discussed in Tuckman stages of group development. The ward has a specified improvement plan with clear actions to enable progress that has measures to sustain the improvements. Peer review actions from July 2024 require review and delivery assurance. Noting there has been a higher safeguarding concerns raised in relation to 10 PIPOTS

Rotherham AMH -Acute: **Changed from Good to RI:** PSII actions and learning highlighted areas the directorate needed to focus on, with the learning being shared and sustained as a key marker for the reduction in rating. Acute wards have weekly ward metrics which are showing recent improvement. Crisis team received a coroner's Regulation 28 due to a gap in service provision for people over 65 years of age. As a result the CEO made a clinically informed decision that the service was extended to all age (and across the Trust), audit of impact is ongoing.

Rotherham AMH – Community: Changed RI to Good: predominately peer challenge supported an uplift, with a clear reflection on patient feedback from the last seven months demonstrated positive feedback, 41 care opinion stories since June 2024, any slightly critical demonstrated direct action as a result of the feedback:

They received the most wonderful provision of care

Posted by a relative

For literally decades, the family member concerned (service user) of CMHT - RDASH has received the most wonderful provision of care, and this is now continuing under the Adult Community Mental Health Team –North.

Their very good practice is highlighted by: *the well monitored and attentive professional care of the patient/client *the sensitive and respectful way in which this care is delivered towards the individual *the conscientious

Memory Clinic - 139 views Posted by a relative

The nurse, Lucia that supported my husband has been very good with us. She has given us lots if information, and has been really, helpful. I don't think she could have done anymore, she has been really on the ball.

5. What are the 'good' themes?

This section of the paper aims to summarise some of the good practice identified through the process, with some proposals on what could be standardised across the organisation.

6. Safe Domain

What the CQC 'safe' domain means – "*People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation*". Within the CQC Assessment Framework, 'safety' relates to: - learning cultures; safe systems, pathways and transitions; safeguarding; risk management; environments; staffing levels; infection control and prevention and medications optimisation.

And what are our 'self-ratings' based on - The RDaSH factors that have contributed to the 'good ratings in terms of the assessment framework are concern:

Firstly, the robust frameworks regarding 'medicines optimisation', with all directorates which prescribe medication, have strong medical and non-medical prescribing leads and actively participation in either local or the trust medicines optimisation group.

Secondly, the rating is linked to the environmental improvements that have been made in a number of key areas, with some distinct examples of good practice. One example of this is in the Physical Health rehabilitation service which demonstrate safe environments with tailored acuity tools and good transitions from acute to intermediate care, and subsequently out of hospital.

Thirdly, all directorates report having 'good' freedom to speak up processes, with champions and mechanisms in place in each area and also regular contacts and visits by the Trust FTSU guardian.

Finally, in over half of directorates, the patient safety incident response framework (PSIRF) is well embedded, in many, this required further development into Q2.

7. What next

As a Trust we are currently working through updating, building upon both what is working well in some areas and also what has been learned internally and also nationally after the first full year of roll out. The revised PSIRF policy, will be scrutinised and ratified at Board in May 2025, and will support the consistency of approach.

Alongside of the renewed PSIRF approach, the ability to audit, triangulate and report upon risks and incidents will be improved linked to the implementation of the RADAR system and development of the Patient Safety Operational Group (PSOG) to oversee and furnish the implementation of PSIRF across the organisation, and the board of directors will review today the patient safety incident response approach (PSIRA), which will propose how we will operationalise PSIRF into the organisation.

There are also specific 'time sensitive' issues which are also pertinent to some of the ratings – for example the restructure currently in terms of the older people's ward areas in Rotherham (detailed in the Board papers in March 2025) and the mental health rehabilitation pathway reviews including the development of a HDU.

These change management processes enable specific opportunities to improve, and also achieve across site consistency. Therefore, the current area ratings must be seen as dynamic, and in the context of change management, and therefore subject to change. In these examples the change management processes consider not only the current actual rating, but also the self-rating and opportunity for improvement.

8. Effective Domain

What the CQC 'effective' domain means – "*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*". Within the CQC Assessment Framework, 'effectiveness' relates to: - assessing need; delivering evidenced based care and treatment, staff and services working together; supporting people to live healthier lives; monitoring and improving outcomes and consent to treatment and care.

And what are our 'self-ratings' based on - Across the Trust we have a strong audit culture, which has been improved upon over the past 12 months, linking the clinical audit programme with the 360-audit programme. Our clinical and managerial leads, supported by backbone services apply structured audit cycles, contribute to and learn from national benchmarking and actions monitored via governance was reported in some of the directorates

The use of clinical outcomes is less common in Learning Disability and Mental Health Services nationally and identified as a national area for improvement in policy drivers such as the CMHT transformation programmes and inpatient mental health transformation programmes, both of which we are actively participating within. In addition, the work we are pursuing related to our RDaSH Strategic Promise 16 is directly related to improving the use of clinical outcomes in practice.

The roll out of training in terms of the use of Dialog+ and paired patient reported outcome measures (PROMs and PREMs) across all adult mental health directorates (community and inpatient) and also children's mental health is an active effort to use and evidence outcomes and patient voice in terms of effectiveness. Good progress has been seen in this area over the last 6 months since the training has started, and an audit facility in terms of paired outcome use has been developed by our clinical systems team to enable managers to track and also support staff who may be struggling in terms of outcome use.

9. What next

Although the example of Dialog+ is progressing, the use of paired outcomes is below the level we would want (approx. 12% adherence – reported through May 2025 Learning and Education sub-CLE group) and therefore work is being conducted to improve adherence in community and inpatient services.

A working group, as part of Promise 16 has been established and will oversee the advancement of Dialog+ across the organisation, alongside our commitment to report and improve our use of PROMs and PREMs, monitoring patient engagement and experience.

10. Caring Domain

What the CQC 'caring' domain means – "*People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible*". Within the CQC Assessment Framework, 'caring' relates to: - the evidence of treating people with kindness, compassion and dignity; the evidence of treatment people as independence; evidence of supporting independence, choice and control; responding to people's needs and enablement.

And what are our 'self-ratings' based on - The across Trust roll out of care opinion and value placed upon listening to, and coproducing care is one of the most significant changes made in the Trusts over the last year. The use of 'care opinion' as well as other strands related to patient

experience and feedback (i.e. the personalised approach to inpatient feedback for people under the MHA, reported through MHA committee) has helped demonstrate peoples experience of kindness, compassion and dignity, which are universally rated as good.

In addition, where there are exceptions to this, the move to a live system rather than the previously PALS and YoCs systems which had inherent delays in terms of supporting discussion has enabled responsive conversations and support for people at the time when they have experienced difficulty. Many care groups have discussed their actions in delivery reviews, including how they have engaged people in community and inpatient services around this tool.

Ratings in this domain also relate to assessments conducted in the past 12 months jointly with patients and staff including the culture of care baseline assessment in our inpatient services, which is reported through, and analysed by our High-Quality Therapeutic Care (HQTC) Inpatient Taskforce.

Thirdly our availability and offer of advocacy services are well respected and used by the people (patients and carers) we serve.

Fourth, workforce wellbeing and enablement is reported well in some directorates, with access to wellbeing champions, flexible working, and leadership development programmes available.

Fifth, the provision and use of accessible information and coproduction is strong in some directorates with accessible documentation and co-designed care planning in place.

Finally, under half of directorates report structured induction and cultural competence training. This structured approach should be considered in RI directorates, where further developments are required.

11. What next

Work within our HQTC is progressing in terms of the areas of improvement identified in our culture of care baseline assessment. Some of these improvements are focussed upon where there is variation in one ward from another, and for this clinical and managerial leads are working together to support change. Where there is a consistent improvement across Trust required / identified we are supporting across Trust action (i.e. enhanced training for Healthcare Assistants in terms of supporting people who have neurodevelopmental disorder diagnosis).

The strategic work regarding engaging communities and also working with minority populations has accelerated over the past year, with representation from all care groups and backbone services to the sub-CLE Equality and Inclusion Group. The work in this area is showing progress and areas which require more development in terms of inclusive and personalised care. The work programme of this group is aligned to the specific strategic promises in this area, including Promise 2 regarding unpaid carers, Promise 7 regarding work in terms of CORE20PLUS5; Promise 10 inclusion health care, Promise 12 which concerns support for rural communities and Promise 13 regarding the ‘home first’ agenda.

This work crosses all directorates however is proportionally focussed upon (i.e. our North Lincolnshire Directorates – children and adults work across a larger rural footprint than our Rotherham and Doncaster Directorates).

12. Responsive Domain

What the CQC 'responsive' domain means – "*People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics"*. Within the CQC Assessment Framework, ''responsiveness' relates to: - person centred care; continuity of care, listening to and involving people, creating equity of access and future planning.

And what are our 'self-ratings' based on -The Care provision and continuity is demonstrated in over half of directorates with strong multidisciplinary working/pathways, personalised care initiatives and strong feedback systems for patients.

What is also considered in these ratings are the pathways between services (i.e. children's physical health to adult physical health) for which we have control over change, and also partnership transition (i.e. GP to specialist services) where we have focussed upon strengthening relationships and pathways over the past year. These are aligned to strategic promises 15 regarding parity of esteem, promise 17 related to multiagency working for children and young people and promise 18 concerning the work on reducing out of area placements.

Evidence for progress against these promises can be seen in the CEO promises report at public board and are evidenced in the delivery review discussions regarding each of the relevant directorates.

In addition, joint planning forums, volunteer engagement and transition processes are used in a small number of areas to demonstrate their ability to effectively plan for the future.

Finally, co-designed patient passports are a strong part of RAMH directorate, however the organisation could benefit from this being shared wider, especially in areas where personalisation and access equity need improvement.

13. What next

The work in terms of the use of Dialog+ does not only pertain to the use of clinical outcome measures, but it also focussed upon the enhancement of personalised care planning. Including the introduction of a consistent care planning structure which looks across life domains. As listed above in terms of the effectiveness section, lined with the outcome focus is the personalised care focus.

The work that has been progressed in all areas to achieve a 4-week wait is linked to this domain. In many of our services, this waiting time shift has been achieved and is having a positive effect in terms of patient engagement, patient satisfaction, clinical outcome and also staff satisfaction. However, it is not achieved in all of our areas, and specifically our neurodevelopmental assessment services in adult and children's services are outliers – this is reflected in the Neurodiversity directorate and children's mental health directorates self-ratings of RI. The focus in terms of improvement in these areas will continue over the next year to further narrow the gap between current wait and 4 week wait.

14. What are the themes of RI?

This section aims to detail some commonalities that have been identified as areas to improve consistently across the organisation. The focussed areas are in addition to those RI areas mentioned in section 4 above, due to the links and variation from 'good rating'. Four areas will be focussed upon:-

The first area in focus concerns **training and related supervision** – one example is the persistently escalated issues in respect of managerial, clinical and safeguarding supervision. Although improvement has been seen (tracked through the People and teams Group) further improvement is still required across the organisation to improve both the frequency of these but also ensure the supervision if of a consistent quality.

Secondly, **safe and effective staffing** is highlighted as an area for improvement, with inconsistent practices in place across the organisation. This is not to say we do not meet the minimal staffing levels, which are both tracked on a shift-by-shift basis as well as monitored through our quality and safety group, however this links with our multiprofessional staffing levels (which contribute to effective treatment) and also our acuity levels which require above safe staffing levels. Progress has been seen in this area, however there are inconsistencies hence the current rating of RI. The work that has been progressed in terms of reducing agency use and filling vacancies is contributing to us having a more stable and safer workforce, this is in terms of both medical and non-medical disciplines.

Thirdly, **Personalised care plans** are not always or consistently co-produced or provided to patients. Several lack consistency and meaningful service-user involvement. Our work in terms of strategic promise 1 (increasing peer support workers) and also our involvement of place-based experts by experience is helping us develop in this area. The focus of the Leadership Development Offer (LDO) including experts by experience and experts by education, learning together is one of the methods we are employing to help us improve in this area.

Finally, the **long waits,** especially in ADHD/ASD pathways, therapy and CAMHS are key risks which mean we have to rate as requiring improvement. When considering our 'waits' as a final theme, there is not just specific pathway waits, but also 'waits' in terms of person factors i.e. Veterans access is also a recurrent issue. The trusts plan around promise 9 (veterans) and promise 14 will improve both identified areas.

15. Inadequate ratings

No directorate scored inadequate for any of the domains. However, the PHND neurodiversity directorate reports inadequate for quality statements within the safe domain including safeguarding, infection prevention and control alongside safe staffing. This talks to their work required to improve safeguarding training, staff productivity and recruitment processes. This is in part to the clear and honest self-assessment of their position.

16. Areas of Focus

Certain areas of focus discussed above are linked with longer term pieces of work which will support improvement (specifically - LoS and Culture of Care Work with HQTC; RaDaR rollout resulting in better data control and risk triangulation; PSIRF review and progression; Neurodevelopmental assessment waiting times; and growth in number of Peer Support Workers), the improvements linked with these strands of work will therefore not be repeated here as they are in distinct terms of reference and programmed activity.

In addition, the improvements listed that are linked with transformation and change management processes, specifically in regard to older people's services and rehabilitation services will not be the areas of focus here as they have distinct workplans with clear time boundaries.

Therefore, in precluding the factors above, this paper aims to recommend 3 key areas of focus as an output from the CQC readiness process and 7 themes that emerged that were cross cutting to include input from all 23 directorates.

Theme	Deliverable
1. Veteran Support	Explore and utilise voluntary sector support for veterans waiting for services
2. Care Opinion Feedback	Improve communication with community colleagues to enhance transitions from inpatient to community and vice versa. Addressing long waits within care opinion feedback and our Promise commitment.
3. Accessible Information	Improve the provision of accessible information for the deaf community
4. Section 17 Leave	Address and improve the process for Section 17 leave documentation
5. Duty of Candour	Ensure that duty of candour is documented and communicated effectively in incident reports
6. Roster Management	Improve the initial stages of roster management to ensure compliance and efficiency
7. Learning Half Days	Find ways to ensure all staff can access learning half days highlighting the challenges

17. Area 1 - Personalised Care Planning and risk assessment

It is clear, both from within this self-assessment process, and triangulated elsewhere, that personalised care planning is pivotal to our delivery or safe, effective, responsive care. Co-production is inconsistent, especially in community services and not all care plans are shared with patients or reflect their voice. Work must be done to improve the quality-of-care plans across the organisation. Linked with this there is inconsistency in the application of risk assessments, particularly related to being clinical ready for discharge (CRFD) or functional analysis of care environments (FACE).

This will be monitored in line with Promise 16, the Quality & Safety plan – always measures and the forward plan of the Quality and Safety Group.

18. Area 2 - The consistent use of Dialog + clinical outcome measures in adult mental health

The training for Dialog+ and the related outcome measures is now complete in mental health services. The use of these outcomes has commenced and have had positive feedback through peer support and patient partners.

The ability to report upon and scrutinise where outcome measures are not being used is going to be enabled by 1st June 2025 (as reported through the informatics service). It is therefore recommended that all services that this measure apply to commence a benchmarking exercise and set an improvement trajectory towards 100% compliance with outcome measure use by the year end. This will be monitored by the education and learning sub-CLE group.

The inclusion of children's services is not stated at this time as the adapted outcome measures and monitoring processes are under development.

19. Area 3 – Improved Safeguarding Training and Supervision

As highlighted in the above section, supervision (managerial, clinical and safeguarding) require improvement to ensure our workforce is appropriately supported in their practice. The transformed safeguarding team, with additional domestic violence officer resource, will provide

Table Two – Assessment summary

Directorate	Safe	Effective	Caring	Responsive
PH Neurodiversity	RI	RI	Good	RI
PH Community and LTC	Good	Good	Good	Good
PH Rehabilitation	Good	Good	Good	Good
Children's Physical Health	Good	Good	Good	RI
Children's Mental Health	Good	Good	Good	RI
DMH+LD Acute/inpatients	RI	RI	Good	RI
DMH+LD Community	RI	RI	Good	Good
DMH+LD – LD and Forensics	RI	RI	Good	Good
NL+TT - Acute	RI	Good (Self rating) / RI *(triangulated rating)	Good	RI
NL + TT Community	RI	Good	Good	RI
NL + TT - TT	Good	Good	Good	Good
Rotherham AMH - Acute	Good (Self rating) / RI *(triangulated rating)	Good (Self rating) / RI *(triangulated rating)	Good	RI
Rotherham AMH - Community	RI	RI	RI (Self rating) / Good *(triangulated rating)	RI
*The triangulated rating is based on internal data and intelligence from quality and safety reporting, including incidents, complaints & peer reviews and associated action plans				
Proposed Internal Rating May 2025	RI	RI	Good	RI

double the amount of training and supervision sessions in the next 6 months to enable training and supervision compliance to improve.

20. Recommendations

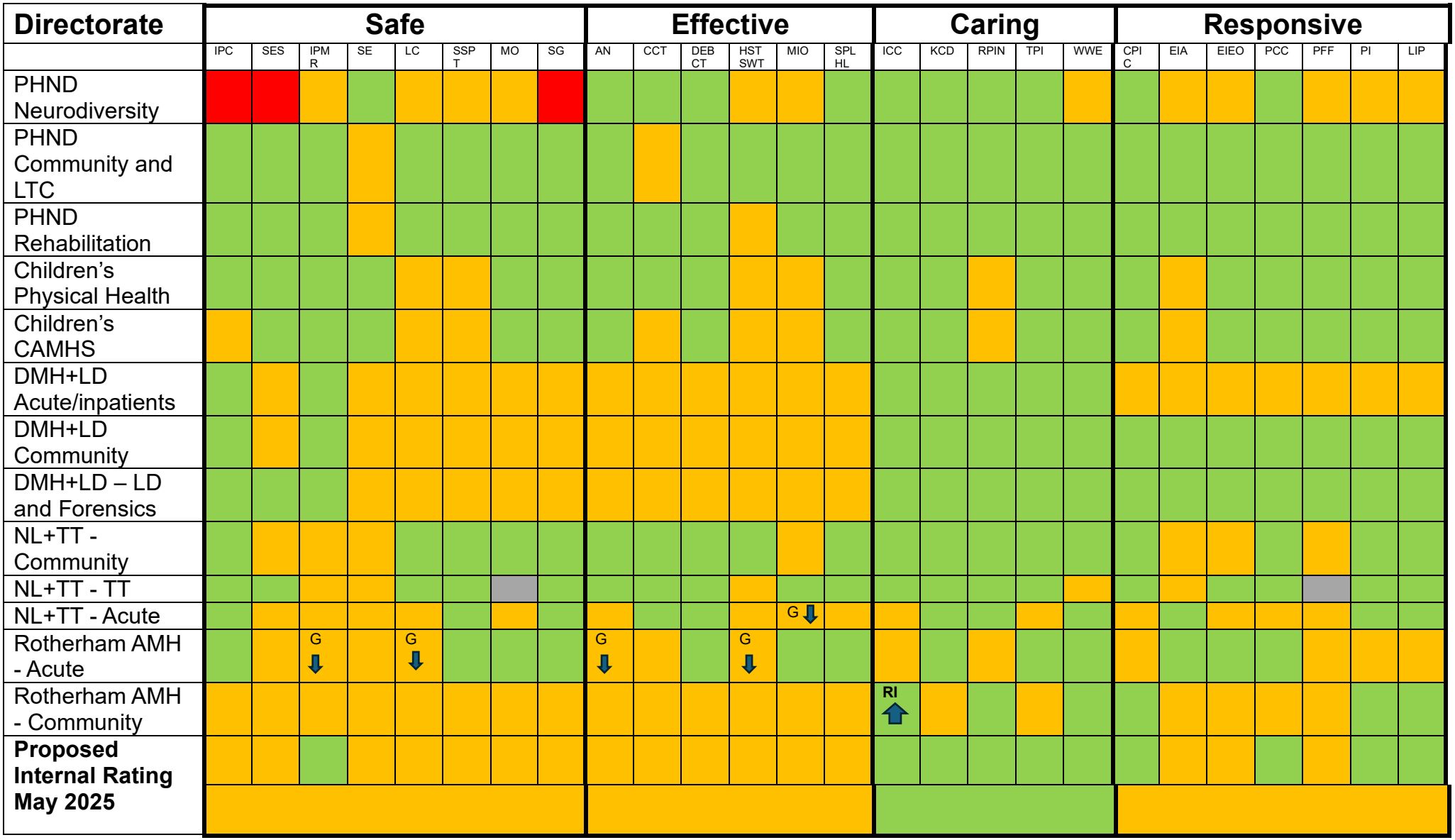
- The board should form a view on this baseline assessment, both in terms of its content and whether or not they ratify the methodology and secondly, the proposed self-assessments.
- The board should expect to see a final self-assessment baseline returning in July 2025.

Appendix 1 details the self-assessment process and proposed ratings for each of the 13 directorates following the process discussed above. Further detail of the evidence and next

steps for improvement by directorate is detailed within appendix one. Similarly, each of the key domains is split into quality statement self-rating within appendix one.

Appendix 2 – Triangulated Breakdown into Quality Statements

Appendix 3 – Untriangulated Self Ratings by Directorate



	Rating	**SAFE**		
Directorate			**What we are doing well**	**What requires improvement**
PH+N ND	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Strong NMP lead within the care group (medicines optimisation) • Established Medicines Optimisation Group (Medicines Optimisation) • Three times weekly hotspot meeting with full SLT to escalate concerns promptly (Safe and effective staffing) • Risk register reviewed in Directorate review monthly (Risks management) • Good utilisation of Care opinion • Good compliance with flu vaccination uptake • Complaints action plans • Directorate reviews – directorate led approach is strengthening and monthly reviews providing assurance, points of escalation, celebrations of achievements • Learning from incidents and complaints – action plans progress monitored through monthly Quality meeting • PSIRF implementation	• Further work to embed the PSIRF approach which is clinician led • Further work to ensure those patients on the waiting list have access to sign posting information, health literacy and self help • Level 3 safeguarding – below 90% trust target (safeguarding) and implementation/embedding • Staffing needs to increase productivity in order to meet the demands of the waiting list and ensure patients are seen as soon as possible (Safe and effective staffing) • More senior staff to attend the appointment of staff training to ensure a robust recruitment process is followed (Safe and effective staffing) • Further work to ensure **all** interview panels have a patient peer/volunteer/someone with lived experience • To fully implement the safeguarding supervision cascade model • Further work to make CQC preparedness everyday business • Uniform and bare below elbow standards still need to be improved
PH+N – C+LTC	Good	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Patient Safety Incident Response Framework well embedded – monthly PSIRF report (Learning Culture) • Freedom To Speak up • Safer Staffing policy and rostering reviews in place • Safer staffing meetings monthly well attended by ward managers • Good oversight from Matron of Health roster utlisation • NHSP Contract in place • PSIRF well embedded, monthly reporting on learning responses from RADAR • Established prescribing and administration system with links to clinical guidelines and protocols. • Strong NMP lead within the care group • Three times weekly hotspot meeting with full SLT to escalate concerns promptly • Risk register reviewed in Directorate review monthly • Good utilisation of Care opinion • Good compliance with flu vaccination uptake	• Further work to embed the PSIRF approach which is clinician led • Level 3 safeguarding – below 90% trust target (safeguarding) • To fully implement the safeguarding supervision cascade model directorate wide • Further work to make CQC preparedness every day business • Further work to ensure **all** interview panels have a patient peer/volunteer/someone with lived experience • Further work to make CQC preparedness every day business

			• Learning from incidents and complaints – action plans progress monitored through monthly Quality meeting • Safeguarding supervision cascade model implemented in community nursing • IPC walk rounds and actions (inpatients) • Tendable completion (inpatients) • Experienced community workforce well practised in dynamic work environment (patient homes), identifying risk and taking appropriate action. • Acceptable behaviour policy levels 1&2 in place • 2 pharmacy Techs specific to community nursing service. • Community nursing has a visualisation screen to help team see what other teams are involved in a patients care.	
PH+ND Rehab	Good	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Patient Safety Incident Response Framework well embedded – monthly PSIRF report (Learning Culture) • Freedom To Speak up well utilised • Safer Staffing policy and rostering reviews in place • Good engagement of ward leaders at the monthly Safer staffing meeting • Good Matron oversight of health roster optimisation • NHSP Contract in place (safe and effective staffing) • Duty of Candor compliance monitored trough the monthly Quality meeting – good coompliance • Strong NMP lead within the care group • Established Medicines Optimisation Group with care group attendance • Three times weekly hotspot meeting with full SLT to escalate concerns promptly • Risk register reviewed in Directorate review monthly • Good utilisation of Care opinion with positive responses from services • Good compliance with flu vaccination uptake • IPC walk rounds and actions • Tendable completion (inpatients) • Safeguarding concerns and outcomes responded to, training 90% +compliance • Transition pathway from children to adult • Access to IT for all ward staff for accurate record keeping as close to time of event as possible. • An acuity tool tailored to the intermediate card wards to support safe and effective staffing and a safe ward	• Further work to embed the PSIRF approach which is clinician led • Further work to ensure those patients on the waiting list have access to sign posting information • Water flushing compliance needs to improve related to data quality • Level 3 safeguarding – below 90% trust target (safeguarding) • Safe to wait offer – needs to be developed for all patients waiting for assessment or treatment • Risk assessments not consistently updated in all areas and not consistently evidencing the patient voice (safe environment) • To fully implement the safeguarding supervision cascade model • Estate is not optimised and reviewing new accommodation (on capital plan)

			• Safe system for pathways and transitions from acute ward to intermediate care ward • Deteriorating patient training in place and excellent evaluation	
CCG PH	Good	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Safeguarding • Involving people to manage risk • Safe and effective staffing • Medicines Optimisation • Safe environments • IPC	• Safe systems and pathways • Learning culture
CCG CAMHS	Good	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Safeguarding • Involving people to manage risk • Safe and effective staffing • Medicines Optimisation • Safe environments	• IPC • Safe systems and pathways • Learning culture
DMHLD Acute	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks	• Monthly Matron walk rounds with IPC team. IPC champions across services. • No qualified vacancies on inpatients. • Benchmarking • Increased collaboration with other disciplines and services (AHPs, psychological professionals) in MDT settings.	• Water flushing compliance on Adult Mental Health • Recruitment and retention within crisis and home treatment and NA's in patient unit • Clinical risk training – low compliance in acute services. • Bedroom door replacement

		Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Bathroom door replacement project across all inpatient wards. Evacuation drill completed for adult mental health. Tendable Audits • No blame culture, staff will complete incident forms to highlight errors and promote learning from incidents. Attendance at patient safety huddles and learning shared. Swarm Huddles and AARs • Joint working with learning disability services to provide support for people with learning disabilities when they are admitted to mental health wards. • Reduction in medication errors • Matron takes lead on safeguarding across directorate	• Wider sharing of After Action reviews to support learning across trust • Embed confidence in PSIRF tools. CRFD refresh • Pathways for people with personality disorder both at the front end (crisis) and once on the ward. CRFD needs refresh • Further training around legal frameworks for administration across nursing, pharmacy and medical staff • Increase compliance with safeguarding supervisor training
DMHLD Comm	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Regular audits competed with 100% compliance. Matron walk arounds with IPC introduced and will be conducted quarterly. IPC leads in community teams. • New Beginnings, our inpatient area has a complement of mental health and general nurses with qualified nursing associates. Safe staffing is met without the use of bank and or agency. Low number of vacancies within services. Benchmarking • 100% compliance for resuscitation audits for New Beginnings. • Risk assessment training for all clinical staff • EIP, perinatal and primary care hubs have weekly multi-disciplinary meetings to support safe management of risk. Homeless worker embedded with Starting Point MDTs to support understanding and managing risk within complex situations • Up to date ligature, fire security equipment risk assessments. • Successful lockdown drill at ONYX. Tendable • PSIRF is being embedded in the community. No blame culture, staff will complete incident forms to highlight errors and promote learning from incidents. Attendance at patient safety huddles and learning shared. Swarm Huddles and AAR's • Improved pathways and transitions. Attendance at CRFD to support safe transitions back into the community. Patient at risk of admission meetings held weekly with matron chairing. Clinical lead working on transition LWI to prevent cliff edge support for CAMH's, working age adults. Transitions between primary care and secondary care process developed. Integrated MH meeting weekly (Tuesday) • Community is supported by the pharmacy team who complete regular audits. • Matron leads on safeguarding for the directorate. Safeguarding supervisor training attended by all clinical leads.	• Water flushing compliance. • Staffing recruitment and retention in the community teams. • Some teams in business continuity. • Improved FACE risk assessment audits to improve quality.- new audit tool in development. • Working with L&D to develop bespoke RRI package to support community teams. • Evacuation plan and lockdown drills diarised – need to be completed. Meeting to commence community peer reviews scheduled for 28th April.

DMHLD LD+Fo	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Monthly Matron walk rounds scheduled in with IPC team. IPC champions across services. • Number of vacancies across the directorate is low with all vacant post out to advert. Amber lodge fully established • Community services use face risk assessment. Several staff are trained in HCR 20 and RSVP risk • Risk Register • Amber evacuation plan due for sign off • Good links with improvement and culture team . Awaiting report form culture work with Danescourt. No blame culture, staff will complete incident forms to highlight errors and promote learning from incidents. Attendance at patient safety huddles and learning shared • Dementia pathway embedded across all three community places . Transition pathway embedded – joined up with children's directorate. These are both on 2025 audit schedule • Physio benchmarking completed again physio competencies, areas of improvement identified which is now a work plan across all the service to ensure safe systems and pathways of care • In reach support provided for people with learning disabilities when they are admitted to mental health wards. • Directorate engaged in the trust medicines audits • Matron takes lead on safeguarding across directorate	• Danescourt staffing- effective use of the roster. • Compliance of face risk assessment is low in LD services • Danescourt evacuation plan need to be completed. lockdown drills – need to be completed. Meeting to commence community peer reviews scheduled for 28th April • Matrons across the care group are adapting a training package for staff to improve knowledge, confidence and experience with the PSIRF tool Kits. 7-minute briefing to be introduced and shared • Review of intensive support team pathways • Embed confidence in PSIRF tools • MCA Audit completed, action plan to be developed
NL +TT - Comm	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Recruitment practices – checks and experience • PSIRF – shared learning, commitment • Freedom to speak up champions • IPC compliance • Safeguarding training and supervision • No agency nurse use • Duty of candour • Medicine optimisation linked to guidelines and protocols • Sharing of learning	• Community safer staffing • Being proactive around training not going out of date • Colleagues taking responsibility for learning needs • Risk assessments – updated timely • Evidence of patient voice in care planning and risk management
NL+TT - TT	Good	Infection prevention and control	• Recruited to full capacity of clinical roles • IPC Compliant	• Ongoing admin capacity/ recruitment issues • PSIRF training to be shared wider

		Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Safeguarding training and supervision • Risk assessments completed at every contact with patient and documented on systm one • Freedom to speak up champions • Duty of candour • Active learning through Bespoke offer/ Learn/ Clinical Skills for Step 2 Team • Regular interface meetings with Secondary Care and PCN teams • PHQ9 Risk question done at every clinical appointment	• Community venues to be vetted more for lone working • Sharing safety plan with patients • Support for admin and other non-clinical staff in managing risk from patients • Duty system for risk escalation queries • Sharing safeguarding supervision dates
NL + TT Acute	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Recruitment practices – checks and experience • PSIRF • Freedom to speak up champions • IPC compliance • Safeguarding training and supervision • No agency nurse use • Sharing of learning • Low average length of stay • Low CRFD • Daily PIPA meetings • Daily Safety metrics	• Being proactive around training not going out of date • Colleagues taking responsibility for learning needs • Evidence of patient voice in care planning and risk management • Band 6 leadership level • Record Keeping
RAMH Acute	Good	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture	• Robust and safe recruitment practices in place that align with the current NHS employment check standards ensuring employees are suitably experienced, competent, and able to carry out their role. • After-Action Review and SWARM training– we have changed practice in the care group. • Freedom To Speak up Champions in place across the care group including the quality leads and well promoted • Up to Date IPC Policy – matron monthly walk rounds with IPC team	• Introduction across all wards of the RRI advocate role • Further estates work required to further reduce ligature risks • Level 3 safeguarding – below 90% trust target– plans in place for all staff • Further roster processes implementation required to ensure most effective use of staff – matron meets with e-roster team and each ward manager on 3 monthly basis • QDLs are working with teams on documentation specifically IR1 completion

		Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Safer Staffing policy and rostering reviews in place – review safer staffing levels 3 x weekly with ward leaders, and improving working relationships between wards for cross cover • NHSP Contract in place • Zero Agency nurse usage for the last quarter • Significant improvement in Resuscitation equipment checks and services across all inpatient areas • Established Medicines Optimisation Group – quarterly input into the care group quality meeting	
RAMH Comm	RI	Infection prevention and control Safe and effective staffing Involving people to manage risks Safe environments Learning Culture Safe systems, pathways and transitions Medicines optimisation Safeguarding	• Robust and safe recruitment practices in place that align with the current NHS employment check standards ensuring employees are suitably experienced, competent, and able to carry out their role. (Safe and Effective Staffing) • After-Action Review and SWARM training (Learning Culture) – we have changed practice in the care group. • Freedom To Speak up Champions in place across the care group and well promoted (Learning Culture) • Established Medicines Optimisation Group (Medicines Optimisation) – quarterly input into the care group quality meeting • Clinical spaces have been audited accordingly • Staff offices cleared of clutter and depersonalised to provide hot desking facilities	• Waiting list action plans required (Adult Locality Services) due to extensive waits • Job planning and review of capacity and demand within Adult Locality Services to improve efficiency • PSIRF responses to be embedded across the community directorate – plan underway for locality Clinical Lead to begin this work

	Rating	EFFECTIVE		
			What we are doing well	**What requires improvement**
PHND – ND	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Involvement in National benchmarking audit • Process to monitor compliance with Best Practice Guidance (NICE, NCEPOD) • Learning from Deaths policy and process • All teams are using the same SystmOne unit now migration has been completed to improve the consistency and equity across the ADHD and ASD services • One SystmOne unit ensure better accuracy of reporting • Physical health checks are part of the review for any patients receiving medication • Bi-monthly all leads workshops to focus on care group priorities and relationship building across the care group • Operational plan - this includes the staff survey findings and actions, Trust promises, this is directorate focused which enables a cohesive approach across services and teams.	• Need to consistently implement shared care across every place • Colocation of the team in one base for both staff and patients, for Childrens and adults services • Implement the direct access route to enable self referral • All staff in post and trained to the required standard
PHND C+LTC	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Involvement in National benchmarking audit for community nursing • Audit participation and actions – monitored through quality meeting • Process to monitor compliance with Best Practice Guidance (NICE, NCEPOD) • Learning from Deaths policy and process • Bi-monthly all leads workshops to focus on care group priorities and relationship building across the care group • Visualisation board development in pilot phase and implementation to be rolled out further • Assessment of lower leg updated to comply with national guidance • Review of Diabetes patients to reduce visit burden and improve quality of life for patients • Joint working across community nursing and specialist teams	• MCA and consent to treatment – improvements still to be finalised following 360 audit • Further work to make CQC preparedness every day business
PHND Rehab	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes	• Involvement in National benchmarking audit • Process to monitor compliance with Best Practice Guidance (NICE, NCEPOD) • Learning from Deaths policy and process • Bi-monthly all leads workshops to focus on care group priorities and relationship building across the care group • Audit and actions • Self-referral and access to appointments and groups • Partnership working with charities	• All staff in post and trained to the required standard • MCA and consent to treatment – improvements still to be finalised following 360 audit • Further work to make CQC preparedness every day business • Better MDT working across teams and services

		Supporting people to live healthier lives	• Pathway from fracture clinic into the specialist falls service to identify those at risk of further falls and provide intervention earlier	
CCG PH	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Evidence based practice • Assessing needs • Supporting people to live healthier lives • Consent to care and treatment	• Monitoring and improving outcomes • How staff, teams and services work together
CCG CAMHS	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Evidence based practice • Assessing needs • Supporting people to live healthier lives	• Evidence based practice • Assessing needs • Supporting people to live healthier lives
DAMHLD Acute	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Multi professional working, increased social work and AHP provision. • Recent audit showed that we are routinely assessing capacity around consent and treatment both as gatekeepers and once admitted. • Evidence based care/ treatment pathways • Acute directorate managers supporting each other, relationship building with other teams outside of the directorate (patient flow).	• Dialog+ training to support patient focussed care planning • Home Treatment clinical leads linking with wards to support early discharge. • MCA training, previously only offered to band 6 and above. There is a benefit to this being extended to Band 5s • Care planning • Better communication with Community colleagues to improve transition from inpatient to community • Directorate Quod leadership • MDT working • PIPA • Length of stay

DAMHLD Comm	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Experienced practitioner in the deaf team with 15 years plus experience working across the south Yorkshire patch • Use of Dialog+ to support patient focussed care planning • Consent is considered and documented in the notes evidencing understanding. • Dialog+ care plans demonstrate patient engagement and voice. • Evidence based care/ treatment pathways in EIP, perinatal, PCMHH • Reviews of NICE guidelines • Clinical lead forums to foster and improve relationships across the care group to improve patient outcomes and staff wellbeing. • Drug and Alcohol services actively engaged with AMBER project and creative support to improve outcomes for at risk cohorts. Naloxone training for third sector, voluntary and police force to improve outcomes for patients. • As above- integrated meeting, transitions between TT, PCMHH and CMHTs (and across to crisis and HTT) • Successful roll out of Dialog and Dialog plus across the community directorate. Care opinion - positive feedback received. • 95% on SMI physical health checks • Also use ReQuOL, GBO's etc • Paired measures of PROMs evidencing impact- VCSE colleagues also trained to use Dialog.	• Regular care plan audits. • MCA Audit completed – meeting scheduled to consider and develop action plan. • Care Planning • Directorate newsletter and QUAD meetings to be implemented. • Directorate Quod leadership • New initiatives to see this used more with the AOS cohort • Push to increase feedback which has seen a decrease since introduction of care opinion. Creative ways being explored. • Working on QUOF • Need to improve reporting of impact for peer support work and other VCSE colleagues' input with patient
DAMHLD LD+For	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Referral process in place across all areas. • Initial assessment completed at first appointment, to identify the person need. • New eligibility MDT established which focuses on the person need. • Consent is considered at all points throughout a person care, documented on system one and in the notes. Where people lack capacity staff will carry out an assessment making reasonable adjustments for the person. MCA link champions that attend the local trust MCA forum • Implementation of stomp pathways • Across the directorate the nursing staff have created a peer forum. Admin cross cover all the services when needed. • Lead OT and Physio are now cross directorate working. Amber lodge hold weekly staff meetings and community meeting chaired by a patient. Fols team in reach into Amber lodge • Directorate news letter • 95 % of physical health check completed in December 2024	• Diamond centre – initial assessment needs reviewing • MCA Audit completed – meeting scheduled to consider and develop action plan. • develop work plan based on the national learning disability standards • Continue to improve 'no wrong door' as priority for transformation • Directorate Quod leadership • Dialog and Dialog+ - roll out and consider how we will ensure people with learning disabilities can engage in this • Care opinion – need to review the structure of the QR codes
NL +TT - Comm	Good	Assessing needs Consent to care and treatment	• Attendance in multiprofessional CRFD meetings to work together • Audit-teams engaged and process for learning • Research - links with grounded research and	• RADAR - rolling out training and information • Dialog + • 4 week wait to be consistent across teams

		Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• NICE – links with centralised system for the trust and working on baselines of core guidance. • Reducing barriers in accessing the right pathway of treatment • Embracing research and innovation – Flow, MCI research	• Local working instructions for teams • Improving relationships with gatekeeping services -timely manner – clinical effective interventions • Clinical supervision recorded on staff portal - % increase in compliance required. • Mental capacity Act – response in accordance to assessment (recent audit suggest improvement needed) action plan being developed.
NL+TT - TT	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Assessments conducted for all patients • Outcome measures completed at every clinical appointment • Regular data monitoring of outcome measures • Consent to care and treatment followed • Follow NICE evidence-based treatments and as per Talking Therapies Manual • Use of step-up meetings to move patients between Step 2 and Step 3 • Regular supervision and caseload management embedded	• Communicate outcome of assessment to GP and patient as gold standard • Minimise patient having multiple assessments within service • Caseload management within Counselling modality
NL +TT Acute	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Attendance in multiprofessional CRFD meetings to work together • Daily PIPA meetings • Mental Health Act Section 132 Rights • Low CRFD • Short average length of stay-Mulberry • QNWA accreditation Mulberry • QNOAMHS accreditation outcome pending – Laurel	• RADAR - rolling out training and information • Local working instructions for teams • Early Discharge work by HBT • Virtual care home reviews • Care Plans not being shared in Partnership with patient • Our out of area patient numbers • Record keeping
RAMH Acute	Good	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment	• MUST score completion is on an upward trajectory to 79.43%, against a performance of below 55% on average for the year previous, work ongoing to achieve target of 100% • Commenced clozapine re-titration in the community, first patient pilot began end of March, going really well, will hopefully be a patient story for the board	• Further development needed for the acute directorate business meeting • Continue to support and embed volunteers across rest of care group

		How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Continued progress with reducing OOA patients and improved flow. • Development HDU ward to return patients from out of area 'locked rehab' wards • Embedding of QDL roles in both directorates – (can share ongoing activity report) • Care plan reviews for all patients, with a focus on Must do's, quality and patient focussed • Embedded and effective CRFD meeting, enhanced relationships with Local authority • Volunteers effectively being used at the woodlands	
RAMH Comm	RI	Assessing needs Consent to care and treatment Delivering evidence-based care and treatment How staff, teams and services work together Monitoring and improving outcomes Supporting people to live healthier lives	• Continued progress with improving flow within the community teams, reducing waiting lists and supported by a Care group wide Integrated Referrals Meeting that focuses on avoiding delays to care • AOT have commenced a partnership with supported accommodation to support the Community Rehabilitation Pathway and reduce OOA placements • Embedding of new Clinical Lead roles in both directorates with a focus on new roles having clear outcome measures • Volunteers effectively being integrated • Poverty proofing work in EIT • MSNAP accreditation in Memory services • Joint working pathway with Peer Support Services • Clinical Leadership Meeting once monthly with Clinical Leads across the care group to share best practice, updates to practice guidance, training and ensuring care is evidence based across all areas • Away days and protected time offered to all community-based teams to support team working • Focus being placed on SMI with ongoing work to develop physical health clinics • Implementation of DIALOG+, ensuring that the patient's care in the community is directed by their own priorities and goals (assessing needs)	• Continue to support and embed volunteers across rest of care group

	Rating	CARING		
			What we are doing well	**What requires improvement**
PHND ND	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Clear Freedom to Speak up Processes in place • Half day learning sessions in place for all staff • Feedback from care opinion • High Quality End of life care St Johns Hospice • Well being offer for the care group established – therapy dog, mindfulness sessions • 5 day induction with day 3 being introduction to the care group – established agenda and all senior leadership team attendance • Staff store cupboard for those in hardship • Period products provided in every base across the care group • Care group recognition events – 3 tier approach being very well received • Contact with service through single point of access 24/7 • Care group focus of kind and compassionate leadership • Interpreter service access	• Improvements care group wide regarding cultural competence • Staff survey actions to be agreed and implemented • Further work to make CQC preparedness every day business
PHND C+LTC	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Half day learning sessions in place for all staff • Feedback from care opinion • High Quality End of life care St Johns Hospice • Well being offer for the care group established – therapy dog, mindfulness sessions • 5 day induction with day 3 being introduction to the care group – established agenda and all senior leadership team attendance • Post attendance survey sent out to evaluate • Staff store cupboard for those in hardship • Period products provided in every base across the care group • Quality improvement plans for inpatient areas • Peer review within the Hospice inpatient with recommendations and lots of positive feedback • To update and improve the service leaflet that is utilised to aid professional discussions and agree mutual expectations at the first point of patient contact. Updating how this can be accessed digitally. • Providing a safe office space for neurodivergent colleagues.	• Full Implementation of personalised care • Staff survey actions to be agreed and implemented • Further work to make CQC preparedness every day business
PHND Rehab	Good	Independence, choice and control Kindness, compassion and dignity	• Clear Freedom to Speak up Processes in place • Half day learning sessions in place for all staff • Feedback from care opinion • Well being offer for the care group established – therapy dog, mindfulness sessions	• Full Implementation of personalised care • Staff survey actions to be agreed and implemented • Safe to wait offer – needs to be developed and implemented

		Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• 5 day induction with day 3 being introduction to the care group – established agenda and all senior leadership team attendance • Staff store cupboard for those in hardship • Period products provided in every base across the care group • Peer reviews have been carried out both in hours and one ward has had an out of hours review – recommendations and actions monitored through the Quality meeting • No overdue complaints and good compliance with the complaints process	
CCG PH	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Treating people with kindness, compassion and dignity • Independence, choice and control • Treating people as individuals • Workforce wellbeing and enablement	• Responding to immediate needs
CCG CAMHS	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Treating people with kindness, compassion and dignity • Independence, choice and control • Treating people as individuals • Workforce wellbeing and enablement	• Responding to immediate needs •
DAMHLD Acute	Good	Independence, choice and control Kindness, compassion and dignity	• Access to advocacy services • Increase in Good Care IR1's • Duty of candour • Access to advocacy services • Offering written information in the right language	• Roll out of dialog+ • Better engagement with relatives • Co-production of Care Plans • Interpreter services

		Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Engagement with EDI team to support staff teams • Each area has a staff access cupboard	• Section 17 texts – then to be rolled out to Care Plans • Access to LEARN
DAMHLD Comm	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Roll out of Dialog to improve patient outcomes. • Increased service offer to include group and individual work within pathways . • Duty of candour • Positive feedback via Care Opinion/ compliments • Compassionate engagement with families under PSIRF • RRI bespoke package is being developed to support both staff, patients and visitors to our buildings. • 100% compliance with resus equipment. • Complaints training received – leaders engaging with patent safety team and investigators to ensure that all legacy complaints are resolved- Matron meeting with patients to address their complaints. • Positive culture – use of culture team • Health and wellbeing at the forefront – positive role modelling. • Each area has a staff access cupboard	• Implementation of dialog+ • Care plans to be co-produced. • Copies to be provided to all and evidenced. • Matron working with physical heath matrons to implement support for GRT community. • Health and well being champions.
DAMHLD LD+For	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• All localities are present at local partnership boards. • Engaged in local speak up groups • Roll out of accessible information standards training • Work placements – Amber • Duty of Candor • Easy read information • Accessible information standards • People with LD carried out a survey on STOMP • Staff attending local authority day services offer training and advice session • Accessible information • Health and well being champions • Each area has a staff access cupboard • Poverty proofing audit • Engagement with culture team	• Co- production of Care Plans • Volunteers • Interpreter service
NL +TT - Comm	Good	Independence, choice and control Kindness, compassion and dignity	• Freedom to speak up events – raising profile • Half day learning events commitments • Responding to care opinion in a timely manner • Workforce engagement events – team away days • Well-being champion in the teams.	• Dialogue + needs to be functional and meaningful in all areas of the community. • Understanding the transition to not having CPA. • Need to identify champions in the teams.

		Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Flexible working patterns for colleagues	• Care planning – quality and patient voice included
NL + TT - TT	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Responding to care opinion and PEQ patient feedback in a timely manner • Patient choice a part of treatment offered within service and how whether video or face to face for example • Patients treated with kindness, compassion and dignity • Learn events • Regular supervision and management support	• Team and Service Away days • Wellbeing champions • Promotion of Freedom to speak up
NL +TT - Acute	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Patient and carer feedback • Oxevision • Advocacy • Carer sessions-Laurel • Patient experience meetings • Activities • Staff meetings • Reflective practice	• Supervision quality • Band 6 and band 7 development • Personalised care plans • MDT preparation • Inpatient environment • Older adult crisis response
RAMH Acute	Good	Independence, choice and control Kindness, compassion and dignity	• Developing all age model for Crisis Services from Dec 2024 • Half day learning events now embedding into rosters • Supportive responses from SLT/SOLT following any incident • Open forum in place for staff to hear the care group priorities and to bring any questions or concerns	• Review of all services in relation to all age • Sandpiper to put into practice and evaluate recent trauma informed care training

		Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Shadow experiences offered to staff for development • Visible service managers and matrons • Reflective practice and huddles in place	
RAMH Comm	Good	Independence, choice and control Kindness, compassion and dignity Responding to people's immediate needs Treating people as individuals Workforce Wellbeing and Enablement	• Developing all age model for Crisis Services from Dec 2024 • Half day learning events now embedding into team diaries • Supportive responses from SLT/SOLT following any incident • Open forum in place for staff to hear the care group priorities and to bring any questions or concerns • Shadow experiences offered to staff for development • Career conversations can be accessed by all staff for focused development plans outside of PDR • Visible service managers and matrons • Reflective practice and huddles in place • Additional support to be provided with information shared to all the workforce on Health and Wellbeing offer • DIALOG+ to ensure individual needs are met and providing independence, choice and control • Triage of new referrals in adult locality team is under review with a plan for improvement • Strong relationships with community partners with additional support offered when required to ensure we all respond to people's immediate needs	• Review of all services in relation to all age

	Rating	RESPONSIVE		
			What we are doing well	**What requires improvement**
PHND ND	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Trust implemented Care Opinion as its patient feedback tool which is being well utilised and responded to in a compassionate and meaningful way • Good links with Peer Support Groups and patient involvement for both ADHD and ASD • Access to service through single point of access 24/7 • ASD have MDT approach with Mental health colleagues to aid diagnosis • Three times weekly hotspot meeting with full SLT to escalate concerns promptly • Generic information template – S1 to ensure patients are asked what is important to them • ADHD now offer Psychosocial interventions as an alternative to medication for ADHD or in combination with medication • No outstanding complaints for the directorate	• The trust has an interpreter policy and interpreter service provision via DA languages – this is a commissioned service across a few organisations in South Yorkshire of which service standards can be variable (Equity in access, equity in experience and outcomes, providing information) • Need to improve waiting times – clear trajectory for both diagnosis and treatment of ADHD (4900 waiting) • Safe waiting to be explored an implemented • Improvements needed for access by Veterans • Further work to make CQC preparedness every day business
PHND C+LTC	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Care opinion being used well and responded to in a compassionate way- positive feedback received regarding staff responses • CORE20plus5 – all patients on the Respiratory service caseload have the importance of the flu vaccine discussed • Outreach to Gypsy, Roma Traveller communities with community partners • All services are available from 18 years plus. • Exceptions to this for children between 16-18 to facilitate transition • Community nursing service available 24/7 365 days per year • Service specific leaflets • Podiatry and the work with homeless people has been very successful • No overdue complaints and good compliance with the complaints process • Implementation of Phlebotomy team • Access to wound care WRAP (Wound Response Packs) packs and training, ensuring early detection, treatment and escalation of skin damage to any patient in their care for AHP's and other professionals who have completed the training	• Improvements needed for access by Veterans • Easy read service specific leaflets • Further work to make CQC preparedness every day business • To expand the amount of peer support groups we link with across our services • To reduce the waits across the remaining services to 4 weeks • The triage process needs streamlining to cut down on time taken from referral received to visit being assigned for the Phlebotomy team • To improve the collaborative approach in the way we work in partnership with other services such as primary care, so our services can work seamlessly for the people accessing care and referring. Developing on the ways we share information to aid how we learn and collaborate together

PHND Rehab	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Trust implemented Care Opinion as its patient feedback tool • Good links with Peer Support Groups and patient involvement • Trust has an embedded Patients trans equality policy • Detailed plans to embed Patient, Carer, Race Equity Framework (PCREF) matched within organisation strategy (Promise 5 and 26) • Access to service through single point of access 24/7 • Inpatients – have admission check lists which include all of the expected risk assessments. Consistently high compliance for VTE and MUST (over 90%) • Individualised care plans • Virtual ward – survey of every patient following discharged. Positive patient stories and feedback • Services provided with access in mind to good bus routes. • Volunteer drivers. • Waiting times for all but SALT (risk register), Physio, Stroke and Wheelchairs (possibly data issue) services are within 4 weeks • Operational plan • Peer support offer for safe to wait workstream	• Complaints process – backlog in responding to complaints • The trust has an interpreter policy and interpreter service provision via DA languages – this is a commissioned service across a few organisations in South Yorkshire of which service standards can be variable • Improvements needed for access by Veterans • To reduce the waits across the remaining services to 4 weeks • Relative/carer communication and input and to encourage visitor/ patient opinion. • Information in formats tailored to individual needs.
CCG PH	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Person centred care • Care Provision, Integration and Continuity • Providing information • Listening to and involving people • Planning for the future	• Equity in access • Equity in experience/outcomes **<u>On the basis of equity in access and waiting lists, more weighting towards RI felt appropriate by the directorate</u>**
CCG CAMHS	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Person centred care • Care Provision, Integration and Continuity • Providing information • Listening to and involving people • Planning for the future	• Equity in access • Equity in experience/outcomes

DAMH+LD Acute	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Ward MDT meetings • In patient collaboration across Acute Wards • Taking a collaborative approach with complex patients to ensure needs are met (joint working with LD and perinatal services) • Developing leaders • Providing information around legal status in a person's first language	• Smoother transition to community for inpatients. • Matron's Days – Commencing in May • Embed older peoples access to crisis services • Gypsy Roma traveller engagement • Personalised care plans with better involvement from patients, relatives and carers. • Developing opportunities for unqualified staff to develop. • Expanding the offer • Care Opinion – limited responses
DAMH+LD Comm	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Improved transition plans. Duty workers in all teams to be able to respond to need. LWI being developed to prevent cliff edge care follow transition. Transition and joint working between CAMHS and EIP well established. • Matron's bi- monthly meeeting • Access and waiting times for EIP met. • 4 week waiting • Review 4 week wait data and impact of services via paired measures (Dialog etc) • Patients are involved in dialog+ to identify what their personal needs are • Developing leaders- clinical leads shadow leaders – deputise in meetings. • Clinical leadership offer • Access to interpreters • Good links with community services outside of RDaSH to support engagement in the local community (PFG, Community connectors etc) • Access to easy read and alternative languages • Complaints • Care opinion	• Smoother transitions. Clearer pathways • Waits for therapy. Looking at perinatal services being one of the RDaSH 5 for increasing support to those experiencing health inequalities. • Gypsy Roma traveller engagement • Co-produced care plan Development of the disengagement policy • All documents available in required language. • Communication into the organisation for deaf people / those unable to speak on the phone neds to be addressed • Business case for matron drop ins to be developed.
DAMH+LD LD+For	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future	• Duty worker across three community localities to be able to respond to need • Trust wide Matron's meetings • Robust referral triage pathways across all areas • Easy read care plan • Social stories for people • Desensitisation work • Matron linked in with Sheffield learning disability team to see what other local areas offer	• Waiting times • Review of all care plans at diamond centre • Workforce plan • Embedding the LD standards more effectively • Matrons drop in sessions

		Providing information Listening to and involving people	• training and education at local day services • Drop-in sessions on the health bus • Easy read information • Care opinion • Carers events –Amber lodge	
NL + TT - Comm	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Care opinion –feedback being sought from all teams • Volunteers being key members of the team – involvement in projects, recruitment and service improvement • RAADS – improving the wait for a diagnostic assessment and treatment in the memory service. • Reviewing incidents in accordance with the PSIRF framework. • OLM – sharing practice together from lessons	• Peer support workers – not established despite going through a tender – needs embedding • 4 week waits across the service • PSIRF to be embraced and responsibility taken by all staff at the times of incidents to follow process. • Learning how to share learning with colleagues across the care group and trust. In various formats. • Safety metric – to make contact 72hrs post
NL + TT - TT	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Care opinion • Recognition of Equality act • Use of interpreters • Patients and quality at heart of delivery of service • Use of translated materials • PEQ (patient experience questionnaire) feedback •	• Peer support workers – not established despite going through a tender – needs embedding • 4 week waits across the service • PSIRF to be embraced and responsibility taken by all staff at the times of incidents to follow process. • Learning how to share learning with colleagues across the care group and trust. In various formats. • Being better bedded in communities • OOH working • Consistent use of therapy contract
NL + TT - Acute	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information	• Increased Care opinion feedback on inpatient • Patient experience meetings on wards • Carer meetings Laurel ward • Advocacy • Laurel end of life care • Daily PIPA meetings • Partnership working • QNWA accreditation Mulberry	• Care opinion feedback across full directorate • Partnership work in developing care plans • Preceptorship • One to one time with patients • Care Home discharge planning • Education sessions for staff • Record Keeping

		Listening to and involving people	• QNOAMHS accreditation outcome pending-Laurel • Audit program in place • Improved meal menu	
RAMH Acute	Good	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Trust implemented Care Opinion as its patient feedback tool – this is reviewed in the quality meeting, volunteers supporting people to complete care opinion • Good links with Peer Support Groups and patient involvement • Open forum for staff • Glade linking in with the hospice to improve learning following several end-of-life patients on older adult inpatient MH ward • Culture of care base line assessment carried out across all inpatient services – short term actions achieved • Piece of work with community patient and Mum, regarding supporting him when patient requires admission, patient passport developed, shared with SLT, matron and SNC reception, an excellent example of patient centred care • Responsive to feedback provided by patients in community meetings • New carers forum established this month at SNC, already embedded at woodlands.	• Preparation work ongoing in all teams for RCPsych accreditation • Feedback from volunteers to be used to improve services and service delivery
RAMH Comm	RI	Care provision, integration, and continuity Equity in access Equity in experiences and outcomes Person-centred care Planning for the future Providing information Listening to and involving people	• Trust implemented Care Opinion as its patient feedback too– this is reviewed in the quality meeting, volunteers supporting people to complete care opinion • Good links with Peer Support Groups and patient involvement • Open forum for staff • Piece of work with community patient and Mum, regarding supporting him when patient requires admission, patient passport developed, shared with SLT, matron and SNC reception, an excellent example of patient centred care • New leadership structure developed in the adult Locality Teams, responding to issues and feedback in a considered manner • Integrated Referrals Meeting and leadership oversight has identified and rectified issues around equity to access with community services • Encouraging staff to utilise community assets to improve access to services • Improved processes around responding to urgent referrals • The trust focused promises offer guidance in planning for the future and ensuring changes are not reactive • 2 week wait for referrals introduced within the adult locality services to be able to support timeframes in access • 2 week wait to be seen remains present in EIT and is working effectively	• Preparation work ongoing in all teams for RCPsych accreditation • Feedback from volunteers to be used to improve services and service delivery • Establishing equity in experiences and outcomes across the community directorate

			• Peer support have been used in a recent recruitment process with their view pivotal to the recruitment selection – listening to and involving people	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Freedom To Speak Up (FTSU) Guardian six-month update	**Agenda Item**	Paper N
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	James Hatfield, Freedom To Speak Up Guardian		
Meeting	Board of Directors	**Date**	29 May 2025

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

This bi-annual paper to Board provides an overview of the key areas of work that the Trust is focusing on in Freedom to Speak Up. The Board is asked to note our consistent levels of FTSU concerns in recent quarters, noting speaking out increase should not be seen as a negative consequence.

There is slippage in some of our results against the staff survey, which we acknowledge and conservatively balance against our FTSU feedback data. Our work on detriment continues and we have looked at specific cases where this has been considered as a factor, testing out our robustness to detriment. Consistently we have seen our top three themes of FTSU concerns relating to staff that utilise and feel safe to speak up, as:

- How they have been treated by others, leading to feeling bullied.
- Secondly, the culture and
- Thirdly, concerns around leadership from within their team or area of work.

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?)

Discussed in People and Organisational Development Committee.

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

The Board of Directors is asked to:

X	**NOTE** work undertaken and comment on any additional steps suggested
X	**ASK** the Trust People Council to continue work on the Trust culture
X	**CONSIDER** how best as Board members you can champion speaking up, even where doing so could be felt to be 'disruptive'

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

Trust Risk Register							
Strategic Delivery Risks							
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 1: 'Have your say' info graph
Appendix 2: How the service works in RDASH
Appendix 3: easy read how to raise concerns poster

Rotherham Doncaster and South Humber NHS Foundation Trust

Board Presentation for FTSU

May 2025

Making **Freedom to Speak Up** business as usual.

James Hatfield is our
Freedom to speak up Guardian
James.hatfield@nhs.net

This presentation provides a dedicated update on our Freedom to Speak Up (FTSU) activities and their impact on fostering a safe, transparent, and learning culture within our NHS Trust. We will review key data from the last two quarters, focusing on the nature of concerns raised, the significant themes emerging, and crucially, the learning and improvements that have been implemented as a direct result. We will also delve into the latest staff survey findings pertinent to Freedom to Speak Up, offering an analysis of overall observations and outlining the specific actions being progressed by the Guardian role.

Looking forward, this update will also cover upcoming developments incorporating valuable feedback and aligning with national best practice, including the National Guardian's Office 2025 objectives. We will touch upon our focused efforts in initiatives to enhance the visibility and accessibility of the Guardian and conclude with key recommendations for the Board's consideration to further strengthen our commitment to a robust speaking-up culture.

The presentation will cover the following key areas:

- **Number of Concerns:** Data from the last two quarters.
- **Concern Themes:** Analysis of prevalent topics raised.
- **Learning and Improvement:** Actions and outcomes from concerns.
- **Staff Survey - Freedom to Speak Up:**

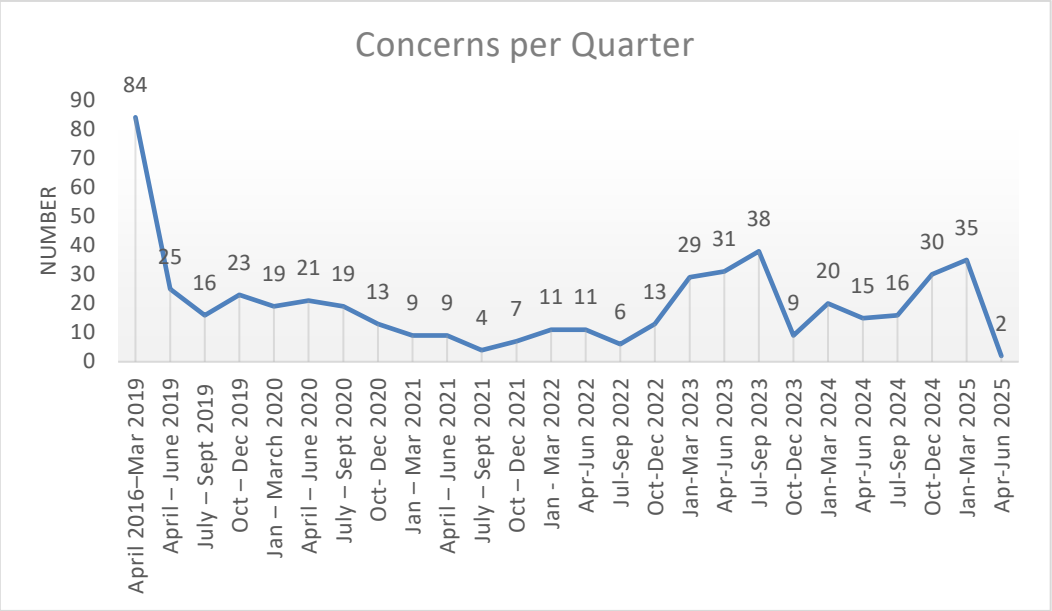
  Overall observations of the data.

  Actions for the Guardian.
- **What’s Coming Up for Freedom to Speak Up:** Future initiatives and plans.
- **Freedom to Speak Up Feedback:** Insights from recent feedback mechanisms.
- **NGO 2025 FTSU recruitment framework:** Alignment with National Guardian's Office objectives on standardising how NHS trust recruit and support FTSU guardians
- **Visibility of Guardian:** Current efforts and future strategies.
- **Recommendations:** Key proposals for the Board

1. Number of concerns per quarter last 6 months

Date Period	Period in Quarters (Q1, Q2, Q3, Q4)	Number of Concerns per Quarter
Oct-Dec 2024	Q3	30
Jan-Mar 2025	Q4	35
Total from 01/10/2024 to 31/03/2025		**65**

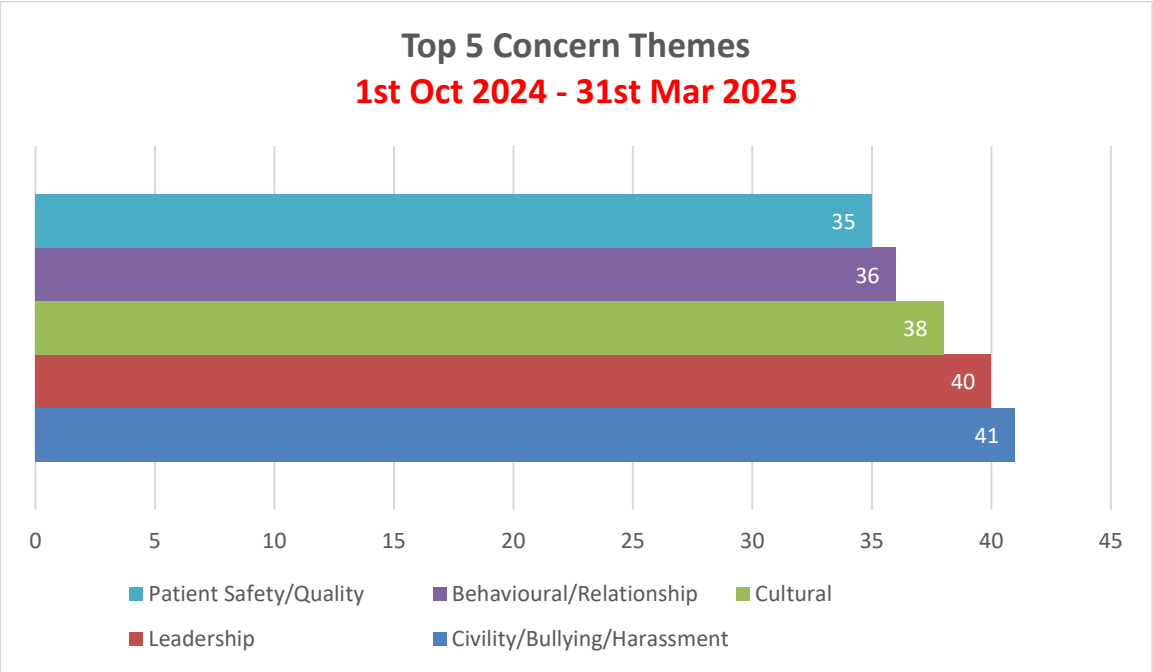
1.2 number of FTSU concerns per quarter 2019-2025



Above shows the number of concerns per quarter April 2019 to 7th May 2025.

Total number of concerns raised in 2024/2025 was n=**96:** Q1 n= 15; Q2 n=16; Q3 n=30 and Q4 n=35*

2. Concern Themes



The above graph shows the top themes held within each of the 65-concern raised over the period of 1st Oct 2024 - 31st Mar 2025. Each concern can have multiple concern themes held within it.

Concerns relating to patient safety have been investigated and addressed with the support of the Chief Nursing Officer. All other concerns are being investigated and addressed within the care group leadership.

Some of the specific learning and issues that have featured include:

- Civility and respect issues.
- Concerns around lack of visibility of senior leadership.
- Lack of support and understanding of the role of medical PA's.
- Staff fatigue and staff shortage
- Team Dynamics – potential disruption of teams working together post pandemic, remote working, pressure, and fatigue.
- Concerns around staff conduct outside of work
- Issues around communication and feedback.
- Concerns around increasing pay for band 2 and subsequent effect on band 3

Actions that we have taken:

- Civility framework and behavioural charter to tackle some of these issues is being explored.
- Recruitment of more FTSU champions- this has been addressed, and training has been delivered to the new volunteers.
- Guardian attending all Peer reviews in inpatient setting.
- Implementation of supervision sessions for FTSU champions

- Development of standard operating procedure for staff suffering from adverse effects of speaking up (detriment)
- Improvement of feedback mechanism for detriment for FTSU concerns (3, 6 and 12 months post closure)

3. Staff survey FTSU

Questions		Comparison	
		2023	2024
Q9h	My immediate manager cares about my concerns (Agree/Strongly agree)	76.9%	77.1%
Q20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree)	78.7%	77.5%
Q20b	I am confident that my organisation would address my concern (Agree/Strongly agree)	65%	63.1%
Q25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree)	76.5%	73.2%
Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree)	69.9%	66.7%
Q25f	If I spoke up about something that concerned me, I am confident my organisation would address my concern (Agree/Strongly agree)	57.8%	55.8%

4.1 Overall observations of the data

There is a deviation in our responses across the questions relating to raising concerns from 2023-2024 and while RDASH is generally around the average, the result for the benchmark Q25F (confidence in action after speaking up) are below average. This could indicate a particular care group where staff **lack assurances** that their concerns lead to actual change.

4.2 Actions for the Guardian:

Further in-depth analysis of qualitative feedback from staff, alongside quantitative data, will provide more comprehensive understanding of the specific barriers and enablers related to raising concerns. The guardian is taking a targeted approach to areas within the organisation that have seen the largest decreasing confidence FTSU survey, with sessions on FTSU principles and FTSU leadership training.

5. What's coming up for FTSU?

5.1 FTSU month Oct 2025- It will be Freedom to Speak Up month in October 2025. The Guardian will be basing himself in a different locality each week. On one day during this month, there will be a stand where there will be some freebies available to staff and the Guardian will be available to discuss with staff the importance of speaking up. Another day there will be a Hub where staff can approach the Guardian to discuss any concerns, they have regarding the places they work in.

5.2 Attendance in the trust induction - the guardian has attended all trust induction in order build an understanding of FTSU principles and process when onboarding new colleagues to the organisation.

5.3 Champion Supervision Sessions - in addition to the meetings, from February we have introduced quarterly Supervision Sessions for all our Champions, one per care group per quarter, these are face-to-face sessions to discuss trends and challenges within specific areas.

5.4 Champion ToR – new Commitment Agreement shared with all Champions asking them to confirm they have read and understood it - copy

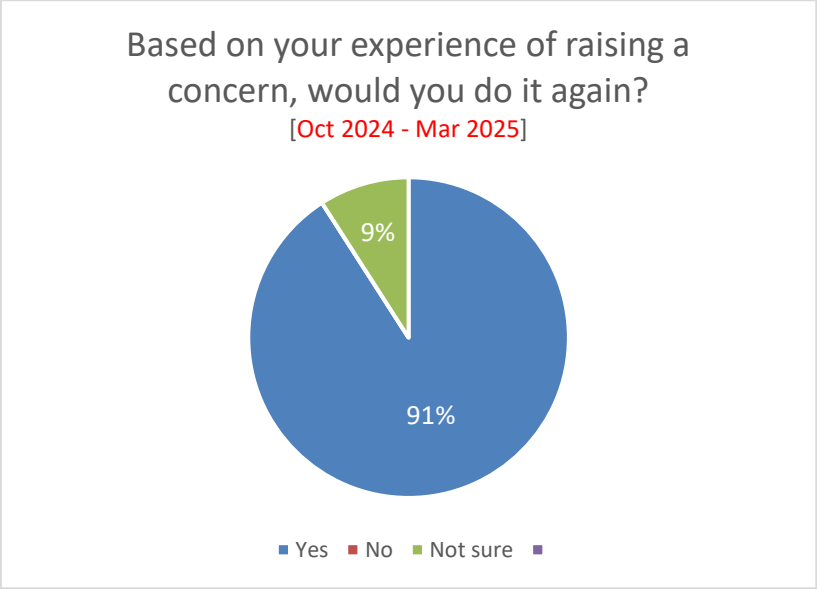
5.5 Champion Expressions of Interest – new "application" form which needs signing by line manager - copy

5.6 Policy Review - the Freedom to Speak Up/raising concerns (whistleblowing) policy has been reviewed and can be accessed on the FTSU page on the intranet. We have also provided an interactive copy, the format of which has been taken from the National policy – available on the FTSU page on the intranet.

5.7 Champions TEAMS page– one stop shop for information and resources, a confidential safe space for Champions to post, share and reflect.

5.8 FTSU G and PNA working together - Both roles and to create safe, open environments where staff feel heard and supported. PNA's offer reflective supervision and emotional support, while FTSU guardians help staff speak up safely when they have concerns. The Guardian and the new Director of Nursing for corporate have started to look at how both areas can work more closely together.

6. FTSU Feedback



In all concerns raised during this reporting period where feedback was provided 91% of respondents answered yes to this question. The current national rates of feedback around this question currently stand at **79.8% (four fifths**).

It is really positive to report a substantial increase in the percentage of individuals providing positive feedback on the process of raising a freedom to speak of concern. **This positive response far exceeds the national average demonstrating that our approach is resonating well with staff once they access the freedom to speak up service**. This achievement reflects our commitment to create an environment where every concern is welcomed listen to and acted upon with transparency and care. The improvement in feedback indicates that our enhanced support networks, clear communication channels and Taylor training have been effective in making the process and accessible and reassuring. Staff now feel more confident that the voices are heard and that their contributions drive tangible improvements in our culture and patient care.
Overall, these encouraging results underlined the success of our initiatives and reinforce our commitment to continuously fostering a culture were speaking up is seen as a valuable tool the collective improvement.

7. NGO 2025 FTSU recruitment framework

This framework standardise is how NHS trust recruit and support FTSU guardians.

https://nationalguardian.org.uk/wp-content/uploads/2025/05/NGO-recruitment-framework.pdf

7.1 What this means for us?

Standardisation: Mandates a clear, transparent recruitment process.
Independence: Strongly recommends stand-alone guardian role, adequate resources, and avoiding conflict of interest (e.g. board members as guardians).
Reporting: Guardian should have appropriate seniority and report to designated executive lead.
Overall clarity: Defines essential skills and values, providing updated job description guidance (minimum band 7/8A)
Support: Requires supportive culture Monday Cherry NGO training for guardians.

7.2 Next steps:

1. Review and appraise the full framework document.
2. Update recruitment policy in line with the framework.
3. Ensure guardian receives mandatory training and ongoing support.
4. Continue fostering a culture where speaking up is valued and act on.

Implementing this framework is essential for a robust FTSU function, crucial for safety and quality of care.

8. Visibility of the guardian

The Guardian has focused on increasing visibility throughout the organisation and visits each Care Group directorate once every 4 weeks to help develop trust within the staff group and to help 'spread the word' of what FTSU does. Some other actions the Guardian has taken are below:

- Present at each staff diversity network.
- Attend all peer reviews (as an independent reviewer).
- Expanded champions network
- Provided shadowing opportunities to staff with the Guardian
- Developed a peer network with other guardians in the region

9. Conclusions

- Excellent data around from colleagues going through the FTSU process well above the national average.
- The top 3 themes of the last 6 months have been civility/bullying/harassment, leadership and culture.

Appendix 1


Have your say
Staff side representative including trade union and staff side
Your line manager/ colleague or supervisor
The Health and Safety Team
Safeguarding
The Human Resources Team
The FTSU Guardian Team
Your Professional Regulator
Chaplaincy and Pastoral Services
The learning or wellbeing services

Appendix 2

How the service works in RDASH

The Freedom to Speak Up Guardian has been making regular visits to all inpatient MH units every 6-8 weeks. As well as this, regular visits have been made to other areas in clinical settings such as the community mental health teams, and physical health wards. These visits are primarily to increase visibility, identify and breakdown barriers and listen to work concerns. Discussions have been had with the inpatient staff team on how to raise concerns through FTSU and to encourage staff to raise concerns with anyone within the senior leadership team. The Guardian continues to educate the inpatient staff team on available options for raising concerns through FTSU whether that be an open, confidential, or anonymous concern.

Open concerns - this is an option for staff members to have their name shared with the senior leadership team in relation to the concern.

Confidential concerns - the Guardian or Freedom to Speak Up Champion may be aware of the name of the individual raising the concern; however, this would not be shared with anyone.

Anonymous concerns – through the Freedom to Speak Up intranet page staff members can raise a concern anonymously by typing their concern in the FTSU tab. This is sent to the Guardian directly for escalation, the only downside is that the individual would not receive any feedback.

The Guardian makes it clear to the individual raising the concern that the only reason confidentiality would be broken is if a patient or staff member is in direct harm.

Feedback - this is discussed with the individual raising the concern at the start of the process. Initially the guardian will contact the individual weekly to give feedback and support. The care group/service may then pick up giving the feedback to the individual.

Outcome – once an outcome has been reached and steps have been taken to address the concern, the Guardian will have a conversation with the individual to feedback and the concern will be closed.

Increasing champions - It has also been noted that not all teams have a FTSU Champion identified within their area. Work has progressed through the month to identify more FTSU champions and we now have 76 trained FTSU Champions and 14 staff who are keen to access formal training. This training will be held in September and November 2023 with a further training session to schedule to capture those who were not able to attend. Work is also being undertaken to increase the number of internationally educated nurses within the champion network.

Database – all FTSU concern are recorded in the FTSU database which the Guardian and one admin have access to. This records all concerns and includes:

- Quarterly totals
- Care Group totals
- Professional concerns
- Patient safety concerns
- Duty of candour concern
- Bullying total
- Detrimental total
- Anonymous totals
- Core Service totals

The Guardian must report to the National Guardian Office quarterly on the number of concerns in the Trust, the themes and the profession of the staff raising the concerns.

The Guardian has quarterly meetings with the Chief Executive and monthly meetings with the Executive Director for Nursing and Allied Health Professionals where the FTSU agenda and any barriers or areas of concern discussed openly.

The Guardian also meets monthly with all Care group directors to discuss open concerns in their area and any ongoing organisational learning that can be taken from the concerns raised.

Appendix 3

Freedom to Speak Up

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Identifying that something may be wrong

Service User / Patient / Carer:
If you are a service user, patient or carer we have specialist teams able to support you to explore your concern. The Patient Advice team can be contacted on 0800 015 4334 and the Patient Complaints team can be contacted on 01302 566617.

Staff member:
If you are a current or former employee, volunteer or student, please follow the path.

1

Raising a concern

What can I 'Speak Up' about?
You can raise a concern about anything you are worried about in terms of patient care or staff wellbeing. Please do not wait for proof about your concern, we arehere to explore any risk and where possible prevent risk occurring.

2

Who can I 'Speak Up' to?
Speaking up is important for patient safety and staff wellbeing. All teams and leaders at RDaSH are able to support concerns. The first route to raise your concern with is your manager, clinical lead or supervisor.

If your concern is in relation to fraud, bribery or corruption you need to report this directly to the Trust's Counter Fraud Specialist in line with the Trust's Counter Fraud, Bribery and Corruption Policy.

Where you don't think it's appropriate to do this, there are a number of other people you can speak to who can help you. See the diagram *left*.

If you wish to pursue support for your concern through the FTSU Guardian team please continue to follow the path.

3

How can I Speak Up? *FTSU Concerns can be raised in the following ways:*

Phone and Text:
07836 680975

Email:
rdash.ftsu@nhs.net

E-Link on the Trust Intranet

Face to face meeting

Post: FTSU Guardian c/o Woodfield House

4

Will I be anonymous?
You can raise concerns anonymously in writing or via the FTSU E Link. Concerns via other methods are considered as confidential. Confidentiality does have limits concerning patient and staff safety, this will be discussed with you. Please ask questions if you are worried, or see our Trust Policy.

5

What will happen next?

Examine the facts
We will make a confidential record of your concerns. We will then look into what you have said, and you will have access to support whilst your concern is explored.

We will try to resolve your concern quickly. We have trained mediators and coaches if we need support with this.

Where this is not possible we may need to conduct an investigation into the concern. We ensure that we select either internal or external independent investigators.
If an investigation is needed we will ask you to provide information, if you are willing.

6

Outcome and Feedback
Feedback is provided to all who **'speak up'** about what we have found when exploring the concern. If your feedback relates to another staff member, we will not be able to provide full details of actions taken due to confidentiality purposes; however we will be able to assure you that Trust processes and procedures have been followed, and also explain any learning and service improvements made due to the concern you have raised.

7

Reflecting and Moving Forward
At RDaSH we are committed to learning lessons, to improve patient care and staff wellbeing. At the point where we agree together that your concern can be closed, we will discuss how the learning from the concern will be shared.

The learning may be very specific to the area in which you work. It may also be that there is learning that will support safety and wellbeing throughout the trust.
Where there is wider learning we will protect your identity.

E-Learning available on ESR or NGO website:
* Speak Up - For all workers
* Listen UP - Supervisors, team leaders and managers
* Follow Up - Senior Leaders

Links to the websites can be found on our FTSU intranet page

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Plans for Approval: Quality and Safety Equity and Inclusion	**Agenda Item**	Paper O
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 May 2025

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

Board members are familiar with these two plans, which have been adapted at issue to reflect comments raised. The equity and inclusion plan documents work that is already, largely, advanced and deployed. As such no additional 'fanfare' or announcement is anticipated if the plan is agreed by the Board.

The quality and safety plan marks a new start in our work on systematically seeking to ensure core standards are in place in practice; and then provides a focus for work to identify, measure, and improve outcomes from care. In an evolving NHS environment where 'commissioning' is again asserted as outcome based, it is important that the Trust builds this collateral – as it is not otherwise available in the literature. We will consider how and when we 'launch' the quality and safety plan, with August our current thinking.

It would be especially useful to discuss the ideas of greatest significance to Board members, and to reflect on the enablers for delivery of large-scale change.

Alignment to strategic objectives (indicate with an 'x' which ambitions 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 addiction 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

Board timeouts Oct 24, April 25, Board meeting Jan 2025

Recommendation

The Board is asked to:

X	**APPROVE** the equity and inclusion and quality and safety plans
X	**ASK** relevant Board committees to have oversight of their delivery in line with their already agreed terms of reference
X	**DELEGATE** to the Quality Committee approval of the final list of always measures
X	**REQUIRE** adaptation of routine governance reporting from Q2 to provide the Board with regular visibility on progress with non-promise related elements of these plans

Impact

Trust Risk Register	X	Various in respect of safety measures						
Board Assurance Framework	X	SDR 1, 2 and 4						
System / Place impact	X	Supports known ICB and LA strategies						
Equality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	by 30/6
Quality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	by 30/6

Appendix (please list)

A – Quality and Safety Plan 2025-2028
B – Equity and Inclusion Plan 2025-2028

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Purpose

1.1 This paper is prepared to support endorsement of two further plans, further to the approval of the L&E document in July 2024. We would expect to put the final People and Teams Plan and digital transformation plan to the July Board. September will see the R&I, estate and finance plans. In the case of the R&I plan we want to be able to focus on discussing innovation at our Leaders' Conference on 30 September.

Introduction

2.1 To a degree, not as much as we might like, but more than we may have expected, the promises that form our strategy have entered consciousness with our people, partners and parts of our population. Nothing in this paper detracts from that focus.

2.2 But the Board envisaged in agreeing the strategy, that some further plans would ensure that we had balance across other areas of work, and in reforming our enablers to deliver the new organisational vision. The two plans presented are necessarily different – one 'reiterates' promises, the other goes beyond the promises in respect of quality of care and patient safety.

Quality and safety plan

3.1 The Trust offers a diverse range of services. That can **make a corporate /centrally synthesised view of risk, harm, outcomes and care quality difficult to achieve**. A small part of our care is relevant to mortality, but much is relevant to morbidity, quality of life, and a healthy life. Measurement in such fields is more subjective and contested.

3.2 The plan is deliberately intended to try to provide **a balanced focus** on inputs and standards, and then on outcomes. Of course, outcomes that matter to our patients and are developed with them. This latter focus should become much more salient at the Trust from summer 2026 onwards, after we have built the approach more operationally – and after we have secured delivery of our safety work.

3.3 That **safety work** includes meaningful deployment of a PSIRF approach to reviewing harms and learning from them (which is the focus of much of the Board's agenda) but it is also, and perhaps especially, consistent delivery of care standards (sometimes labelled CQC standards) and our own always measures and safety metrics. Safety metrics are ones that we would want to consider on a monthly, quarterly or annual cycle of improvement: always measures are a small number of 'through the eyes of our patients' measures of initial delivery at the outset of care.

3.4 **Patients' experiences of care** form a key part of the Quality and Safety Plan. Whether collated through Care Opinion or identified through cycles of feedback at a local level (for example work with detained patients), the plan

seeks to build systems that support impactful change or reinforcement – feedback with reason.

3.5 The plan **requires change**. Our corporate clinical functions have been subject to significant changes in form and role during 2024/25. The commitment to ensuring that the IQPR contains more meaningful quality indicators across our 13 directorates is known to Board colleagues. But it will also require change in our directorates and Care Groups. SLTs and DMTs necessarily often have to manage day-to-day care flow issues and hold a responsibility for people and for finance. Emergent or moderate harms can be sometimes overlooked until escalated. We need to work to build maturity in this space, and to reinforce the idea that safety and quality is every leader and managers' work, not work ringfenced for clinicians.

3.6 The Board, through our chair, has been explicit that leadership of **quality and safety is whole Board business**, with the quality committee playing a role in certain elements of scrutiny. As we move forward our agendas and our time in the coming year, we need to pay attention to the phasing of this plan (para 3.2). Importantly, we need to retain sufficient financial control for us to live the promise that "we will always find money for safety" – but we also need to recognise that tackling harms often requires us to help people to adapt, to work well within and across teams, or to directly challenge behaviour.

Equity and inclusion plan

4.1 As Board members have discussed this document is very **much framed around the promises** the strategy relies upon. The largest number of such promises are inequalities focused, and they represent a significant shift in management attention and service effort. Rather than seeing a lack of equity as a nice to have issue to be addressed in time, the plan views exclusion has mainstream work to be tackled now.

4.2 Some of the promises within the plan are very locally delivered, necessarily requiring shaping inside teams or specific services, working alongside neighbourhood colleagues. But in more cases, there is **a need for programmatic support to ensure that ideas can be implemented** intended to make a difference. Under promises 8, 10, 11 and 12 it is especially important that we are thoughtful about what problem is actually needing to be solved.

4.3 The enabler of data to move forward with this plan is rehearsed in other parts of the Board's papers. **The mindset shift** however behind that is to assume that analysing all elements of our work through the lens of often-excluded populations must become routine. Clearly that must be done mindful that some aspects of exclusion do not appear in datasets: perhaps especially within the inclusion health space.

4.4 **The Board's role** in this plan is to create permission, encouragement and expectation that senior leaders in team, service, directorate and group level will focus on inequalities. This was a theme for the 2024 leaders' conference,

and there is some sense that more involvement is apparent among colleagues in identifying and responding to issues. In our self-assessment work we need to look for evidence of that being deployed.

4.5 Having segmented our promises to support the operational plan for 25/26, many of the promises within this plan are due for **significant acceleration in year**: the board has latterly considered promises 6 and 9 from that perspective. Work on inclusion health is intensifying this summer, and we know have all five aspects of the Promise 8 commitment identified.

4.6 Promise 5 is, as ever, foundational to how we deliver this work. We cannot expect to tackle inequalities from the outside-in, and our poverty proofing work identifies the very different perspectives that need to be brought to bear – as an example. It is helpful that **the Council of Governors** continues to identify inequalities, prevention, and promoting wellbeing as priorities for the Board's work.

4.7 The plan consequently does not generate new or additional work beyond work already envisaged within the Clinical Leadership Executive over the past eighteen months. **Each corporate director** is already focusing on how their teams can support this plan and these promises. It will be important as we consider our estate plan that rurality is not neglected, and important as we develop our digital plans that they support inclusion rather than reinforce it. It will not be possible to deliver our quality and safety plan without addressing latent patterns of disparity.

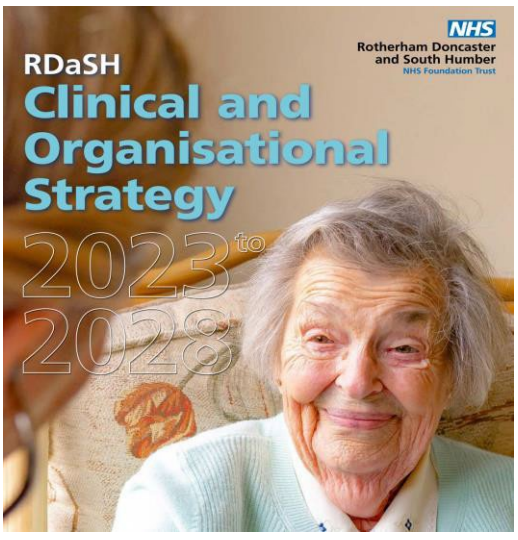
4.8 **There is not an equation in public health** between the projects within this plan and a single population health improvement goal. Through our membership of the three local Health and Wellbeing boards, and through the work of the Public Health, Patient Involvement and Partnerships Committee, we will work to ensure that we remain agile to new and emerging needs (children not in school, for instance, or patterns of migration and arrival). If national policy remains focused on adding health to years (as distinct from life expectancy), then the plan contributes. It combines secondary and primary preventive work, alongside work on the social and commercial determinants of health.

4.9 In approving the plan we are choosing to focus on the success measures, promises and areas of first attention within it. It is important to acknowledge this. **We are choosing this not something else**. So, to give an example, in Talking Therapies there are many apparent patterns of exclusion from care – our chosen focus is older adults. In effect our aim is to grow by 1000 the number of older adults accessing the service. In this example, but in others within the plan, we are actively not diffusing effort to other patterns of exclusion, those are, in effect, a next step after delivery of these promises and this plan.

Toby Lewis, Chief Executive

May 23rd 2025

2025 – 2028 Quality & Safety Plan



The context to our plan

People who use our services expect them to be safe. As patients trusting our expertise, or carers expecting kindness for their loved ones, there is an anticipation that the Trust is able to meet consistently good standards of care. Our teams want to deliver quality in all that they do; improving services to match that offered elsewhere in the NHS.

The plan tries to define what safety means to us, and what we are striving to improve about the quality of care we deliver. It explains how we will go about implementing this, in our thirteen directorates that provide physical and mental healthcare to young people and adults of all ages. Necessarily focuses on the measures and ideas within this plan means not spending time on other things or ideas: we are intending to consistently succeed in these chosen areas. And consistency itself is at the heart of our plan. Because if we can do in each team, on each shift, every week, what we do most of the time, we will be able to deliver better care for those we work with.

We strive to meet standards defined by those who commission our services. We also give attention to professional guidelines issued either by particular bodies, or through the National Institute for Clinical Effectiveness (NICE). We are regulated to meet core standards set by the Care Quality Commission (CQC). At the time of publication, dating from 2019 and before, the Trust is considered Requires Improvement in its work as a whole, with most services rates as Good. This plan seeks to move the Trust to a Good rating overall, with that a minimum across our services. Consistent with our values and the strategy explained below, we are striving especially to have an outstanding rating in the Caring domain.

Our 2023 – 2028 clinical and organisational strategy

The mission of our Trust is to nurture the power in our communities. This recognises that health comes from our lives as a whole, with the NHS a support to that wider household and neighbourhood. To become better at embedding ourselves in that wider community, in support of carers and patients, we developed and are working towards our strategy. That strategy has five objectives:

1. nurture partnerships with patients and citizens to support good health
2. create equity of access, employment, and experience to address differences in outcome
3. extend our community offer, in each of, and between, physical, mental health, learning disability, autism and addiction services
4. deliver high quality and therapeutic bed-based care on our own sites and in other settings
5. help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations

Locally, including within the Trust, the strategy is understood through Our 28 Promises. Their focus on research, education and service change are important, recognising that the quality of care we offer must be understood in partnership with patients and that we cannot offer a truly safe service it is not culturally competent nor accessible to all who live locally. This plan reinforces these Promises and articulates how certain related promises will be delivered by 2028.

Why the quality and safety plan matters

No care we provide is delivered by an individual. *We work in teams*. Those teams include colleagues from the voluntary sector, professionals working within local authorities, schools, prisons, and the police. We work in partnerships and through collaboration, especially with patients themselves, and those who matter most to them, some of whom are carers. Because of this interdependence it is important to define clearly what we mean because only by doing that can we align everyone's efforts to a common purpose.

The plan sets out some important commitments to safe care that we will be expecting to deliver all of the time. Understanding those measures will help to explain why they have such focus, *as we look to provide improved consistency of care across our organisation*, regardless of place, time of day, or the specific team who are leading a service at that moment.

The work of improving the quality of care we offer is one that requires innovation, experimentation, and effort over time. The outcomes that our patients want are not simple nor always the same. We will need to able to shape services to individuals as we look to measure and then to improve our outcomes. The plan tries to outline *how we will cohere the effort of many people to improve outcomes*, starting with consistent measurement across our services.

Unashamedly, the plan includes reinforcement of *our promise to be a short wait organisation*. We typically do not provide episodic, one-off care. Our services are alongside a patient for some time or may be available again in the future when a condition exacerbates. We know that we will be most effective if we can rapidly engage and assess someone's needs, at the moment, or as close to it as we can, that they seek help, or a primary care partner asks for our expertise.

Patients' *experience of care* is part of our quality and safety plan. It is woven throughout our promises: and promises 4 and 5 underpin our intention to involve people in their care and in our services on an ongoing basis. Since 2023 we have worked hard in services, directorates, care groups and at Trust and place level to put in place systems to make a reality of that intention. That matters because, as we change how we offer care, as we shorten waits, or reorganise services into our communities, we need to improve and never worsen the experiences of care that our patients and their carers tell us about.

Delivering safe care, and increasingly high-quality care, is not all about resources. But having stable teams over time – *a fully staffed organisation with time to learn and to change* - is essential. That is why this plan should be considered alongside others – our research and innovation, equity and inclusion, learning and education plans in particular. Moving money to patient care and investing to deliver our promises remains at the heart of the Trust's work in the months and years ahead. We will always find money for safety. We will always use our risk registers and analysis of patient safety events to determine priorities.

Before explaining the detail of the plan, the next pages outline a summary of the focus of our work and describe what success looks like over the coming three years.

The focus of our work

We are intending to meet defined safety measures which are explained within this plan and to measure and improve outcomes of care. In doing that we intend to learn from patient safety events, including the experiences of our staff, and consistently hear the voices of our patients. These ideas are reflected in the two-by-two matrix below, which defines our quality and safety focus.

Safety first	**Quality**
We will meet core 'always' standards consistently in new care episodes – and where relevant other ongoing safety standards consistent with the CQC domain	We will focus our efforts on meeting promise 16, with its commitment to outcome measures: this will be delivered in part through RCP accreditation and the implementation of DIALOG+
We will apply agreed approaches to understanding, investigating, and improving our care when things go wrong – rooted in our PSIRF model	We will embed patient voice into our routine management and clinical process, protecting what patients tell us they value, and improving how we work to best meet diverse needs in our communities

<u>Why safety first?</u>

By deliberate action, not coincidence we will minimise risk and maximise consistent good care. It will empower and support people and services to make safe choices, and it will protect patients from avoidable harm, neglect or abuse and breaches of human rights. In focussing upon safety, we will be 'just' and transparent, learning and making improvements if problems occur.

- Safety takes priority and we never walk past
- Safety is an 'always event'
- Safety means minimising things going wrong
- Safety means maximising things that go right
- Safety continuously reduces risk
- Safety empowers, supports and enables people to make safe choices
- Safety protects people from avoidable harm, neglect or abuse and breaches of human rights
- Safety ensures improvements are made when problems occur

Why quality improvement?

Through focussed effort, improving quality is ultimately linked with improving the efficiency and effectiveness of care. This means we can support more people to get well, faster, keep people well for longer. Whilst improving the support for people to self-care, improving the speed of access to care for those who need it and reducing the length of inpatient stay.

- Quality means supporting and enabling quality improvement and transformation at all levels
- Quality means building and nurturing a learning culture
- Quality means supporting and enabling quality improvement and transformation at all levels
- Quality means ensuring staff have the right skills and capabilities for quality improvement
- Quality means sharing best practice
- Quality helps design processes to identify & manage risks
- Quality means providing a stable basis on which to improve

What is success by 2028?

RDaSH in 2028……

What does the future look like?

- We will deliver our always measures in our services
- Sustained improvement will be visible in our safety metrics over time
- Meaningful changes will be demonstrated based on patient feedback
- We will be collating and reporting outcome measures for all of our services
- Our benchmarks of quality against other providers will typically show us in the upper quartile
- We will be rated good for the services we provide
- Our colleagues who provide services will consider them safe and effective

How will we know we have succeeded?

- Our patients will cared for at home wherever possible
- Our patients will stay in our bed based services that is appropriate for the least amount of time
- Our patients will be cared for in a bed based service local to where they live
- Our patients will feel that they are cared for in a compassionate and caring way
- Our patients will feel that their personal goals for recovery and improvement are identified and worked towards during their stay with us
- Our patients feel that they have received good quality care, seven days a week
- Our patients will feel satisfied overall with their stay with us
- Our patients feel safe

Safety metrics and always measures

There is a lot of data and information that we can, should and must collect in order to analyse our services. This data needs to be as accurate as possible, and to be usable. Wherever it is compassionate to do so, this same data will be available and visible inside the places where and the teams who provide care. And visible too to our patients. This visibility will serve to focus us on timely and accurate data – data which is entered by local clinicians and administrative teams.

Care group leadership teams have worked to define quality and safety measures that they consider will help them to operate services within their directorates. The Integrated Quality Performance Report (IQPR), and where necessary further locally issued datasets, will be used from 2025/26 to evaluate the care provided to our patients.

This raft of analysable data, which makes sense of the prior week, month, or quarter is not the same as our always measurement: our Always measurement focuses on a small and selected handful of metrics which we are clear will happen within a defined timeframe (daily, within 48 or 72 hours, or weekly) for all relevant patients. The discipline of introducing this overwhelming focus on getting things right 100% of the time, or catching omissions in near real time, will require focused effort across our 13 directorates. For many of our wards it will be delivered as part of our HQTC approach in 2025. Care Groups will consider the rollout of deployment into other points of care from July 2025, contingent on the availability and deployment of data to do so.

Introducing always measurement changes the dynamic of management that we apply within the Trust. This is because it introduces peer accountability. It is unlikely that a manager, even a relatively local manager, can tackle what is preventing a team from meeting an always measure: instead, their role is to help the team involved in care to do so. It may be that the process of undertaking an assessment is too cumbersome and not intuitive. Or it may be that team-working has created a single point of error – bearing in mind these always measure apply night and day, across seven days of the week.

The list of Always Measures is shown at Appendix A of this plan. Over time, and with experience, our measures may change slightly.

Our wider safety metrics include:

- Having personalised care plans in place for every patient in our care
- Operating safer staffing metrics aligned to professional judgement in our services
- Delivering our wait time promises including a 4-week maximum wait from April 2026
- Eliminating the use of inappropriate out of area placements
- Ensuring we comply with consent and information standards under the MHA
- Only using Oxevision, or similar aids, with the explicit consent of our patients
- Ensuring that we provide care including medication in line with MCA standards
- Complying with expected assessment standards including VTE, MUST and falls
- Meeting equipment and environmental effectiveness standards
- Supporting our staff and patients by implementing acceptable behaviour guidelines in our care settings and patient contacts

It is important that our safety metrics cover the range of care we offer within our directorates – and the full age-range of our patients. This is a change from the Trust's legacy practice where data-points often concentrated overwhelmingly on inpatient mental health settings.

Implementing our PSIRF framework

Since spring 2024, the Trust has been actively deploying the Patient Safety Incident Response Framework (PSIRF). With the implementation of our RADAR system from May 2025, and a revised PSIRF policy, we have an opportunity to test the effectiveness and comprehensiveness of this work: and improve it further by learning from that deployment.

The framework is intended to support Trust employees to work in partnership with patients to learn from what works and what has not worked in providing care. We do that by applying a range of techniques in *reviewing experiences of care and whether the best and most appropriate care pathway was applied*. In a small number of cases, this work will involve a Patient Safety Incident investigation (PSIi).

But it is the learning from these techniques that is central to our Quality and Safety Plan. This will be collated principally through thematic analysis of the PSIRF investigations that we do, ensuring that the Trust: at local, directorate, and Group level – and then across the organisation and our places – understands the most common, harmful and preventable errors. What then matters is to take steps to mitigate their impact and to reduce their likelihood.

As an organisation we want a rich culture of identifying risks, incidents and other events. So, the number of reporting incidents is not a helpful measure of overall risk. Over the time of this Quality and Safety plan, we would look to see *a reduction in preventable harms*, and a gradual reduction in the most serious harms staff and patients experience.

Our Quality Account for each of the three years covered by this Quality and Safety Plan will be used to account for our learning and impact from our PSIRF work. We would expect to see consistent application of the PSIRF toolkit across all teams within our 13 directorates.

Part of this work is *timely and conclusive application of these tools*, with incidents concluded and fed back to those involved – usually the reporter and any affected patient. We will pay attention during 2025/26 to a consistent rhythm of work to deliver investigations within timescales, without sacrificing the quality of those outputs.

Meeting the core standards set by the Care Quality Commission

CQC standards exist to support staff to provide the best care to our, and their, patients. These core standards are ones that we need to consistently consider in developing our services – and to assess evidence against when we self-assess our services. Notwithstanding inspection regimes, the Trust is expected to maintain a consistent view of its compliance, linked to its license to provide care. At a minimum, *annual consideration of our compliance will occur before the Annual Members' Meeting, so that the Trust's Board can candidly describe our current state to governors, members and the wider public*.

Care Group senior leadership teams (SLTs) are expected to routinely review services against standards for effectiveness, responsiveness, safety and caring. The well-led assessment is held centrally but consider local leadership models that have responsibility for

services. Ordinarily compliance with our safety measures and always metrics is an essential part of demonstrating safe service provision, and our short wait time culture aligned to strategic objectives 1 and 2, are central to demonstrating a responsive service delivery model. Neither can be confirmed without evident of acting on patient feedback which is discussed below.

The Board will itself, and through its quality committee, consider whether self-assessment of compliance is suitably evidenced, and reflect on whether data exists to contradict an assessment. This will draw on learning from PSIRF material, as well as evidence form formal complaints, FTSU material, coroner's reports, and the views of Healthwatch and our commissioners.

It is important to be explicit that our plan here is to see the standards set by our regulator as reflective of our own ambitions for quality and safety: we are not aiming to comply, but to demonstrate that these standards are met or exceeded. Regulatory standards are, typically, subjective. Instances of falling below those standards may be weighed differently by different parties. But the public should expect that commitments to being a safe and well-led organisation are consistently delivered – and where omissions or errors occur they are identified rapidly and acted upon.

Acting on the views and feedback of patients, carers and communities

Critical insights into what works, and what goes awry in our care, will come from patients who experience our services, and carers with whom we work, and on whom we rely. Promise 4 is intended to place this feedback at the very heart of our services, including how we manage them and evaluate their work.

The adoption of Care Opinion as our key source, but not only source, of patients' feedback in 2024, is intended to both broaden (to all services) and deepen (having frontline clinicians and leaders respond) our approach. In 24/25 we received over 900 stories from patients about our care. A number led to service change, while others reinforced what works well in our services and systems. Learning Half Days create a tremendous opportunity for local teams to share their learning from sources like care opinion.

Patient representatives form part of all our Board and executive committee spaces. Increasingly they are also visible at directorate and Care Group level too, influencing priorities, practice and policies. Patients play a critical role in shaping what is discussed and how we explain changes in care models. Co-production matters in how we work and we would always wish to hear patient perspectives on how care is offered, not only at the inception of changes, but throughout. The recent introduction, for example, of Quality Indicators agreed by the Trust's Board into our older peoples' mental health model for inpatients will be accompanied by consistent consideration of patient and carer feedback.

Carers, volunteers, and peer support workers, have an important additional perspective to bring to our review of services. This is why promises in relation to all three, form part of our first objective. As the number, diversity, and spread of partnerships with PSWs, carers and volunteers within our Trust grows, it will be important to ensure that we give weight to their insights into our care. The new shadow Clinical Leadership Executive, launched in 2025, will provide a locus for that feedback as we look to curate a way in which the most senior decision-making forums of the Trust are influenced by voices from alongside our services.

High quality therapeutic care models

The care of patients away from their home, outside their community, is among the most specialist, and certainly the most intrusive, provision we offer. In establishing our strategy, the Trust's Board recognised that this should only take place where alternatives were not feasible nor in someone's best interests. We also acknowledged that the care offered should be therapeutic and should continue only for as long as could be justified. This recognises that inpatient care can be iatrogenic in nature, exposing patients to enhanced and new risks.

In 2024 we created our High-Quality Therapeutic Care taskforce which brings together patient and professional expertise with the intention of implementing promises 18-23. At the heart of this work is introducing greater consistency of care: adopting standard work in how our wards operate and the models of care we offer: ensuring that diagnosis is rapid and admission purposive. From 2025 onwards, the Board committed to a bed-base for mental health care that offered local services in each place but that worked together as 'one hospital'.

We cannot deliver our quality and safety plan as a Trust if we are not able to provide Good and Outstanding services for inpatients, either of working age or among older adults. Doing so requires a radical reset of the current service offer. Seven-day admissions and discharges, linked to accessible short stay health-based places of safety, with minimal use of seclusion, and effective use of intensive care. Delivering our commitment to eliminate out of area placements demands that we reduce legacy length of stay, on average, even if many patients require stays beyond thirty-two days. The Trust must provide alternatives to admission and work with partners to use well our community-based team, crisis houses, and other facilities, whilst after a period of admission using effectively step-down facilities including long term rehabilitation tenancies.

The taskforce is focused on psychiatric inpatient care. But our promises apply equally to our physical health, hospice and addiction beds. Each sit amid a wider service offer which we are working to optimise. Increasingly we will want to deliver older adult care, in particular, in close collaboration with acute hospital colleagues, providing aligned services especially for patients with dementia.

From 2026, we will be implementing changes to achieve these goals and testing our ward provision against a scorecard of excellence rooted in professional guidance, and, as appropriate, against Culture of Care standards established nationally. In our application of these principles, we will give equal weight to the feedback of staff and patients as we aim to deliver care consistently well across Rotherham, North Lincolnshire and Doncaster.

Quality improvement through outcomes and accreditation

The elements of our Quality and Safety Plan above focus predominantly on inputs, and sometimes outputs, of services. In providing focus to our work on quality, we are looking to use accreditation to further strengthen those assessments. The outside-in perspective provided by, for psychiatric services, our Royal College accreditation ambition, will offer staff, and partners, the chance to test the calibre of care we offer against that provided elsewhere. We offer a number of services beyond this framework, and we will work with our service teams to identify relevant measures of similar professional validation to apply. *During*

2026/27 and 2027/28 the Trust will look to move all services through these frameworks, whilst not holding back teams ready sooner to apply. Mulberry Ward in Great Oaks for instance achieved accreditation in 2024/25.

In 2024/25 the Trust decided to apply DIALOG+ across all children's and adult mental health services. The implementation programme to support that work concludes at the end of 2025/26. We are replacing the Care Programme Approach which has been widely used in services since the 1990s. DIALOG+ provides, if well used, very **rich data on our ability to meet or exceed the expectations of our patients in the care that we offer. Increasingly, measurement of this type will be used to help services to assess their own strengths and improvement areas**. The data will never be used to create simplistic 'performance improvement' trajectories: the circumstances of someone's care may mean that modest changes are impactful, or that outside-events prevent the gains they sought. Misuse of outcome data could create an incentive to adverse selection, which excludes complex cases from care. But as a Trust we are clear that the potential of outcome-related data will ensure that we remain focused on what matters most to our patients, even as we look to become more productive in the way in which services are organised. As we move to the later months of the strategy and this plan, success would involve outcome-based data being increasingly the most-studied information we hold about quality of care.

Linking quality and safety to a culture of learning

This plan is grounded in applying the best of the care RDaSH already offers to all of our settings, shifts and venues. Though policy and guidance have a part to play in that improvement cycle, it will be largely achieved by teams themselves adopting practices they recognise among their peers to be most effective.

The use of national accreditation or common cultural standards reflects professional feedback about what is best practice for the Trust to apply. It forms part of this plan because of that feedback from teams. Similarly, the metrics and measures that are the basis for the safety work we need to do reflects what we already deliver some of the time. By doing this consistently, we will not only offer better care, but will release time from the tasks of monitoring, explaining and adapting work. That release of time to care is also the release of time to learn. As a Trust we are committed to investing consistently more in learning, reducing time spent on rote study, and creating time for teams to develop together.

PSIRF, safety huddles, learning half days, and our commitment to research and quality improvement are all mechanisms to support adoption of best practice across the Trust. We know that to succeed we have to overcome barriers to change and our prior efforts suggest that some systemic blockages need to be overcome if we are to succeed – these include;

- We have some unwanted clinical variation across the geography
- We have some inconsistency of leadership
- There is a need to engender a climate that asks *"what we do not know*" as well as "*what we know" and "what we need to know"*
- We need to make better use of benchmarking opportunities – 'pinching with pride' and sharing best practice
- Not having the right digital equipment to see live data is one of the aspects that hinders us reaching our full safety potential

Getting things done

Our Quality and Safety Plan is not words for the sake of it. Just as our Promises have come to be at the heart of the way that we work within RDaSH. The timing of progress will vary by service, by directorate and by group – recognising differing start points and competing priorities. The intention is to see progress balanced across our Research and Innovation, Equity and Inclusion, Learning and Education, and our Quality and Safety Plan.

But we would expect that the timetable below is broadly adopted in the work we do:

2025 and 2026

- Consistent implementation of our safety metrics and always measures across our organisation during 2025, including within Board level data such as the IQPR. In the first half of 2026 we will look to address any residual areas where services are unable to consistently meet our Always measures.

- Widespread adoption of our PSIRF framework, and clear evidence of local and cross-organisational learning from it: with indication of progress in preventive action being effective.

- Impactful use of the CQC core standards to self-assess the quality of care the Trust is able to provide across four key domains: caring, effectiveness, responsive and safe.

- Strong evidence that personalised care plans are used within all of our services.

- Continued use of patient feedback, and increasing evidence of acting on the advice of other stakeholders within strategic objective one, in shaping services and making improvements.

- Execution of consistent standards in the ward care we offer, reducing stays within our wards to that necessary for recovery in collaboration with our community teams.

2026, 2027 and 2028

Completion of work to adopt DIALOG+ in our care models for mental health: adoption must include not simply the training of existing and new employees in this model, but its clear local and aggregate use to assess service outcomes and act to improve them.

Adoption of accreditation models, including the RCPsych model, across services – led initially through our community directorates as the Trust seeks to test whether our core standards match those encouraged by professional expert bodies.

Broad use of outcome measures within services, replacing other measures in care group and Trust level data, as routine operational management comes to locally led – and expert input is deployed to advise teams on how to improve outcomes and innovate at a local level.

Concluding summary

The Trust is committed to improving the quality, and the equity of our care. **Promises 4 and 16** define that commitment through our work to embed the feedback of our patients into the work we do, and a big switch to focus on co-produced outcomes rather than other measurements of quality. Putting patient voice and outcomes at the heart of our work at directorate, Care Group and Trust 'level' requires intention. We will need to design in both mindsets to our management systems and behaviours and prioritise these over other forms of improvement work or other initiatives or encouragements, including those from national and professional bodies.

Before we can make those changes, we need to ensure that we have a baseline of consistent safe care across our 13 directorates. Three efforts are needed to do that, and we will progress them alongside one another.

- Introducing **always event** monitoring into our daily standard work. This will require us at a very local team level, but where it is not complete at directorate – and ultimately Board level – to make sure that a specific input or task has been completed. The always events listed here are those we have chosen that merit that focus. They are not everything that needs to be done to care. But we believe that if we insist on some shift-by-shift must-haves, then the wider MDT will develop a broader focus on the inputs they know matter (in addition to these always events)

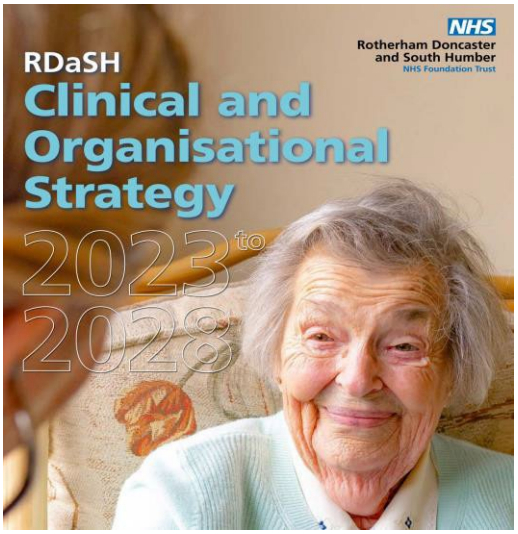
- Evaluating, talking about, and testing ourselves against **the 'we' and 'I' obligations** suggested by the Care Quality Commission as part of their current regulatory approach. Whilst we will consider responsive and effective care in what we do, our initial focus is on the safe and caring domains.

- We recognise that, despite this, healthcare work can create or reveal harms. Either as near misses or actual detriment. The Trust is committed to applying **a PSIRF model to understanding and acting on those insights**. Aided, in particular, by our Learning Half Days and the reform of our corporate clinical functions, we will look to ensure that we identify and act on sources of feedback and insight: and demonstrate real, evaluated change from them

This plan sets out a clear vision for success in 2028. It describes the steps to be taken over the coming eighteen months and seeks distributed local leadership to move towards an organisation where outcomes and patient feedback define quality improvement.

To have the freedom to work in that manner, we need to secure consistently safe care. Through national mechanisms and core standards, and through local change efforts outlined above, and exemplified through HQTC, we are determined to offer Good care. In setting a clear ambition, we need to remain candid about where we fall short, and open to error and excellence. The actions within this plan are deliberately a choice – to prioritise these over other efforts and in so doing to help to achieve the strategy and our mission as a Trust.

2025 – 2028 Equity & Inclusion Plan



The context to our plan

Fairness lies at the core of what we strive to provide, treating those we care for justly. Yet we know that differences of heritage, background, poverty and circumstance mean that access to care and outcomes from services vary too much. Being inclusive does not mean uniformity but, rather, shaping what we do to meet someone's personal needs where we can.

The plan tries to explain how we will live up to our promises which focus overwhelmingly on tackling inequality and promoting equity. This goes beyond national commitments to the Core20PLUS5 standard for children and young people, and for adults. And it goes beyond simply changing service models, because we know that altering employment and education chances, intervening to support stable housing, and addressing debt and income matter. Their health impact is significantly greater than that originating in services themselves.

A responsive service, a standard defined for us through our regulator, the Care Quality Commission (CQC), has to offer effective and safe care to all local citizens. Addressing heath inequalities is not, therefore, an 'extra' matter but one that reinforces ambitions within our quality and safety plan. Doing this well depends too on the diversity and cultural competence of our people and our teams, and our ability to listen deeply to communities, perhaps especially to those most marginalised and excluded.

From 2025, the Trust no longer pays wages below the Real Living Wage, and we work with commercial partners who meet that standard too. Work since 2024, which will conclude in 2026, aims to poverty proof all of our services: taking practical steps to make sure that local people living with less money and privilege are able to obtain our care when they need it.

Our 2023 – 2028 clinical and organisational strategy

The mission of our Trust is to nurture the power in our communities. This recognises that health comes from our lives as a whole, with the NHS a support to that wider household and neighbourhood. To become better at embedding ourselves in that wider community, in support of carers and patients, we developed and are working towards our strategy. That strategy has five objectives:

1. nurture partnerships with patients and citizens to support good health
2. create equity of access, employment, and experience to address differences in outcome
3. extend our community offer, in each of, and between, physical, mental health, learning disability, autism and addiction services
4. deliver high quality and therapeutic bed-based care on our own sites and in other settings
5. help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.

Locally, including within the Trust, the strategy is understood through Our 28 Promises. More than half of those promises are reflected in this plan. That reminds us that the status quo is one that persistently excludes, and that we need to consistently challenge ourselves to shape care around the person, and to reach into communities we previously neglected.

Why the equity and inclusion plan matters

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They are rooted deep within our society, and they are widening, leading to disparate outcomes, varied access to services, and poor experiences of care. **This results in lost years of healthy life, intergenerational effects from traumatic experiences, and has significant economic costs for society**. Yet, health inequalities are often preventable.

As a Trust we cannot address all of the causes of inequalities. Yet we do have a significant opportunity to offer preventive and *early intervention services* which mitigate the consequences. We work with children from birth, and through their school years; periods of time when the impact of inequality becomes deeply embedded in the life chances of families. While we provide long-term specialist mental health care, we also support schools and GP practices with input at a more formative stage; and our physical health teams offer screening and advice work which we have to ensure reaches into all communities. For example, our memory teams work to offer dementia diagnoses and support, but nationally and locally access for citizens from black and Asian communities are much less likely to have an early diagnosis.

We can, and do, *advocate for the needs for our patients*, working in partnership with other parts of public services and through the voluntary sector. Our expertise in doing this well can enhance the support available to our patients, and in so doing improve the outcome of our own care which is usually co-dependent on the actions of others. This work too can be anticipatory. In the gypsy, Roma, and traveller communities, among other inclusion health groups, we know that there are significant practical and cultural barriers to seeking support. Trusted professionals can alter these patterns – shaping our services to be accessible too.

Trust services do not currently always reflect the communities that we serve, nor their *diverse needs*. Whether in the languages we use, the customs we observe, or the traditions we privilege we can reinforce exclusion present in wider society. People living with the least income, or with the most debt, with transient housing or funds, are least likely to attend appointments with us. Rates of detention under the Mental Health Act nationally vary by ethnic background without due cause. Gender and ethnicity, those from the trans community, or assumptions and prejudices rooted in age, all explain differences in outcome and access to services ranging from specialist Parkinsons care to Talking Therapies.
Projects to address these disparities exist across our organisation: *this plan seeks to ensure that they are collectively sufficient to meet the deep inequalities faced by our communities.*

By 2028 work to address health inequalities will not be complete. But what we can succeed in doing by 2028 is to make effort to tackle these inequalities ‘mainstream’ in how we work and in how the Trust is managed.

Each promise is considered in turn, recognising that it is only in aggregate that we can move to that mainstream ambition: equity of access, employment and experiences.

The focus of our work: systemic change not projects

In 2024, the Trust established two new groups intended to give impetus to this work. Supporting the Trust's Board, we established the Public Health, Partnerships and Patient Involvement committee. This holds senior leaders to account for progress in delivering this plan and the promises within it. It includes Board members, governors, and works alongside both patient representatives and those from local authority public health departments. And in the operational 'space', the Trust's Chief Executive chairs the Equity and Inclusion group which supports our clinical leadership executive. Of course, changes are truly led at a much more local level, with teams and directorates, but the oversight of Board leadership is intended to unlock the work of teams across the Trust, whether that is in accessing data, funds, or in creating partnerships beyond our boundaries.

Sometimes there is good evidence about what we need to do differently. In other elements of this work, we are unsure what needs to change. In either circumstance we need to work alongside excluded communities and individuals to consider how best to adapt what we do. Often our best support may be to enhance, fund, or align ourselves with others who have better insight into a community, or are trusted there to work in a manner we cannot be. Our leadership development offer needs to build the confidence of leaders to support those models, and to remain present and active where we are facilitating others to lead.

Our promises vary in their shape. The table below tries to consider those differences in three parts: in effect where we are altering what we do across all services, areas where we are scaling up our current offer, and finally changes where we are introducing a specific service or programme to reach into an excluded community. The delivery model for these types of changes may differ, not least in how important it is that we work consistently across the Trust, or where there remains scope to work very differently at a local or hyper local level.

Trust-wide change of offer	Scaling up current services	Specific service support
Promise 2	Promise 7	Promise 8
Promise 3	Promise 9	Promise 10
Promise 5	Promise 11	
Promise 6		
Promise 12		
Promise 15		
Promise 17		
Promise 21		
Promise 27		

Promise 8 reflects the organisation trying to address systemic exclusion within mental health, autism and learning disability services. The acknowledged focus of Core20PLUS5 lies largely in physical health conditions, and solely within access to healthcare. Our chosen work tries to improve access to services in Talking Therapies, perinatal mental health, and dementia diagnosis: and to address issues of experience and outcome for those with learning disabilities or who have neurodiversity.

The inclusion of 'Net Zero' within this plan is deliberate: impacts of climate change will be felt very disproportionately among citizens locally. As a Trust we are committed to managing climate adaptation effectively – and investing when we can to eliminate our reliance on gas.

Always in partnership

The Trust is an active member of local Health and Wellbeing Boards in all three places. We work collaboratively with a wide variety of formal and informal networks relevant to this plan. Over time those collaborations will adapt, grow and change – and it is important that all five of our care groups, as well as executive relationship leads by place support that growth.

Current relevant collaborations include – Making It Real board in Doncaster, work alongside experts by experience in North Lincolnshire, the armed forces board in Rotherham, partnerships with VCSE and peer led organisations in all three places, employability projects, work with partners like the faculty of inclusion health and Equally Well, reach into specific minority ethnic and faith-based groups across the RDaSH landscape.

What is success by 2028?

All of our promises have established markers of success. Some have clear timescales within the promise, all have indicators which are considered and tracked by the clinical leadership executive and by the Board. Promises 3, 5 and 9 are due before 2028, and given the breadth of ambition within this plan, delivery will need to be consistent across the promises in the plan over time. During 2025 and 2026 we are determined to deliver the majority of the commitments made within our strategic objective 2 (promises 6-12). This recognises that promises 2, 17, 21 and 27 may take the duration of our strategy.

But this work is not project based. It intends to alter what we consider mainstream.

By 2028 we would therefore expect that:

- all services routinely analyse and act on data which suggests inequalities of access, wait time or outcome
- all services have made measurable progress to have staffing models which reflect the populations that we serve
- all services are credibly self-assessed as responsive in the manner in which they provide services, including the information provided and the cultural appropriateness of our offer
- we have implemented and evaluated the changes made as a result of poverty proofing our services as a whole (a process that concludes in 2026)
- our work on co-production associated with Promise 5, has become irreversibly embedded in how services, directorates and the very senior leadership of the Trust operate

Delivering Promise 2

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

In 2025, the Trust has established a new staff network, focused on carers. This will provide a locus to take forward better support for the many employees we have who hold caring responsibilities. Within our People and Teams plan we want to ensure that the Trust is a flexible employer, able to support the work / life balance of our colleagues.

Four success measures underpin this promise:

- Achieve Carers Federation accreditation for the work that we do across the Trust.
- Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.
- Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.
- Identify all-age carers that use our services and ensure their rights under the carers act are recognised

What and when?

The first two measures focus on our employees. Working across our People and OD corporate team, with first line managers, and through our network, we will take steps to respond to weaknesses of policy and practice identified through our staff survey and through other feedback. We recognise that, over time, patterns of behaviour and belief develop, and it will take time to become consistently flexible in how we manage teams. Our revised remote working policy, being launched during 2025, will play an important role in trying to shift that balance. We would expect to seek accreditation for our work by the end of 2026.

During 2025, led through our High-Quality Therapeutic Care taskforce (HQTC), we will introduce consistency of access for carers and others into all of our wards. This standardisation of hours, permissions, and norms will need to be introduced thoughtfully, as existing diversities of approach have developed for valid reasons. However, as we move to view our wards as ‘one hospital’ we want to be able to support expectations among our communities, and a reduction in unwarranted difference for staff who move between settings. We will use Care Opinion and other feedback systems to test the effectiveness of these changes that are central to our commitment to the national Culture of Care standards.

By far the most far-reaching measure of this promise, is the universal adoption of processes to ensure that our practice always aims to identify, and where suitable positively refer, carers for additional support. It is recognised that local authority led assessment models, configured under the Carer’s Act, vary, and cannot always then offer the fully range of support. However, our obligations to assess, to support, and to refer are clear. Unpaid carers form the bedrock of health and care in all of our neighbourhoods.

Recognising the scale of change needed to deliver this universal adoption we will work through 2025/26 to be ready to migrate to a new normal from Q1 2026/27. Within DIALOG+, personalised care planning, and in how we communicate more widely with our patients this work needs to become embedded; with patients making clear their preferences for carer involvement at assessment.

Delivering Promise 3

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

Since 2024, the Trust has worked to expand our volunteering network from 100 volunteers focused largely in one place and a handful of services, into a much broader approach reaching across all Trust services. Volunteers are not simply able to offer time and attention that is not always possible for professionals, they also offer insights into the community and into patient perspectives which are valuable to altering the balance of power in our teams.

Two success measures underpin this promise:

- Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.
- For that body of volunteers to reflect the diversity of our populations.

What and when?

At January 2025, the Trust had over 200 volunteers and could demonstrate significant change in the age and ethnic-origin diversity of those recruited. This work is underpinned by efforts to establish new roles within services and to have sufficient volunteers within those roles to span across several days if not the week as a whole.

Sustaining this expansion will require continued work through the Nursing and Facilities directorate who hold primary responsibility for our volunteers, even if they receive input from local line managers. The restructure of this function is intended to ensure that this is achieved, and that no volunteer waits more than four weeks for induction.

The success measure recognises that the Trust must not compete with other valued volunteering bodies across the area. Instead, we need to collaborate because those who offer time in one setting, often choose to do so elsewhere. Our voluntary sector partnerships are critical success factors for the Trust's mission as a whole, and for this promise.

Moving to 350 volunteers, inducted into roles, is to be achieved by October 2025. Each group within the Trust is expected to host at least 50 volunteers, and further expansion is needed within North Lincolnshire and Rotherham to meet this expectation.

It will be crucial that this sizeable body of volunteers are able to find a collective voice. A volunteer representative sits within the Trust People Council, and during 2025/26 the Council of Governors will review progress with volunteers and volunteering. This reflects the priority that they have given to these issues. A key part of our membership offer is to support volunteering – and all volunteers automatically become members of the Trust.

We have not explicitly defined volunteer diversity. The start point reflected a female, Caucasian, older adult profile not atypical within the NHS. It is important that changes made do not dissuade these citizens from volunteering with the Trust: we would expect, based on the evidence of 2024/25 that younger adults, including those from minority ethnic backgrounds, may seek to join us as we expand the range of volunteering roles, and as we make clearer the pathway-into-employment that volunteering can represent. We will continue to monitor diversity by reference to both population census data and our resident population.

Delivering 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.

In early 2025, external reviews of our work on this promise since 2024, by both 360 Assurance and GGI offered positive feedback on the progress being made to ensure that key points of decision, whether that is committees, interview panels, or major events always include purposively patient representatives. But the work to meaningfully retain this breadth, and add to it depth, will need to be consistent over time through to 2028.

Five success measures underpin this promise:

- Involve patient and community representatives fully in our board, executive and care group governance.
- Deliver the Board's community involvement framework (CIF) in full.
- Apply patient participation tests to new policies and plans developed within the Trust.
- Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.
- Deliver the annual priorities set by our council of governors.

What and when?

We would expect in 2025/26 to conclude work to consistently apply patient participation tests to new policies. This work will be led corporately, as the Trust, with the adoption of RADAR, alters how we manage and deploy policies both clinically and corporately in the organisation. The director of corporate assurance will lead this work, and it will form part of the 2026/27 H1 audit programme.

The Council of Governors approved the revised membership offer at its session in March 2025. This work was rooted in engagement work undertaken in autumn 2024. Deployment of that offer, and the gradual reinvigoration of the construct of membership within the Trust will be an important step in spring 2025. The annual members meeting in July 2025 will be a 'check-in' point for this work and we will agree before the end of quarter 2 a forward trajectory for what constitutes successful roll out over the balance of 25/26 and into 26/27.

Whilst progress with community representatives forming part of Board and committee work, the establishment of a 'shadow CLE' from Q2 2025/26 is intended to support a more overt move to ensure that Care Group and directorate governance also have patient voices at the heart of their governance, not simply on individual issues but consistently over time. This will be an important part of a maturity matrix that looks to develop our corporate governance model, bringing diverse patient voices into effect to help set agendas, as well as to comment on proposal developed by leadership teams.

The priorities set by the governing body were established in autumn 2023. They mirror closely the promises and focus attention on health promotion, on volunteers and on community participation. With changes within the Governing Body, during 2025/26 we will need to consider again whether they have been met, and adapt them to reflect the priorities governors have for the management and Board of the Trust.

The Community Involvement Framework was developed over time in 2024, and adopted by the Board through its public health, partnerships and patient involvement committee in January 2025. The framework needs to be used to test how deeply the Trust is embedding itself in local communities, as well as the work being done to ensure the organisation is open to those communities. In September 2025 we will bring a self-assessment to the Board, working jointly with our community engagement partner, the People Focused Group.

Delivering Promise 6:

"Poverty proof" all our services by 2025 to tackle discrimination, including through digital exclusion.

The methodology of poverty proofing has taken root in parts of our organisation in a manner that is encouraging: it recognises the lived reality of employees' life experience as well as their professional interaction with our patients. We have agreed a team-based schedule for full Trust-wide deployment by mid-year 2026.

Three success measures underpin this promise:

- All our services to have completed poverty proofing and be able to evidence resultant change (including digital).
- Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.
- Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'.

What and when?

Changes to how we work cannot wait for the conclusion of a Trust-wide poverty proofing programme. Instead from spring 2025 we are implementing changes arising from the initial pilot work, with three teams, and the wider rollout of the methodology with directorates. This includes funding to support transport and travel for patients from the poorest communities we serve.

Benefits and debt advice services have been established, or re-established, in all three places served by the Trust. However, the aspiration of this plan is to ensure that this advice is embedded into patient pathways. We know that a simple handoff cross referral is relatively ineffective in persuading someone to seek help, and, in all likelihood through DIALOG+, we are looking to make this advice a core part of the Care Plan. It will be important that our support and advice is equally available to children and families to whom we offer care, and a service offer relevant to those services continues to be explored ready for go-live during 2025/26.

The Trust is in the midst of exploring how to best communicate with our patients, and to enable them to better communicate with Trust services. This work will culminate in efforts to change how we create and confirm appointments, share key clinical information, and provide advice about Trust services including cross referral. That work, led through the director of Health Informatics, alongside the operational leadership, will take account of digital exclusion, acknowledging the reality that many people who live locally cannot rely on technology as a consistent route to communication, and acknowledging that this includes the specific needs of those who are neurodiverse.

The firm measure among our success criteria is our Was Not Brought / Did Not Attend rate. Work on communication can certainly improve that rate, which will need to operate to the standards established in our access policy. Investment may help to tackle barriers to attendance, as we focus on the wasted time and work associated with scheduled gaps in service. The Trust recognises the index of deprivation faced by our communities and will look to reduce by at least half the disparity in rates of overlooked appointments – with consistent use of known measures of success including text reminders.

Delivering Promise 7:

Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.

This promise spans a number of services within the Trust and considerable time has been committed to agreeing individual indicators for the relevant elements of the national model. PLUS5 considerations are addressed through other promises contained within this Plan.

Two success measures underpin this promise:

- Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people's mental health by 2026/27.
- Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.

What and when?

Work since 2024 established that historic measurement of Trust's work on health-checks relied on a subset of 'in service' patients for both measures. Subsequent effort has moved to addressing a QOF (i.e. general practice held) measure of ill-health/population registers intended to ensure that there is a common view by locality of those who are unwell. There remains work to do to establish patterns of shared responsibility with primary care colleagues, further complicated by interim changes to the GP contract.

In 2024/25 considerable effort was expended ensuring that where the Trust was in contact with patients, the relevant checks for patients were being conducted. The learning from that effort is being used to roll out work through 2025/26 to reach as many of those listed patients as possible, whilst retaining a live list or register. The gap between the Trust held dataset and the primary care held data set is very sizeable for learning disabilities, and further consideration is needed about how this will be approached: a factor also under consideration for promise 8 where we are seeking to use AHCs to reduce disparities in mortality.

The balance of promise 7 measures are largely being achieved from the outset of 25/26, and a review of the data quality of the work will be undertaken to test how sustainable this position will be into the coming quarters. Care Group leaders are driving forward efforts to ensure that the seven services involved are able to reflect on any changes needed to provision based on the experience of seeking to extend the service offer to those traditional excluded.

The clinical audit programme for 2026 will take account of the work above, testing whether health checks undertaken, and other assessments contained within this promise, have been evidentially acted upon.

Delivering Promise 8:

Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality (“the RDASH 5”).

These commitments are ambitious. In most cases there is some knowledge of what needs to be done and how to do it, drawn from experiences outside the Trust. In other examples, data is limited, and our chosen interventions are more experimental. It is recognised that individuals stepping forward to lead this work are sometimes working without additional time and offering leadership across a diffuse landscape. Support to deliver these goals is being provided through both strategic development and through the change and improvement team.

Five success measures underpin this promise, with the fifth subject to change:

- Increase access to health checks for minority ethnic citizens with Learning Disabilities.
- Increase diagnostic rates for dementia among minority ethnic citizens.
- Improve access rates to talking therapies among older adults.
- Ensure ward-based care is suitable for patients with neurodiverse needs.
- Ensure proportionate access to perinatal mental health by black and minority ethnic residents.

What and when?

A clear project to adopt best practice in dementia services is being established, drawing on examples from Bradford in particular. The Clinical Leadership Executive has funded support for this work for 25/26, which is intended to improve penetration and reach into communities that do not traditionally present to primary care for memory referral. No trajectory for improvement has yet been set, but the Trust is committed to improving access and awareness among our own teams, and those in general practice.

Similarly, the path to increasing by 1,500 people the volume of older adults using Talking Therapies at the Trust is well-advanced. This work draws on the need of patients already using Trust services and efforts to offer the service to those not referred in, for example within Care Homes and other settings of association. It is recognise that exclusion of older people from mental health talking therapies is a longstanding national pattern, and some experimentation may be needed to understand what sustains therapy and makes it beneficial. Careful monitoring of progress through 2025/26 will be used to see what can be accomplished for the existing plans, with a review at December 2025 to consider whether that will deliver our chosen measure.

In 2024, the Clinical Leadership Executive reviewed wider work to support patients with neurodiversity in using Trust services. This is distinct from work to tackle the appallingly long wait times experienced by children and young people, as well as adults.
From that wider ten-point action plan, Promise 8 focuses on ward-based environments, both the built environment and the skills and knowledge of our teams. Additional training and reflective practice time will be provided to ward-based teams recognising the likelihood that

about a fifth of service users at any given time may have additional sensory and other needs.

Nationally perinatal mental health services are not successful in reaching high risk and sometimes excluded groups. This includes families from black and minority ethnic backgrounds, as well as those parents within Inclusion Health groups. The project that will be supported within this promise aims to tackle these patterns, deliberately shifting resource through outreach work towards communities services are not currently able to reach.

It is presently unclear whether learning disability registers within the Trust and primary care reflect the ethnic origin diversity one might expect among our population. The key step is to demonstrate that they do: if this can be established, then the focus shifts to health check take up and action. If they do not, then the Trust will need to work with the local authority and primary care to address these gaps. The aim of the work is to act on markers of risk that can be overshadowed by an LD diagnosis and to ensure that individuals and their carers are supported to access specialist services. By July 2025, the decision needs to be clearly made as to which direction or path this work is focused on.

Delivering Promise 9:

Consistently exceed our apprentice levy requirements from 2025 and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.

The Trust's legacy approach to the levy favoured high cost/high wage apprenticeships. This was changed in 2024/25 with the introduction of the apprentice-first model for all band 2 and band 3 roles in the organisation. At the same time, nationally, apprentice levy arrangements are changing. The aim of this promise is to support into employment citizens traditionally excluded – and to use the qualification and funding of apprenticeships as one tool to do this.

Four measures underpin the success needed from this promise:

- Achieve the levy requirements in 2024/25 and thereafter.
- In 2024/25, introduce tailored access scheme for veterans and for care leavers.
- In 2025/26, introduce tailored access scheme for refugees and homeless citizens.
- In 2026/27, introduce tailored access scheme for people with learning disabilities.

What and when?

The Trust fell short of full use of our levy in 2024/25. The Board has agreed a revised plan for the year ahead, which focuses both on entry-level apprenticeships and on mid-career roles. Fully utilising the levy remains a focus for the organisation, as we expand our training spend and work as a Trust to be known for the development of our people, and their teams.

During 24/25 there was some good work done to prepare to the ground to deliver tailored access schemes moving people into employment from specific backgrounds or circumstances. However, that work focused on making inclusive our general recruitment approach. The focus in 2025/26 will be on tailored and dedicated access work for four communities listed within the success measures.

During 2025/26 we also will work to put in place a programme of opportunities over the following twelve months for young adults with learning disabilities. The Trust works, through

our intellectual disabilities team, with young people of a range of ages, and our ability to support people into employment is a key intervention as people age. This work is likely to be focused on particular roles within the Trust, as entry level roles, building on learning from elsewhere in the country.

Delivering Promise 10:

Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and misusing substances, and forced migrants.

Inclusion health is a diverse field, and the Trust serves three geographies. Our work is in two parts therefore: ensuring that 'mainstream' services are accessible to all, through taking positive steps to reduce actual or perceptual barriers to care (GP registration, fixed-abode, etc) and through developing bespoke services and outreach efforts into our communities. The Trust will work with partners to make progress, recognising that over the coming two years, significant changes are needed if we are to meet this promise.

Three success measures underpin this promise:

- Meet standards set out in published guidance issued by NICE/NHS England (2022).
- Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.
- Specific service offers in place for all or most inclusion health groups by 2027.

What and when?

There are already a lot of project-based efforts in pockets within the organization. This includes work with sex workers in Doncaster, refugee support through prior migrant hotels, and our podiatry project for homeless people. During the summer of 2025 we will complete, aided an organization called Pathway, a review of support for people experiencing homelessness and the right pattern of service support that we could curate or indeed provide. A two year funded homeless health team will be created on the back of this review work, which will compare its outcomes to other similar services nationally.

Using our leaders' conference event in September 2025, and our QI poster contest, we will look to build a registry of existing services collaboration projects and work towards our investment fund for 2026-27 in seeking to 'plug' gaps, either among inclusion health groups or between our three places.

During 2026/27, having completed our poverty proofing work, and mindful of other foundational work on care planning, the implementation of DIALOG, and alterations to how we communicate with patients, we will undertake a structured audit and review of whether the manner in which we interface with our patients is consistently trauma informed – and whether in any respect it is unintentionally exclusionary. This will include funding peer-researchers from inclusion health groups to 'mystery test' our processes.

Delivering Promise 11:

Deliver in full the NHS' commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and trauma responsive services

The Trust has renewed its accreditation, at silver level, for work in this field. The intention is not simply to be recognised as a gold standard supporter of our veteran community but also to ensure that we develop bespoke support for the voluntary sector provision that veterans themselves have created locally. Current data suggests that we see only around half as many veterans as one might expect given prevalence, and we need to continue to support

our services to have the specialist service pathways in place to provide timely care.

Two success measures underpin this promise:

- Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).
    - Introduce peer-led service support offer for local residents.

What and when?

There are three steps to moving forward now with this promise, grounded in the steering forum that supports the Equity and Inclusion Group.

There remains work to do to ensure that our data capture at the point of care is comprehensive. This applies to our waiting list as well as our contact points. This will allow to confirm whether we are meeting a priority commitment.

There are a range of formal alternative services for veterans and their families, as well as strong local provision that is peer-led in the voluntary sector. The Trust's expertise needs to be nested alongside that provision and is not a substitute for it. That requires our professionals to have good knowledge of that landscape, for example through Learning Half Days.

There will be gaps in provision, and steps that the Trust can take, potentially in partnership with Your Hearts and Minds, to address those gaps. The peer-led support that we would wish to see veterans have access to needs to be available across the RDaSH landscape. In 2025 we will work to see that developed and delivered moving into 2026.

Delivering Promise 12:

Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.

The exclusion of rural citizens from services, and different patterns of need within those communities is acknowledged nationally and locally. Impetus behind this work within the Trust is considerable, with clinical and Board level leaders working with acknowledged experts in the field to identify what the organisation does well and what could be done in addition or differently. Care Groups have established leads in this field, intended to recognise that whilst North Lincolnshire is predominantly rural, rurality is relevant to all parts of the RDaSH landscape.

Two success measures underpin this promise:

- Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.
- Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.

What and when?

The focus for delivery of this promise lies in 2026 and 2027. That timescale is consistent with using 2025 to complete analysis and development work about how best the Trust can adapt its offer. It is worth considering, for example, in light of promises 15 and 21 how best this work is advanced.

The specific North Lincolnshire context is one in which the Trust needs to operate in collaboration with the revised Local Authority strategy, which alters the community approach previously taken. The designations of hubs within the localities of the council will be important

for the Trust to respond to, thinking carefully about both children and adult services. Working alongside the Health and Wellbeing Board the Trust will need to consider what gaps in provision rural communities, notably farming communities, and itinerant workers too, may experience.

In Rotherham and Doncaster, our estate plans need to take account of village disposition. Again, the working assumption needs to follow the footprints identified by local authority leaders and politicians, and there needs to be a clear thread from their description of localities to the organisation of RDaSH services. This may come into conflict, or certainly juxtaposition, with the PCN configurations in both boroughs.

One important consideration to have ready for 26/27 will be the use of mobile facilities to provide service in-reach into village communities across RDaSH. The Trust has some experience of this offer, as do other partners, and whilst there are alternative approaches it seems attractive to have an ability to provide an organisational presence in different places over the course of a year: doing so will however challenge our ability to join up services internally across teams, and it is this that we need to consider over the coming months.

Delivering Promise 15:

Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs

The Fuller Stocktake, published in 2022, set out expectations of the NHS to develop neighbourhood teams. Policy implementation was sporadic over the period to 2025, but the expectation is that neighbourhood health will be at the heart of the NHS Ten Year Plan. The Trust is in a unique position to offer support to teams, both for adults and for young people, which reach across traditional mental and physical health divides. Critically, we need to confirm expectations of what neighbourhood teams can achieve: even if we play a part in shaping what they 'look like'.

Four success measures underpin this promise:

- Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.
- Restructure Trust services into those INTs during 2025/26.
- Evaluate and incrementally improve joint working achieved through these teams.
- Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.

What and when?

The time for this promise is likely to arrive over the period from summer 2025 through the following twelve months. There is an expectation that the NHS will determine how it wishes to shift care models into more formal neighbourhood teams. With strong place partnerships in position in all three localities, the Trust for children and adult services, across mental and physical healthcare, will need to determine our most purposive response.

We would anticipate that new guidance will see roles moved either formally into INTs, or in relationship to INTs. One critical factor in that journey will be the degree to which the Trust and its partners begin to shift away from specialism and towards neighbourhood generalism. This has implications for training and expertise, but it may be the only credible route by which caseload pressures can be managed, and through which services can genuinely be shaped by neighbourhoods.

Both staff and community partners will have seen similar 'shifts' previously within and related to the NHS. It will be important to draw lessons from those prior efforts, locally and

nationally, and to consider carefully the counter-measures to address what may not have worked in previous change models.

It is possible that an initial national focus will be quite driven by an adult physical health agenda, and in that context as a Trust we need to ensure that our response is holistic and draws on the integrative benefits of a combined community and mental health service model. But those benefits will need to be demonstrated, as we have begun to explore for older adults.

In advance of this guidance, it would seem premature to set out defined Trust timetables, but there is a need over the later part of 2025 to begin to explore these issues with our teams.

Delivering Promise 17:

Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.

There is recognition that early year's support, especially in aligning children to the needs to education and development, is a hugely valuable investment of time and effort. Universalist services leave gaps by age and gaps by need, despite reform over recent years. The Trust has endorsed specific services changes, with additional health checks, and further training associated with toilet training, to try and address these issues – or contribute to efforts locally to do this.

Two success measures underpin this promise:

- Narrow the school readiness gap between our most deprived communities and average in each place in which we work.
- Seek to see 80% of children meet their own potential for school readiness by 2028.

What and when?

During 2025 we will moving to implement the changes developed by teams over the prior year. That needs to be undertaken in a manner which collects data as we go to test the impact over the following two years of the changes that we are making. The work will require strong collaboration with educational partners to understand any unintended consequences and positive signs from the first year of implementation.

The programme of work is concentrated within one of our five Care Groups. But it remains of Trust wide and corporate level interest, as the long-term consequences of this work matters to a left-shift pattern of health investment locally: albeit one less acknowledged nationally, whereby we need to invest more in children and young people's care.

It may be that this work does move the Trust further away from a universalist model, and we need to recognise the choices that may come as we concentrate more resource on specific children and families. The implication of this work is that we need to use predictive tools to identify those most at risk and intervene to offer peer-led support at an earlier stage of family development.

During 2026 and 2027, we need to be attentive to a lack of impact from the new model, and to consider how we adapt 'in flight' the new model developed by our teams. The Board considered the development of this work in February 2025, and will return to it in June 2026 to assess how things are progressing.

Delivering Promise 21:

Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis

This promise speaks to the development of PCNs, neighbourhoods, and in particular work led through local authorities to focus attention on particular communities of disadvantage. Each local authority is concluding work to identify its priority neighbourhoods, consistent with Health and Wellbeing plans. The Trust offers services within those neighbourhoods and the focus of our effort needs to be on getting better coordination of care in our efforts, aligning to those led through VCSE partners in particular.

Five success measures underpin this promise:

- Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness
- Contribute actively to the city-wide Thrive programme within Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced
- Implement anticipatory preventive care models supported within the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care
- Understand and act on local research into patterns of referral, cross referral and best fit services for mental health in adults and older adults linked to general practice
- Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes

What and when?

This promise is locally led. The emphasis of place leadership within the Trust has shifted towards an expectation that collaboration of primary care and VCSE bodies will be taken forward by Care Groups working together. It is also a promise which depends on the ambitions and thoughts of other stakeholders. This is why it has taken some time to develop success measures for this work, as the aspirations need to be developed from local partnerships.

The leadership development offer that the organisation has invested in is based on the idea that leaders within all functions among our Band 8+ roles will be able to operate to develop new collaborations with partners. This promise manifests that hyper local intention. Of course, it is important that choices about how to develop projects remain rooted in analysis of population need – and that the effort required to work at a focused or small scale is not always dependent on an expectation of future scaling up. The Trust has to be able to operate very locally as needed.

We would expect as we move towards 2026 that we place increasing emphasis on how to reform and adjust our community mental health offer. Teams gathered into directorates will need to consider how best we support both pathway work with complex inpatient care and work to wrap services around primary care teams. That is why a partnership with the third sector, and why work to understand current referral patterns, matters very much in 2025.

All three local authorities have set out intentional neighbourhood and community development strategies. The Trust must play our part in reflected those strategies, whilst acknowledging that our service models will simultaneously need to be broadly consistent between our places. This can be a difficult balance to strike and one that will need strong lateral collaboration inside the Trust, alongside work outside it.

Delivering Promise 27:

Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.

The Trust has seen good progress to 2023 in reducing its emissions, however, this was entirely achieved through suppliers' changes of practice. Further progress requires Trust led change, which requires a shift in our energy supply model for the main estate hubs, together with change in our use of transport and travel. Climate adaptation work is central to local authority plans, within which we need to align, and, as a Trust we need to reduce our reliance on staff travel and patients travelling large distances for care.

Three success measures underpin this promise:

- Reduce our carbon tonnage by 2000 (and offset balance).
- Agree and deliver specific contribution to local authority climate change plans.
- Change service models for patients and staff to reduce travel required by 2027.

What and when?

The key step required of the organisation is to reduce our dependence on gas as an energy source, using older boilers to support our estate. Propositions to move to new technologies are contingent on funding streams and on our wider estate plans. During the first half of 2025 we will develop proposals that could be funded on this basis and look to move the retained estate within our Tickhill Road site, as a priority, to these revised methods by the end of this decade, if not by 2028. In developing our estate, we need to take opportunities to update the heat retention and wider energy efficiency of our buildings. This will help us to reduce cost, and waste.

As a Trust our services and our staff teams are distributed across an extensive geography. In the majority of cases, there is not a credible travel alternative to the use of individual cars. There are opportunities to plan our services with a reduced travel footprint, both in how we schedule our service, and where we base our teams. These opportunities will be useful to us and active consideration of them needs to be explored as teams develop their plans for 2026/27.

The prime opportunity remains for the Trust a more systematic approach to remote working. The revised policy will need to bring forward a fair, service relevant, model that supports roles to have some time outside the workplace, without sacrificing team working, training, line management and supervision, or access for patients.

As part of our work to meet a wider environmental and sustainability commitment, the Trust continues efforts to reduce single use items, including plastics. This work is led and supported through our network of Green Champions. It will be important that this distributed enthusiasm for the work that we need to do is developed and supported as the Trust looks to meet its commitment over the lifetime of the strategy.

Concluding summary

At appendix A is the timetable for the commitment made within this plan. They spend 2025, 2026 and in some cases 2027. This recognises that, despite the drive to deliver many of inequalities promises over the public service year 2025/26, some of our commitments rely in partners, and many too rely on work to truly understand the nature of the remaining issue to be addressed.

The majority of our promises within the Equity and Inclusion Plan are Trustwide changes in how we support employment, support our people, or deliver services. Only a minority of the work to be done is bespoke to a particular team or service. But whether it is working hyper-locally, or whether it experimenting within promises 8,10, 12, or 17 we need to ensure that we are courageous in the changes we seek to make.

The plan cannot be delivered unless during the early months of 2025/26 we address the data deficit that we have: we benefit from good systems to connect services to the NHS spine, and as such ought to be readily capable of reporting the measures within this plan, as well as testing our IQPR against protected characteristics.

Work to deliver our poverty proofing and annual health check work, in particular, remain high profile within our organisation. The scale of what we are seeking to achieve is intended to meet the moment of a society that is still yet recovering from a pandemic. The investment of attention and time to these programmes reflects the left-shift demanded by Lord Darzi from the future NHS.

Only promise 27 within this plan is, in full, not yet funded. Changes to public service capital regimes are likely to positively the estate transformation that we need to accomplish. Our deployment of Promise 2 will conversely test the resource of our wider system to properly support unpaid carers.

During 2025 we would expect to celebrate continued success with Promises 3 and 5. Both seek to alter the voices that we listen to and act on within the Trust. That, perhaps more than anything else, is the precise purpose of this Plan.

Equity and Inclusion Plan - Due dates for delivery	2025				2026				2027				2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Promise 2 - Unpaid Carers																
Remote working policy																
Carers Federation Accreditation																
Safe, flexdible access to inpatient areas for carers																
Consistently identify carers and refer carers for support																
Promise 3 - 350 Volunteers																
Reach 350 volunteers																
Reflect the diversity of our populations																
Promise 5 - Community Involvement																
Participation tests to new policies																
Deploy new membership offer																
Establish shadow CLE																
Deliver Governor set priorities																
Self-assessment against Community Involvement Framework																
Promise 6 - Poverty Proofing																
Introduce money and debt advice																
Build referral to money and debt advice into pathways																
Conclude poverty proofing audits																
Improve communication with patients																
Introduce financial support with transport																

Equity and Inclusion Plan - Due dates for delivery	2025				2026				2027				2028			
Promise 7 - Core20Plus5																
Develop integrated SMI and LD registers with primary care																
Undertake annual health checks for those patients																
Undertake clinical audit of quality of health checks																
Promise 8 - RDaSH 5																
Employ community engagement works in Older Adults																
Deploy plan to offer TT to older adults in physical health services																
Neurodiversity training and improve ward based environments																
Promise 9 - Apprenticeships																
Exceed apprenticeship levy each year																
Work on offering tailored apprenticeship offer to four communities																
Develop programme for young adults with learning disabilities																
Promise 10 - Inclusion Health																
Meet standards set out in published guidance issued by NICE/NHS England (2023)																
Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.																
Specific service offers in place for all or most inclusion health groups by 2027.																

Equity and Inclusion Plan - Due dates for delivery	2025				2026				2027				2028			
Promise 11 - Veterans																
Improve data capture on veteran status																
Improve knowledge of veteran support in services																
Introduce peer support for veterans																
Promise 12 - Rurality																
Complete analysis and development work on approach																
Deliver approach																
Work with NLLA on locality hubs																
Use of mobile facilities to provide service in-reach into villages																
Promise 15 - Integrated Neighbourhood Teams																
Explore options when guidance is issued																
Promise 17 - School Readiness																
Implement plan developed by teams inc data collection																
Review model and make appropriate changes																
Promise 21 - Improve co-ordination of care with primary care																
Leadership Development Offer focus																
Scope how we need to adjust community mental health offer																
Understand referral patterns																

Equity and Inclusion Plan - Due dates for delivery	2025				2026				2027				2028			
Stop bounce back of referrals																
Promise 27 - Sustainability																
Develop proposals to reduce gas emissions																
Apply for funding																
Implement estate plans which divest of energy inefficient buildings																
Develop plan to reduce travel footprint to deliver services																
Remote working policy																

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 29 May 2025

Item 19

Patient Story

Human trafficking and Modern Slavery – Multiple Services

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

	2024/25 Serious Patient Safety Incidents – Learning update		Paper P
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer Jim Cooper, Deputy Chief Nursing Officer Natasha Collinson, Patient Safety, Carer and Community Practitioner		
Meeting	Board of Directors		29 May 2025

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

***Reader note and caution – the report refers to harm, this includes reference to suicide, the mechanism of suicide, unexpected deaths and other harms that the reader may find distressing.**
Please contact steve.forsyth1@nhs.net if you require support before reading this paper and a redacted version can be shared to support the readers wellbeing in a trauma informed manner*.

In March the Board sought to discuss the outcomes of PSIIs, however, many had yet to be reported and learnings/success measures were unclear. This revised report contains almost all serious incidents investigated over the last twelve months: and summarises lessons learned. It may be that the learning is sometimes imprecise, and improving the quality of our investigations and reports is a priority for 202/26 – a matter covered in the PSIRF policy appended to the Chief Executive's report.

It is requested that Board discuss whether the actions outlined to address each learning is realistic, achievable and will be sustainable. So not just to share the incidents which have led to the most serious of harms, that we as a board discuss the learning, noting any changes to service delivery, clinical practice and processes because of the actions and findings from the incidents detailed within this paper.

From May 2025, escalation of key learnings from PSIIs will form part of the delivery review cycle. A sample of specific actions from 24/25 will be audited during July and August.

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

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

Recommendation (indicate with an 'x' all that apply and where shown elaborate)	
The Board of Directors is asked to:	
X	**DISCUSS** the lessons learned from PSIIs reported during 2024/25
X	**NOTE** the measures of success outlined
X	**UNDERSTAND** how, where and when we will have confidence that the changes required have been made arising from these instances of patient harm

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)		
Trust Risk Register	X	NQ 5/23, NQ 8/24, N&F 22/24
Board Assurance Framework		n/a
System / Place impact	X	Note inter-organisational PSIIs with ED/acute

Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	Note demographic analysis in report
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	

Appendix
Number of actual harms by total and impact in RDaSH 2024/25

Apology

On behalf of RDaSH this is a formal record of our apology, my apology as Chief Nursing Officer, this is not acceptable. We promise to do better. This is why I present today to the Board of Directors, our public and communities, this is not a comfortable conversation or reading, and nor should it be, I say this as a nephew to my auntie who felt there was no other way out but to end her life by suicide, whilst under the care of multiple secondary services, including CMHT. This is not conveyed with the intention to detract in anyway from the seriousness of the message in this paper, but to give an insight to the level of commitment given by our CEO, RDaSH and myself. Mental health wellbeing and in particular suicide, will potentially impact on us all; either personally, a family member, carer or friend.

We will commit to learning from the tragic loss of life and harm that has occurred.

1. 2024/25 Serious Patient Safety Incidents – Learning update

This paper serves as a detailed update from March 25 Board of Directors. This paper provides data on 18 of 19 PSII reported in 24/25 and importantly the organisational learning from our first year of implementing Patient Safety Incident Response Framework (PSIRF).

This paper tabulates the key issues with each PSII since 1 April 2024 with completion of 18 PSII occurring in 2024/25. It is important that Board and our public have absolute awareness and insights, with the detail of these most serious patient harms that have led to a person's death or the highest severity of harm. Revised governance for PSIIs is contained within the CEO's report to Board.

Our learning from 18 PSIIs completed to date is set out, with the available data, and the marker of success for each listed.

It is requested that Board discuss whether the actions outlined to address each learning is realistic, achievable and will be sustainable. So not just to share the incidents which have led to the most serious of harms, that we as a board discuss the learning, noting any changes to service delivery, clinical practice and processes because of the actions and findings from the incidents detailed within this paper.

Concern remains over the learning model within the organisation for safety. We will continue to embrace PSIRF, our Education and Learning/Quality & Safety plan and Learning Half Days (LHD) to ensure there is a systematic approach to learning from After Action Reviews (AAR), swarm huddle, Multi-Disciplinary Team (MDT) huddles and PSIIs.

From May, escalation of key learnings from PSIIs will form part of the delivery review cycle, in addition to work through the organisation's quality and safety plan.

2. Analysis of data for PSII reported between 1 April 2024 to 31 March 2025

There were 23 proposed PSIIs reported in total during 2024/25.

- Four were investigated within the PSIRF and learning was expedited as an after-action review (AAR) or MDT review.

- One PSII is a current Crown Prosecution matter, this is subject to an independent investigator, who has interviewed staff, reviewed the care provided by RDaSH, met with the families of the person in our care and the person who has tragically died, their family members.

The remaining 18 PSII reports are all completed and further analysis of the data and learning is discussed.

Rotherham MH and Doncaster MH & LD were the highest reporting care groups, with six and five PSIIs reported. The Acute (Mental Health) directorate is the highest reporter across the Doncaster, Rotherham and North Lincs localities.

The largest proportion of PSII reported incident type was suspected suicide; this is in line with the 2024/25 PSIRF plan priorities. The Trust reported two PSIIs relating to the unexpected death of an inpatient, and two PSIIs due to an opportunity for learning identified.

The age group of people where a PSII was undertaken, affects 46 to 55 years, it is a comparator to the data within the national confidential enquiry into suicide and safety in mental health, which identifies the highest risk age group of suicide in men 45 to 54 years. 72% of the patients involved within the PSIIs were male.

As we embed Patient Carer Race Equality Framework and the work being undertaken in the Equality and Inclusion Committee, we have work to do 25/26 to understand the protected characteristics of the patients who come to harm in our care.

3. Summary of key learning

***Incident** Learning - What this means at RDaSH.* The charts above and summary table concerning the 18 PSII are presented separately for transparency purposes. Many of the PSIIs are not related, and have some specific actions related to the specific clinical area/ service in which they happened. However, when collectively we can see that the PSIIs concern dominantly middle-aged males who died via suicide. If we compare this to the analysis made last year by the Trust CMO (BoD paper March 2024), the demographic is similar, but the number is reduced.

Additional to the 'person' and demographic factors, we have seen learning, in a larger number of the cases that requires multi-organisational change. These changes have ranged from policy to clinical pathway changes, and where these findings have been highlighted, multi-organisational meetings have been held to collectively own and collectively agree and advance actions.

There are three other areas which have been mentioned in more than two PSII's, involves working with carers and two areas which are key to the work of the High-Quality Therapeutic Care (HQTC) taskforce which concern enhanced home treatment services and ward environmental support. The work with carers is a focus objective in the transformed nursing and facilities directorate and has focus through the launch of the Trust carers network and closer working with carer partner organisation.

Finally, the learning and actions regarding some of the cases outlined above relates to training (i.e. medications management), the Trust 'LEARN half days' provide time and opportunity for this. The pharmacy department have put a set of medications management processes and care planning.

4. There are 9 key themes within the 18 PSII that call out the significant issues

1. Communication both internally and externally.
2. Our standards of record keeping falling below the required standard.
3. That our care plans were not in these instances personalised and did not reflect the person's needs.

4. It certainly felt significant to the author, that we did not hear our family and carers, when we did, that did not always translate into the care we should have delivered. Certainly, it was not recorded as it should have been as relating to (2).
5. We let down the people who were waiting to see mental health services and in at least one of our A&E's.
6. Our work with people who disengage with our service needs a cultural shift and the policy change has been a starter for this.
7. Our risk assessments need to be better at formulating the contextual risk and aligning that with other personal factors and stressors such as physical health deterioration.
8. Our physical health offer and intervention must improve for people experiencing an acute relapse of their mental health.
9. Our support to people who are in crisis, whether in the community or in seclusion needs to be timely, multi professionally led and always consistently applied. Communication and their rights must be shared with the person we are caring for, irrespective of gender, race, religion or where they are located.

5. <u>Process Learning</u>

What this means at RDaSH. The delays in the PSIRF processes, means learning has not been progressed or not fully shared or embedded in a timely manner. The revision of the PSIRF approach and policy (detailed in the CEO paper for this Board of Directors), combined with the restructure of the Nursing and facilities directorate – enabling a business partner model for each care group that supports investigation pace, will both help to support timely learning.

This will mean that the new 50 day standard that has been put in place will enable faster learning and also audits and safety processes to ensure that actions are put in place and measures of success are realised.

6. <u>Speciality Learning</u>

What this means at RDaSH. All of the incidents listed above are in adult services, predominantly focussed upon mental health care. This is not representative of all of the services in RDaSH as we also provide a substantial number of physical health services, children's health and mental health services and learning disability services as well.

Despite this speciality focus, due to the nature of some of the learning (i.e. record keeping, VTE assessment and carers engagement) the sharing of this learning and across service action is important. The Learning event scheduled as part of the sub-CLE Education and Learning group will focus on this within the forward plan for 2026-27 in partnership with the Nursing and Facilities service.

7. ‘Learning Points’ and ‘Markers of Success’ from each PSII

PSII		Learning identified
Ref:-2024/4279	Male patient aged 28 years diagnosed with testicular cancer in 2023 and admitted to Swallownest court in October 2023. Patient died unexpectedly whilst an inpatient. The Trust was notified that the direct cause of death was bronchopneumonia with Cardiomyopathy a contributory factor but not directly causative.	Learning: • At the time of the incident staff did not fully adhere to Trust’s physical observation policy - physically checking patients at a minimum of hourly intervals by a staff member, unless an individualised care plan states it is not therapeutic to do so. • The Trust recognised that its prescribing of clonazepam has increased, specifically in Rotherham Care Group. • The lack of robust and holistic care for patients with complex comorbidities between physical health and mental health providers is acknowledged within this investigation. This is all our responsibility to address locally, with the participation of other agencies. • In this case there were issues identified in regard to pre-discharge liaison and support planning. Actions: • Clear information on the function of Oxevision, has been circulated to all inpatient ward staff. • The Trust is moving to the new Oxe-academy online training for the use of Oxevision. This is a certified course, and compliance will be mandatory for those required to use it. Compliance will be monitored with the support of the learning and development team. The use of Oxevision has been reviewed as part of the Trust’s supportive observations policy and in line with the national review of Oxevision. • All inpatient leadership teams receive a monthly report of the Oxevision usage. This is to aid the identification of any increased use or reliance on the system. • The Trust is implementing a monthly audit that will monitor staff compliance with supervision and training around Oxevision. The audit will be completed, and data circulated to ward leadership teams, Care Group leadership teams and Nursing and Facilities for corporate oversight. • The Trust has scoped processes utilised in other Trusts to support a review of standard operating procedure for Oxevision. The Standard Operating Procedure (SOP) has been presented at the National Director of Nurses forum in Q3 2024 and subsequently approved. • Additional training around clonazepam has been provided to medical staff to highlight the dose equivalence and to consider switches to other medications such as diazepam when withdrawing this medication to allow for more gradual reductions. • The findings of this investigation have been shared with our Integrated Care Board (ICB) and importantly with our physical health trusts and patient safety teams. This has provided an

PSII		Learning identified
		opportunity for joint learning, and an intention to develop shared protocols and improve communication relating to potential biases, to what is diagnostic overshadowing. • A meeting between RDaSH, Rotherham District General Hospital, Sheffield Teaching Hospitals and ICB clinical leads took place in Q1 25-26. The outcome of this was that TRFT have undertaken their own PSII in relation to attendances at ED and their discharge/transfer process. • All inpatient areas are to conduct audits that ensure appropriate and individualised physical health care plans are in place, and these are to be reviewed as a minimum weekly as part of the Multi-Disciplinary Team meeting and patient reviews. • The Physical Health Care Group are piloting training regarding identifying a deteriorating patient with the Rotherham acute inpatient wards. • Patient flow and community team processes reviewed and improved to highlight and recognise the importance of pre-discharge planning. <u>Measure of success</u>: • Monthly audit will show that SOP is adhered to at all times in order to best support patients. • Reduction in the use of Clonazepam, measured via prescribing audit and stock use. • Since this incident, Clonazepam use in Rotherham inpatients has significantly reduced. At a ward level, Kingfisher has had no supplies between July to November 2024 and for Sandpiper there has been prescribing, however it is in general decline. *Reported by Chief Pharmacist, 3 January 2025. • Patients have coproduced individualised physical health care plans in place 100% of the time. • A joint protocol is being developed and progressed between the acute Trusts and RDaSH. • When a patient is out of area and a Community Treatment Order (CTO) is considered necessary, repatriation to an RDaSH inpatient ward is undertaken, to enable the local team to reconnect with the patient pre discharge.
Ref:-2024/4896	Male patient aged 30 years, previously had no contact with crisis team or secondary mental health services. Patient was found deceased on 18 February by ligature.	<u>Learning:</u> • This review demonstrated that it is important for service users to be heard and listened to. That service provide information and explanations of how people can access services and prioritise their recovery. The Crisis Practitioner spent time explaining to the patient the various options available to him to access services that were geared towards promoting his recovery.

PSII		Learning identified
		Action: • To ensure signposting, additional support, direct points of contact are clear within a personalised care plan, at the initial stages from first contact and assessment. Measure of success: • Implementation of promise 16 and personalised care planning. • Patient Feedback regarding clinician engagement and support.
Ref:-2024/5228	Female patient ages 41 years, recent diagnosed with ADHD and discharge from the perinatal mental health team. Patient suffered with severe adverse effects of steroidal treatment. Patient found deceased following a jump from height.	Learning: • Patient demonstrated forward planning until the time of her death. Actively seeking out support to address the distress she was experiencing; this indicating that she experienced a crisis that then diminished her ability to see a way forward. • Contributory factors **-** Patient was suffering from chronic eczema and was prescribed steroidal medication, to which she believed was having an adverse reaction. She presented with physical symptoms that were having a significant impact on her daily life and her ability to care for her two children. The level of distress associated with these symptoms are likely to have contributed to an escalation of crisis alongside life stressors in terms of returning to work after a significant absence and commencing new treatment for a recent diagnosis of ADHD. Action: • Physical health checks and mental health receive equal exploration, to ensure we as a PLACE eradicate diagnostic overshadowing. • Communication between service providers. Measure of success: • Service responsiveness and multi-agency working is in place all patients who require this. • Oliver McGowan training – emphasis on diagnostic overshadowing also present in LD.
Ref:-2024/5229	Female patient aged 36 years, had a history of alcohol and drug misuse and was involved with ROADS. Patient had minimal contact with RDaSH mental health services. Patient had multiple physical health	Learning: • Patient engaged with various supportive organisations to address her alcohol dependency; however, she appeared to struggle to maintain abstinence. She had multiple physical health issues as an underlying complication of alcohol misuse.

PSII		Learning identified
	conditions, including chronic liver disease and related diagnoses. Patient died of a suspected overdose.	• Patient was estranged from her children and had no other family contact which she personally aligned to her alcohol misuse. It is clear from the patient's records that personal health challenges substantially impacted on relationships. • Patient's contact with mental health services were limited to the crisis and hospital liaison services. These services were responsive to her needs and demonstrated good multi- agency working and communication however long-term interventions were affected by the patient's alcohol misuse. • No care or service delivery problems identified.
Ref:- 2024/ 7457	Female patient aged 69 years with a diagnosis of depression. On home leave from when she took a fatal overdose of prescribed medication. "***I can't live in this pain physical and mental anymore, voluntary euthanasia is my choice***"	<u>Learning:</u> • The patient was prescribed medicines for multiple physical and mental health difficulties, which were dispensed on a four-weekly prescription from the GP. There was no indication for the GP to not prescribe medicines four weekly, which is common practice in primary care. • The patient is the only person who has oversight in primary care of what prescription are ordered from the GP and dispensed by a local pharmacy. FACE risk assessment documents were completed in line with local policy and pre leave assessments did occur before leave. • However, support advice and planning pre leave form the ward were not discussed with the patient and their relative. • The quality of care planning, MDT documentation and risk assessment with CRHT fell short of the service expectations. <u>Action:</u> • A rapid improvement process put in place to address care planning, MDT documentation and risk assessment quality. • The introduction of a standardised process to ensure that patient's families and carers are involved in the planning of care including leave arrangements. • *Noted issue as part of PSII - Review the process of repairs and improvement to the ward environment to ensure that work is completed in a timely way. <u>Measures of success:</u> • Families must always involved in leave planning arrangements. • Trust standards for record keeping are adhered to. • Repairs are completed in a timely manner, overseen in the Finance and Estates department.

PSII		Learning identified
Ref:-2024/8656	PSII undertaken to identify learning and safety actions, following a review of the patient journey for an individual (male aged 49 years) who was admitted to PICU, required seclusion and was transferred to a seclusion in another locality within RDaSH and was later transferred to an out of area placement.	<u>Learning:</u> • It was anticipated at the point of admission that a seclusion facility was required. No facility was available on PICU in the trust. • Transfer of the patient to RDaSH PICU (without seclusion available) meant that the patient did not wait in the Emergency Department (ED) whilst a private provision was located. • When PICU seclusion facilities are not available for patients and therefore low secure facilities can be inappropriately used. • When a patient from another ward is in seclusion, the member of staff observing them does so for long periods of time, as the ability to rotate staff members can be limited. • Seclusion reviews are not always well communicated to the patient, there are at times low level of planning as to roles within the review and contingencies in the event of agitation or distress. • Threats of violence likely contributed to a hesitancy in engaging with the patient to explore complaints of chest pain and to progress transfer from seclusion to secure transport. • The patient had been in four locations, transported three times and had contact with two clinical team, two transport teams and the police within 24 hours. • The training RDaSH staff receive on physical intervention with a patient is different to that of secure transport. There was not a cohesive plan between RDaSH staff and the secure transport staff on how to move the patent out of seclusion and into the secure transport. There is no shared training or protocols between RDaSH and secure transport services. <u>Action:</u> • The learning is to be shared within the HQTC as a significant focus to; average LoS, bed capacity/availability, PICU standards of care, always measures in the Quality & Safety plan and the use of S140. • RRI training team to ensure training identifies lead for transfer when restraint is required – this will be reflected in our policy and follow BILD standards. • CMO to ensure seclusion policy and clinical practice encompasses the patient being at the centre of outstanding care and care planning. • Physical health checks and the importance to ensure diagnostic overshadowing is not a precursor to absences in care delivery. <u>Measures of success</u> • Good communication with patients about seclusion processes. Assessed through patient feedback and incident debrief.

PSII		Learning identified
		• Reduced patient transfers, to reduce distress at an already strained time. Evidenced through patient flow data. • Consistent physical interventions to be provided by all agencies, that enable proactive exploration of physical health symptoms.
Ref:-2024/8654	Male patient aged 51 years left DRI whilst awaiting a mental health bed. After a police search, information was received that the patient had been found deceased due to ligation. Joint investigation undertaken with Doncaster and Bassetlaw teaching hospitals and the city of Doncaster council.	<u>Learning:</u> • Record keeping was not at a level expected in regard to patient and carer/family interaction. <u>Action:</u> • Peer review to capture family engagement as part of the domains for observation and feedback • Learning half day to provide importance of the family/carer voice in personalised care planning/risk assessment. • Record keeping standards training. • Matron audit of record keeping in relation to family/carers. <u>Measures of success:</u> • All interaction with patients, family and feedback to staff by MHHLT is documented in the patient's clinical record to capture good practice and is in line with RDaSH record keeping policy.
Ref:-2024/9559	Male patient aged 53 years requested an arm wrestle with staff as a non-approved practiced distraction technique he had utilised previously. Patient sustained a fracture.	<u>Learning:</u> • The PSII report highlighted the need for positive behavioural support plans to be formulated to support patients with challenging behaviour. • The report notes that the formulation of care plans to reflect physical and mental health needs need ownership from the local care team and will require support from physical health directorate matrons. • The impact on the patient's behaviour of being unable to use nicotine in the same manner and amount once in hospital. Clinical staff to look at the wider multi professional team to explore creative options from a from a personalised and supportive viewpoint for NRT. • The RIDDOR process was not completed timely in this incident. <u>Actions</u> • The Health and Safety Lead will undertake a retrospective review to provide assurance that no other incidents that meet the RIDDOR reportable incidents have been overlooked.

PSII		Learning identified
		• A co-ordinated approach to undertake future investigations that require a PSII and HR and/or Safeguarding - revised PSIRF policy and governance processes. • RRI matron to lead with RRI training PBS training and de-escalation techniques. • Review of OT support to inpatient areas to be directed to the HQTC. <u>Measures of success</u> • All inpatient staff confident in the use of 'positive behavioural support' planning. • The use of positive behavioural support plans evident with all patients who would benefit from this. • Patients who smoke and vape to be supported also with proactive distraction interventions as well as substitution. • RIDDOR processes consistently followed. Evidence through audit.
Ref:-2024/9561	Male patient aged 46 years with a diagnosis of resistant depressive disorder. The identified possible triggers for his mental health deterioration were stress related, stemming from his MSc dissertation, his grief following the death of his grandmother and relationship stressors. Patient was under the home treatment team. Patient had been found by police having had ended his life by ligature.	<u>Learning:</u> • The PSII report highlighted the need the Home Treatment Teams to regularly review carer's needs, signpost to relevant agencies and document the outcome. • The role of the carer is an important aspect in promoting patient recovery and carers should be signposted to relevant agencies that provide this support. • The need for carer's support should also be regularly reviewed and outcome documented. <u>Action:</u> • (Community) Peer review to capture family engagement as part of the domains for observation and feedback. • Learning half day to provide importance of the family/carer voice in personalised care planning/risk assessment. • Record keeping standards training. • Matron audit of record keeping in relation to family/carers. • Carers assessment offered as an always measure in the Q&S plan. <u>Measures of success</u> • Positive carer feedback in terms of involvement and support. • Carer assessment in place and regularly reviewed (enabled by audit).

PSII		Learning identified
Ref:-2024/9565	Male patient aged 59 years known to crisis and home treatment, died by suspected suicide.	Learning: • The crisis service needs to review doctor's cover during annual leave for MDT meeting. • Crisis team must action, and document attempts to carry out all follow up plans. • Community mental health services are meeting January 2025 for an extraordinary meeting to discuss triage pathways and consistency on decision making for referrals in all teams. Action: • Review the process for discussing cases when the usual doctors are not on duty around. • All MDTs and professional discussions to be documented and regular audits undertaken to ensure this happens. • A meeting undertaken with Community mental health services to discuss triage pathways and consistency on decision making for referrals in all teams. Measures of success: • All agencies involved in the care journey clear of their roles and responsibilities. • The patient and all agencies clear about actions and responsibilities when patient is discharged or transferred across agencies.
Ref:-2024/9566	Male patient aged 47 years. Had a recent breakdown in relationship. Contact with Aspire. Recent contact with crisis team and referral to the primary care mental health hub.	Learning: • The PSII report demonstrated good partnership working between Yorkshire Ambulance Service and the crisis team. Action: • The positive learning needs to be reflected in all our teams to ensure handoffs do not lead to poor care pathways and increase risk to patients. Measure of success: • Eradicate unwarranted clinical or procedural variation and have one way that is consistent through teams – community transformation, Promise 16 and HQTC are conduits for action.
Ref:-2025/473	Male patient aged 61 years. Referred to the community mental health team on a number of occasions and multiple contacts with the crisis team, had a period of support from the home	Learning: • In response to managing high demand for the service, the practice of paper triage was in place within the CMHT, which resulted in the patient not being spoken to on each occasion he was referred to the CMHT.

PSII		Learning identified
	treatment team, person died by suicide – ligature.	• The patient was not always aware if he was being offered an assessment by the CMHT, which likely resulted in him feeling frustrated and lacking in trust of services. • The use of the template letter within the CMHT meant that communication with the patient's GP was not bespoke to his referral and did not give context or details regarding the reason for the referral being declined. • The information collected at assessment was relevant and appropriate. There was evidence of enquiry into the patient's suicidal thoughts at each visit by the home treatment team. • The FACE risk assessment document was not updated in line with local guidance. The timescale and frequency of updating the FACE risk profile is not included in the trust clinical risk management policy or the home treatment team local working instructions. • The local policy for disengagement available to clinicians on the trust intranet was not within the stated date of review. <u>Action:</u> • Following this incident, the process of "paper triage" has been removed by the service. • Work to make communication with patient trauma informed is underway within CMHTs. • Service improvement work is underway within the CMHT to manage capacity and demand and improve the service delivered by the CMHT. • The clinical risk management policy and local working instructions for the home treatment team is under review to be aligned to give guidance to clinicians of when to update formal risk assessments. • The Trust disengagement policy is under review, led by the CMO. <u>Measures for success:</u> • Patients always able to speak to CMHT when contact is made – within the CMHT working hours. Outside of this time there is access to the crisis team or related place-based services (i.e. safe space). • Patients will always have coproduced and up to date risk assessments. • Trust disengagement policy reviewed and adhered to.

PSII		Learning identified
Ref:- **2025/ 474**	Female patient aged 54 years with a longstanding history of depression and anxiety with psychosis. She had several admissions to acute mental health units. Following assessment, under section 136 she was found not to be detainable. She had engaged well in the assessment and was discharged to her home to be followed up by her CMHT. Patient took an overdose the next day and was admitted to hospital and later passed away.	Learning: • There was not a clear entry on the patient's notes from the assessment carried by the section 12 Doctor with the patient when she was seen in the Place of safety. This meant that the outcome of the assessment could not be clearly checked in relation to outcome and follow up required. • There was a discrepancy in the outcome of the assessment carried out in the place of safety, it was initially recorded that the outcome was for the patient to be sent home and followed up by home treatment, home treatment had not received any referral. When checked it was clarified that the outcome was for the patient to be sent home and followed up by the CMHT. When this was looked into it emerged that a draft AMHP report had been uploaded to the system which contained historical information and not the most recent assessment outcome. The CMHT picked up on this quickly and took proactive action. Action: • All assessments need to be clearly documented on patient record to ensure appropriate intervention and follow is provided to patients. • Social Care services agreed to ensure that AMHP's do not upload draft reports, on to the clinical system. Measure of success: • Reports are up to date and accessible by the whole care team. Evidenced by notes audit. • Assessments clearly documented and up to date.
Ref:- **2025/ 1065**	Male patient aged 68 years with a long-standing history of mental health problems dating back to 2011. He had several admissions into acute mental health units. Following a significant paracetamol overdose of approximately he was assessed by the mental health hospital liaison team. Ending his life by ligature shortly after discharge from TRFT..	Learning: • The patient was seen post discharge from TRFT with an expedited visit and assessment with NoK, family present, there was no predictor for this outcome noted in that assessment by the visiting team. • The agenda for the South CMHT meeting needed clarity over establishing tasks on the EPR. The meeting is chaired by the staff member on duty. • The wider service and Senior Leadership Team acknowledged there was a lack of process that contributed to the depot in November 2024 being missed – this was significant as patient referred to this as a reason for MH decline. Action: • Depot medication schedule/recall report produced at the start of each week which confirms all patients who are due for depot administration. The morning meeting then clarifies that all visits are covered.

PSII		Learning identified
		• Individual responsibility for setting recalls on SystmOne has been reiterated with a user guide sent out. • Further training depot medications. This training will focus on depot administration, the different types of depots and the anticipated responses if depots are late or missed. • A directorate/service review has taken place - leadership structure cover both North and South Locality Team for consistency. • There is a dedicated Clinical Lead for Psychosis and Bipolar Disorder which is new for Rotherham Care Group and will place additional focus on developing this patient pathway. <u>Measure of success:</u> • Depots administered in the time period prescribed for all patients, without error. • Focus of pharmacy audit and sustained depot errors in the community.
Ref:- 2025/ 1066	Female 85 years died following a cardiac arrest. Supported since 2018 by OPMHT.	<u>Learning:</u> • VTE assessment completed, however prophylaxis not prescribed and administered in the optimal timeframe. <u>Actions:</u> Ensure processes are in place to oversee the compliance of both the assessment for VTE prophylaxis, and initiation of appropriate VTE prophylaxis for patients in line with NICE guidelines. The Trust currently has assurance regarding completion of VTE assessments but needs assurance that appropriate action has been taken. • When a non-medical Approved Clinician is the Responsible clinician there are no clear guidelines in the Trust regarding oversight of the medical aspects to provide a timely and appropriate review of the patient's physical health assessment by a designated Consultant Psychiatrist. <u>Measure of Success:</u> • All patients will have a VTE assessment on admission. Monitored via the reportal and IQPR. • For patients assessed as requiring prophylaxis, this will be administer in the required timeframe. Indicated through medication audit.
	Male patient aged 41 years died by suspected suicide- ligature.	<u>Clinical Issues – Learning</u> • The electronic patient records were at times not at the standard expected, having errors or poorly written and lack of formulation. • Face to face appointment were not prioritised.

PSII		Learning identified
Ref:-2025/1496		Action • There is a current improvement plan in place for the Crisis Team that includes both record keeping and also prioritising the offer of face to face appointments when a patient is presenting as high risk. Measure of success • All patients presenting with high risk will be provided with a face to face appointment when they require this. Monitored by clinical and managerial leads. • Records will detail all care factors as per policy. Monitored via records audit.
Ref:-2025/1494	Male patient aged 40 years died by ligature.	Learning: • The teams involved from a North Lincolnshire community perspective (RDaSH & North Lincs Council) have consistently tried to work with the patient over many years, in the least restrictive way, so that he would accept some level of support. • The patient's preference was to be admitted into hospital, rather than to take long term antipsychotic medication. Between 2017 – 2025, he was subject to 23 MHA assessments and during this time the level of risk to others and himself increased, including staff when admitted as an inpatient. • The last discharge was the first time he was subject to a community treatment order, that under the MHA required he comply with medication. Action: • As a Trust, we have a focus through Promise 19 of the RDaSH clinical and organisational strategy 2023 to 2028, to end out of area placements during 2024, supporting people to be cared for as close to home as possible. This is primarily on those patients who are deemed "inappropriately" placed OOA, as those deemed appropriate, or need specialist provision, may still need external placements. • This work promise is part of Strategic Promise 4, with a focus on high quality and therapeutic bed base, so not just a focus on flow but the whole inpatient improvement experience, which is now under way, through our High-Quality Inpatient Task Force • Clinically ready for discharge (CRFD) numbers vary, though impact on out of area patients, if we cannot discharge. The chief operating officer established the complex clinically ready for discharge monthly meeting, 6 months ago, with ICB and senior Local Authority Leads to address any

PSII		Learning identified
		significant discharge delays. This is focused on the most complex patients and local CRFD systems in Care Groups have escalation process to resolve delays. • The Nursing and Facilities team are to review the April 2025 NHSE guidance 'staying safe from suicide' and the recommended change from risk stratification, to assessing risk collaboratively, understanding changeable safety factors, and co-produce safety plans. <u>Measures of success:</u> • When a patient is out of area and a CTO is considered necessary, repatriation to an RDaSH inpatient ward will be undertaken. • All community teams are trained and receive refresher training in the CTO process.
Ref:- 2025/ 1500	Male patient aged 45 years died following an overdose.	<u>Learning:</u> • The PSII report highlighted the need for clarity of roles & responsibility when a patient is in an A&E department, and leaves before assessment by the MHLT. <u>Action:</u> • A joint protocol for patients who leave A&E before being seen by MHHLT is required. The service has actioned this and a process is in place to monitor. <u>Measures of success</u> • When a patient leaves A&E before being assessed by RDaSH services a process is followed which includes a timely safety check and follow up.

Appendix 1.

Care Group	Directorate	No. of incidents by actual impact						No. of Mortality forms	No. PSIIs
		0 - Near Miss	1 - No Harm	2 - Minor (Minimal Harm)	3 - Moderate (Not Permanent Harm)	4 - Major (Not Permanent Harm)	5 - Catastrophic (Permanent Harm)		
Children's Care Group	Children's Mental Health	45	142	47	10	2	1	0	0
	Children's Physical Health	106	250	92	23	6	0	0	0
Doncaster AMH And Learning Disabilities Care Group	Acute (Mental Health)	141	858	339	35	5	1	9	6
	Community (Mental Health)	112	233	78	17	2	1	181	0
	Learning Disabilities	29	192	95	11	3	0	26	0
North Lincs AMH And Talking Therapies Care Group	Acute (Mental Health)	121	652	173	17	4	1	9	2
	Community (Mental Health)	54	105	40	8	3	1	104	1
	Talking Therapies	36	106	26	19	4	0	3	0
Physical Health and Nuerodiversity Care Group	Adult Neurodiversity (Trustwid	7	21	15	2	0	0	4	0
	Community And Long-Term Condit	184	621	2414	194	62	0	182	0
	Rehabilitation	178	605	356	34	6	0	9	0
Rotherham AMH Care Group	Acute (Mental Health)	206	802	429	29	2	0	28	7
	Community (Mental Health)	59	147	74	12	7	3	106	2

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Readiness: Well-Led	**Agenda Item**	Paper Q
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 May 2025

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

This paper updates the position, first presented in November 2024. There has been a continued collation of evidence in support of the stated position and this second assessment represents a marginal improvement from the initial assessment (one quality statement) recognising the concerted work with our leaders, most notably the LDO launch, and our staff, most notably the new induction. External partners such as internal audit and Good Governance Improvement have provided related feedback and assurances. Internally many workstreams have progressed and work in 25/26 on Think Directorate (and the related directorate maturity matrix) will also provide additional evidence.

There continues to be the intention to engage more widely e.g. with the Clinical Leadership Executive (CLE) and to reference any relevant insight via Internal and External Audit. Later in the financial year, we will welcome an external partner to undertake a Well-led review. A further update to the Board of Directors will be made in Nov 25.

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

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

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

Board of Directors (Nov 24) - first self-assessment

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

The Board of Directors is asked to:

X	**RECEIVE** and **NOTE** the update and status report in respect of the Well-Led key question.
X	**COMMENT** on the status currently assigned of each of the eight quality statements and with specific reference to the examples of key sources of evidence.
X	**NOTE** the next steps and planned reporting schedule.

Impact

Trust Risk Register		All					
Strategic Delivery Risks		N/A					
System / Place impact		Reputation, Partnership, Workforce					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	Relevant to subject but not this paper
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Appendix 1. CQC assessment framework key questions and quality statements – examples of the key evidence and potential gaps.
Appendix 2. Good Governance Improvement (GGI) Report – April 2025.

Rotherham Doncaster and South Humber NHS Foundation Trust
CQC Readiness - Well Led

1. Introduction

1.1 This paper is the third in a series of papers that focuses on the Well-Led key question, a part of the overall CQC's single assessment framework. Previous papers were presented to the Board in May and November 2024. It is also complementary to the papers on todays' agenda that focus on other CQC key questions – specifically paper M regarding Safe, Effective, Caring and Responsive key questions. Taken together the Board of Directors can continue to appreciate the interdependency across the other key questions, with them each in their own right also considering well-led related matters.

1.2 The Board will recall the work in the previous year from Good Governance Improvement (GGI). Colleagues from GGI returned to the Trust in 2024/25 Q4 and completed a follow up review. The predominantly positive output from that work is reflected in the content of this paper and their report is appended at Appendix 2.

2. Well Led Framework Assessment

2.1 The Trust developed an assessment framework using CQC guidance and scoring methodology and gathered information from diverse sources to provide a basis for the initial self-assessment in November 2024.

2.2 Supporting the assessment is a detailed 'vault' of evidence that demonstrates compliance with regulatory standards and allows for the triangulation of information from all relevant sources and purposefully to include a range of types of evidence. The design of the vault aligns to the requirements set out by the CQC itself, within such as "*CQC Guidance for NHS Trusts and Foundation Trust: Assessing the well-led key Question*" – and to the eight key statements and their respective 42 supporting statements.

2.3 The table below summarises and presents the outcome of the initial assessment (Nov 24) and the latest position (May 25), providing a 'rating' for each area that is based on the evidence identified to date when compared to the expectations outlined by the CQC. For each question there are four levels of assessment indicated in the key below the table.

Quality Statement	**Assessment**	
	Nov 2024	**May 25**
Shared Direction and Culture		
Capable, compassionate and inclusive leaders		↑
Freedom to Speak Up		
Workforce Equality, Diversity and Inclusion		
Governance, Management and Sustainability		
Partnerships and Communities		
Learning, Improvement and Innovation		
Environmental Sustainability – Sustainable Development		

Evidence shows significant shortfalls
Evidence shows some shortfalls
Evidence shows a good standard
Evidence shows an exceptional standard

2.4 Within the table above, one area has improved – reflective of the investment in our leadership in the period since the initial assessment. Whilst remaining in 'green' the Governance and Partnership quality statements are stronger for the work undertaken, potentially moving closer to the 'blue' status; the remaining areas are consistent with the initial assessment albeit there has been progress in each but further work, as set out in Appendix 1, is required in each area.

2.5 Appendix 1 provides additional information in support of the latest assessment including the additional 42 supporting statements (and their individual respective assessment 'rating').

2.6 The initial and latest assessments were undertaken approximately six months apart. During this time, there have been multiple areas of progress, pertinent to the Well-led Framework and in particular the following are highlighted given their individual and collective impact:

- LDO launch – Both cohorts have commenced (150 people including community partners) – early modules include Active Bystander and Community Immersion
- Staff Induction – 400+ new appointees attended the revised 5-day induction enabling greater understanding of the strategy, promises and communities; to meet colleagues including the Board and senior leaders; to undertake local induction and mandatory training.
- Internal Audit Reviews – Strategic Delivery Risk; Promises 3, 4 and 5; Partnership Governance and Risk Management; Strategic Risk Management; Fit and Proper Person Tests; MAST .
- Care Opinion – launched as main focal point of feedback; increasing number of feedback provided (1000+ stories) and responded to by our teams with some leading to change.
- Staff Survey – maintaining a 7+ score for engagement and some progress but with a decrease in scores across each people promise theme, further work to be done to improve scores linked to compassionate leaders and inclusion.
- Good Governance Improvement (GGI) report – continued positive reflections on the operating model from Board, its Committees, CLE and its Groups – most notably the inclusion of patient and community voices in those meetings (Promise 5).
- Plans – continued development of the supporting plans with three on today's agenda for approval to add to the Education and Learning one already approved.

2.7 In addition, emerging work led by the Chief Operating Officer, with colleagues in the five Care Groups utilising a maturity matrix approach has also provided relevant evidence in support of aspects of the Well-led Framework. This matrix is used to plot progress and areas for development linked to leadership; people management; finance; performance and delivery; strategy and promises; quality, safety and risk; and system collaboration. There is obvious crossover and relevance to the Well-Led quality statements within the matrix. Within the initial assessment in November 2024, it was noted that it was very much based on a high level, Board focused response. This maturity matrix together with parallel work on 'Think Directorate' will provide a strong basis for assessing our Well-led readiness at a different level and afford the Board of Directors the confidence that leaders are active and engaged throughout the Trust. This will be a key focus of the next stage of development in the Well-led work in the next six months.

3. Continuing our assessment

3.1 Any well-led organisation will need to demonstrate leadership across and throughout the whole organisation - this principle must be prevalent through all trust services**.** The assessment will continue to develop particularly in this regard with more engagement from a broader cohort of colleagues in our 23 directorates.

3.2 This continues to represent a positive assessment which will be further added to in the coming months as the assessment receives further input from the Board, EG and CLE and as planned work progresses. We continue to identify further evidence sources and will log and update the vault accordingly.

3.3 Within the Appendix and for each quality statement there are examples of the key pieces of evidence that support the assessment. It also identifies examples of the potential gaps and therefore areas of focus in the coming period that will need to be addressed. These are not the entirety of the evidence available, but included to provide supporting information to the assessments.

3.4 In making the assessment we need to consider not just the quantity of evidence but the type – we should include evidence to support processes, feedback, links to strategy, culture and values. This ensures a rounded set of evidence is in place. Embedding a mechanism of sharing information: This will be done to ensure that all evidence, learning, best practices and legislation are being acted upon and recorded across all five key questions with precision to enable the vault and the resultant assessment to be maintained.

3.5 We will continue to engage with partners on related work that will contribute and be reflected within the next iteration of the assessment. These partners will include; 360 Assurance as report on their 2024/25 internal Audit plan, present their Head of Internal Audit Opinion at the year-end and deliver their H1 audits of the 25/26 Internal Audit Plan; Deloitte, our external auditors as they too report on their respective audit and value for money work in the coming two months.

3.6 Other related work such as our assessment of compliance with the Code of Governance, our reflections on CQC inspections at peer organisations, feedback from our stakeholders, and our work in respect of CQC readiness focusing on the other four key statements – will all play an important role in the strength of the assessment in respect of the Well-led key question. As will any specific and related feedback from the CQC based on their work at the Trust in May 2025.

3.7 The outputs referred to above will be appropriately referenced in the evidence vault and considered in future assessments.

3.8 Foundation Trust's are strongly encouraged (in the Code of Governance) to "*Carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years"* The Trust previously commissioned a review by the Office of Modern Governance in 2022 and whilst not a formal Well-led review, also engaged Good Governance Improvement in 2024 on related matters. To ensure we respond to the Code of Governance expectation and to provide us with an independent view on our more recent work, during Q4 2025/26, we will commission a formal, externally facilitated Well-led review.

3.9 Further reflections by the Board: It is important that the Board continues to remain sighted on the position and on the further work necessary. A further paper will be scheduled to come to the Board in November 2025.

4. Recommendations to the Board

RECEIVE and NOTE the update and status report in respect of the Well-Led key question.

COMMENT on the status currently assigned of each of the eight quality statements and with specific reference to the stated sources of evidence.

NOTE the next steps and planned reporting schedule.

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

Quality Statement	Quality statement criteria	Current	Previous	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Shared direction and culture: We have a shared vision, strategy and culture that is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding and meeting the needs of people and our communities.	Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.			Inclusion of Governors within Committees and patient representatives in CLE Groups – Feedback via GGI Revisit Report Staff Networks inc new Carers network Fit and proper person's test (Internal Audit review – revised opinion significant assurance) Strategic Delivery Risk management (internal audit review – significant assurance) Leadership Development Offer (LDO) – both cohorts now launched. Includes Community immersion. Cohorts include partner representatives. First Line Managers training launched Clinical and Organisational Strategy 23-28 – Development process and engagement/distribution. Partnerships with 3rd sector organisations. Development of roles with Strategic Development Directorate Governance framework – reporting Board to Ward. - PHPIP Committee - Promises aligned to CLE groups. QSIR Programme	Leadership development offer (Implementation / Maturity) Risk management framework (Maturity) Peer review – Outcomes / Actions / Impact Stakeholder feedback - demographic information being collected / analysed. Measurement of social impact. PSIRF (Embed) – Internal Audit to review in H1 25/26 First line manager training – (Maturity)
	Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.				
	Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement.				
	Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care.				
	Equality and diversity are actively promoted, and the causes of any workforce inequality are identified, and action is taken to address these.				

	Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plan			IQPR QS29 – Racist incidents reported against staff. Robust training / OD offer in relation to Culture and Equality and Diversity Revised 5-day Induction	

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Capable, compassionate and inclusive leaders: We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead	Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered, and risks are well managed.			Leadership Development Offer (LDO) – both cohorts now launched. Revised Induction and sessions pointed towards our communities. Dedicated Half day learning (Embed, Maturity) – to be mandated PSIRF – progress on implementation Trust People Council Training needs assessments. FTSU , 3 C's, OD offer. Introduction of Matron roles. Peer review timetable. Board visits programme.	PSIRF (Embed) – Internal Audit to review in H1 25/26 Shadow CLE (Q2 25/26) Leadership development offer (continue to deliver the programme through 2025/26) Succession planning / talent management (Maturity) Delivery Review 'League tables' (Implementation / Maturity) Pulse survey Job Planning
	Leaders at every level are visible and lead by example, modelling inclusive behaviours.				
	High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning.				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

effectively and do so with integrity, openness and honesty.	Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role.			Sexual safety charter. IQPR Safe recruitment – values based, fit and proper persons test. Code of Governance compliance	
	Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly.				

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Freedom to speak up: We foster a positive culture where people feel that they can speak up and that their voice will be heard.	Staff and leaders act with openness, honesty and transparency.			Care Opinion Quality Account 2024/25 Staff Survey (57% response) +7 in engagement score; Decrease in scores across each people promise theme Training and Awareness offer – Induction programme (Inc. Medics) FTSU Guardian (Peer reviews, listening circles, Oversight / support of FTSU Guardian at Exec level. FTSU Reporting to QC and Board Complaints / Duty of Candour	Embedding / Maturity of 'detriment' procedures. Staff survey – action re discrimination and appraisals; plus identified 'true aims' to achieve to 2028 Promotion / Awareness records (Comms) Outcomes / Impact Open staff meetings – recommence (Outcomes /Actions / Impact) Triangulation - Peer review process and other areas of 'speaking up'. Care Opinion to be utilised in every service; regular thematic analysis
	Staff and leaders actively promote staff empowerment to drive improvement.				
	They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard.				

	There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.				
	When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again				

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Workforce equality, diversity and inclusions: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.	Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion.			Staff networks inc new Carers Network Equity and Inclusion plan – presented for approval at the Board of Directors (May 2025) Reasonable adjustments – dedicated budgets available with intent to overspend Acceptable Behaviour Policy launched Leadership Development Offer (LDO) – both cohorts now launched. Includes Active Bystander. Gender and Ethnicity Pay Gap (December 2024) Staff Survey (57% response) +7 in engagement score; Decrease in scores across each people promise theme (areas of positivity diversity,	Equity and Inclusion plan (progress with implementation / Maturity) Acceptable behaviour policy (Audit of use underway) Staff survey – action re discrimination and appraisals; plus identified 'true aims' to achieve to 2028 Pulse survey relaunch. Leadership development offer (continue to deliver the programme through 2025/26) Social Impact Code of Governance compliance
	Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact.				
	Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all.				
	Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

	Act and those from excluded and marginalised groups.			discrimination but work needed in compassionate culture / leadership and inclusion.	
	Leaders make reasonable adjustments to support disabled staff to carry out their roles well.			Promise 26 – Board of Directors consideration	
	Leaders take active steps to ensure staff and leaders are representative of the population of people using the service.			Governance framework - reporting Board to Ward - E& I CLE group - WRES WDES reporting	
	Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation.			Robust training /development offer Global majority programme Health and Wellbeing offer Accreditations: Veterans, PICU standards, baby friendly	

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Governance management and sustainability: We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment	There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff.			GGI Revisit report – operating framework and community voices Data security reporting (DSPT review underway Q1 25/26) Code of Governance Compliance (in Annual Report 24/25) Safe recruitment - Fit and proper person's test (Internal Audit review – revised opinion significant assurance) PSIRF – progress on implementation	EPPR Compliance Policy on Policies (Implementation / Maturity) Risk management framework (Maturity) Delivery review 'league table' implementation Feedback from stakeholders including at Annual Members Meeting – July 2025
	The systems to manage current and future performance and risks to the quality of the service takes a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service.	⇧			

and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.	Data or notifications are consistently submitted to external organisations as required.			Strategic Delivery Risk management (internal audit review – significant assurance) Operational Risk Management improvements – risk identification, risk velocity, risk profile; training, RMG Risk Appetite Robust budget sign off process Revised Induction and sessions pointed towards our communities. MAST – Internal Audit (significant assurance) 'Think Directorate' more devolved, delegated and distributed leadership approach Governance (Operating) Framework IQPR Annual Report Research and Innovation CLE Accreditations - Veterans, PICU standards, Baby friendly,	PSIRF (Embed) – Internal Audit to review in H1 25/26 Information Quality Work Programme (Implementation / Maturity) Think Directorate – completion of work to enable all data and reporting by directorate; and hold to account mechanisms for directorates
	There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care.				
	Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities.				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

Quality Statement	Quality statement criteria	Current	Previous	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Partnerships and community: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.	Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies.			Care Opinion launched and implemented. Community reps within governance structure – CLE and its Groups GGI Revisit report – operating framework and community voices PSIRF – progress on implementation Leadership Development Offer (LDO) – both cohorts now launched. Includes Community immersion. Cohorts include partner representatives. Revised Induction and sessions pointed towards our communities. Primary Care Liaison role (since Nov 24) within Strategic Development Team P3, 4 and 5 – Internal Audit (significant assurance) Partnership Governance and Risk Management – Internal Audit (expect significant assurance) Staff Networks Provider collaboratives Virtual wards Peer support workers	Care Opinion (continue to embed, mature our use and extract and act on learning) PSIRF (Embed) – Internal Audit to review in H1 25/26 Leadership development offer (continue to deliver the programme through 2025/26) Relationship Managers (Embed / Maturity) Feedback from stakeholders including at Annual Members Meeting – July 2025 Social Impact data
	Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care.				
	Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people.				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

				Partnerships with 3rd sector organisations. Governance framework – reporting Board to Ward. - PHPIP Committee - Promises aligned to CLE groups. RNC Cadets Hospice Step Down Accreditations: Veterans, PICU standards, Baby friendly	

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Learning, improvement and innovation: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.	Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact.			Leadership Development Offer (LDO) – both cohorts now launched PSIRF – progress on implementation Quality and Safety Plan – presented for approval at the Board of Directors (May 2025) Approved Learning and Education plan Implementation of RADAR system to better facilitate reporting and learning Dedicated Half day learning (Embed, Maturity) – to be mandated Responses to R28 letters Diverse OD offer Research collaboration with service users.	PSIRF (Embed) – Internal Audit to review in H1 25/26 RADAR implementation and embeddedness – benefits realization. CLE and E&L Group considerations in June 25 on the learning model Quality and Safety plan (progress with implementation / Maturity) Leadership development offer (continue to deliver the programme through 2025/26) Approved Learning and Education plan (progress with implementation / Maturity) Research and innovation plan (Implement /Embed)
	Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives.				
	There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving.				
	Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives.				
	Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff.				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

	The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation.			Grounded research initiatives Governance framework - E & L CLE group Guardian of safe working Safe staffing NICE compliance Peer reviews	Change team (Embed / Maturity) QSIR programme (Embed / Impact) Pulse survey – embed Listening events - Restart 2025

Quality Statement	**Quality statement criteria**	**Current**	**Previous**	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
Environmental sustainability - sustainable development: We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.	Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population.			Equity and Inclusion plan – presented for approval at the Board of Directors (May 2025) Climate Adaptation Day Promises and Priorities Report to Board – Promise 27 Annual Report – inc enhanced task force on climate-related financial disclosures Virtual Ward Carpool offer Cycle to work scheme. Executive leadership Governance framework	Project Development / Future bids – e.g. Gas heating replacement Climate Adaptation Framework Self Assessment to complete Equity and Inclusion plan (progress with implementation / Maturity) Trajectory / Targets Place and system work. Health promotion i.e. Quit team.
	Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity.				
	Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others.				

APPENDIX 1 : ASSESSMENT – MAY 2025 (previous ratings from November 2024)

	Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible.			- Estate and sustainability group Change in working practices.	
	Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time.				

Strategy
Leadership
Governance

NHS
Rotherham Doncaster
and South Humber
NHS Foundation Trust

Rotherham Doncaster and South Humber NHS Foundation Trust

Governance Impact Review – Refresh

March 2025

About GGI

GGI exists to create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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Document name:	Governance impact report – refresh
Date:	March
Author/s:	Aidan Rave, Principal Consultant

This report has been prepared by GGI Development and Research LLP (GGI) for the board of Rotherham, Doncaster and South Humber NHS Foundation Trust. The report highlights the conclusions drawn from the evaluation programme and an outline of future suggested actions and improvements to address the identified shortcomings and strengthen the governance structure and processes.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist. This report is prepared solely for use by Rotherham, Doncaster and South Humber NHS Foundation Trust. Details may be made available to specified external agencies, including regulators and external auditors, but otherwise the report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

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Overview & Context

Between December 2023 and February 2024, GGI conducted a governance impact review of the (then) new structural arrangements which were in the process of being rolled out across the trust. GGI was asked to look at issues such as the effectiveness of the new operating arrangements, the chairing, leadership and impact of meetings, behaviors and focus, and the effectiveness of assurance and performance/operational systems within the operating model.

In April 2024, GGI produced a detailed report for the RDaSH board which set out three broad findings and seven specific recommendations for the consideration of the board. The three findings were:

I. Operational level meetings need to be more integrated with those at strategic and board level.
II. The meetings themselves should be clearer about purpose, conclusions and actions in order to be more effective.
III. Participation in and leadership of meetings must be extended to include more people than it currently does.

Based on these findings, we have made seven specific recommendations relating to the relative maturity of different aspects of the trust:

I. Get behind the change.
II. The conduct of meetings.
III. Balancing participation.
IV. Continue to increase the focus on service-users.
V. Managing the implications of the ongoing change.
VI. Refresh the BAF.
VII. The evolving system.

Recognising the timing of the initial review *apropos* the implementation of the new arrangements, the plan was to come back and conduct a lighter touch refresh of the initial review, based on the same framework and drawing on the findings and recommendations set out above.

Overview & Context (continued)

Perhaps unsurprisingly, a consistent theme throughout our discussions and observations last year was that of the still new arrangements being embedded in the the organisation and the consequent degree of maturity in how they were being implemented. It was clear in many cases that the new arrangements, whilst broadly welcomed by staff and NEDs across the structures, were still viewed as very new and unfamiliar, indeed it was because of the reticence we observed during the first review that we explicitly implored the organisation to ‘get behind the change’.

In the first review, we also commented on the prominent role of the chief executive and other executive directors in conducting the pace, tone and content of meetings. While we recognised the role of senior leaders in leading the organisation, we were also looking for evidence of others responding to the challenge and bringing forward their own thoughts and ideas as part of the effectiveness and assurance generated through the new arrangements. Again, this is a theme we were eager to return to during the refresh.

This is not intended to be a rerun of the first impact review. In the report that was produced after that review we set out a series of findings and recommendations which have informed this refresh, but not as a like for like comparison.

In summary, our focus through this refresh is the extent to which the new arrangements have been embedded in the organisation, the level of maturity with which discussions are held and decisions made and the sustainability of the arrangements going forwards.

Methodology

Evidence for the refresh programme has been gathered through two means:

1. A review of relevant documentation, principally administrative materials supplied for the meetings being observed.
2. A series of onsite and virtual meeting observations over the course of January and February, including:

The observations undertaken were as follows:

- Research & Innovation Group – 14/01/25 (online)
- Public Health and Neurodiversity Care Group – 20/01/25 (online)
- Clinical Leadership Executive - 21/01/25
- Public Health, Patient Involvement and Partnerships Committee 22/01/25 (online)
- Operational Management Group – 07/02/25 (online)

Our observations were focused on the tone and effectiveness of meetings, breadth of participation and the willingness and ability of participants to ‘swim outside their lane’ in terms of providing insight, challenge and value to matters beyond their immediate brief.

Review focus 1 – committing to the change

In April 2024 we said…

The new ways of working are embedded and here to stay. There is a clear recognition from the chief executive and board that not everything that went before was bad, but change was necessary and has happened. It is therefore critical that the leadership team in particular continue to associate themselves with – and be seen to associate themselves with – the new strategy and operating model. That doesn't mean there shouldn't be challenge and debate about how things can be improved, but the lingering sense of things reverting back to how they used to work should be dispelled.

The trust has gone through a considerable change – in terms of personnel, strategy and pace. Even those who were initially sceptical about the nature and pace of the changes accept that change was inevitable and those who championed it equally recognise that it is having an effect on the staff charged with delivering it. Continuing to support the well-being of those charged with the ongoing implementation and execution of the new operating arrangements is both consistent with the actions of a compassionate employer and a pragmatic way to protect the investment that is being made.

March 2025…

Through January and February 2025, we have observed a series of meetings that point to an organisation that is more committed to and comfortable with the changes that felt new and quite unfamiliar twelve months earlier.

How have we assessed this? Well, the agendas we saw were clearer and more purposeful than those we saw twelve months ago, the meetings (as referenced in subsequent slides) were more participative and conclusive and the general sense we get is of an organisation benefiting from an apparent process of steady maturity.

In less tangible terms, there was a greater sense of ease and confidence on display at the meetings we observed; an indication of an organisation more at ease with itself and what it is trying to achieve.

The foundations laid in 2024 have clearly been built on and suggest further progress can now be made through 2025 and beyond.

Review focus 2 – meeting effectiveness

In April 2024 we said…

The meetings we observed were conducted in a constructive and positive environment. However, to keep pace with the ambitions set out in the strategy and to meet the challenges of demand and capacity, there will need to be continuous improvements in the conduct of these meetings. We therefore recommend that a programme of improvements be implemented based on common principles across meetings, including:

- The inclusion of a brief but clearly articulated purpose for each meeting held.
- The inclusion of a strategic context – what does this meeting connect to and how does it contribute to the strategy and promises.
- Each meeting should produce clearer conclusions, actions and implications from their discussions – both explicitly through the notes and implicitly through the application of the 'so what?' principle by the chair and participants.

In addition, based on our observations, there is a need for greater maturity in terms of meeting participation. This will require a number of improvements:

- Attendees having a very clear knowledge of why they are at the meeting and what is expected of them.
- Attendees having the confidence to contribute beyond their brief and challenge more constructively and strategically.

There is also a specific challenge in relation to meetings chaired by the chief executive. In these meetings the natural charisma of the chair very much dictates the pace and tone of the meeting and while this is not a problem per se, for the purposes of contingency and continuity, it would be good to see other members of the leadership group playing a more prominent role in these meetings.

March 2025…

We have observed a significant and positive shift in the conduct and effectiveness of the meetings we observed as part of this review.

The benefits of an additional twelve months operating under the new arrangements are palpable. Meetings are more free-flowing, participants are more confident and contributions are coming from a large proportion of the meeting, rather than just specific elements of it.

The 'new' ways of working are now clearly embedded. The meetings we observed in late 2024 were at times hesitant and uncertain of how they should conduct the meetings and what they should be covering. This has evolved markedly, with the meetings we observed in early 2025 moving towards, if not already demonstrating a high degree of unconscious competence.

There is still further work needed to attain high-level maturity, with a tendency for senior managers to still restrict their broader contributions by 'swimming in their lanes'. This means that while managers are clearly competent and confident when speaking within their own area of subject matter expertise, there was less evidence of this happening across different items on agenda. Given the demonstrable progress made, there is little doubt that further progress can be made as the arrangements mature further..

Review focus 3 – the focus on service users

In April 2024 we said…

What was clear from our many discussions and observations is that the trust is very focused on service user outcomes, and further is restless to develop greater capacity to meet them. This was cited as a key driver for the new strategy, and the ability to assess performance and impact is a key design principle of the new operating model.

However, this inherent passion was not fully reflected in the meetings we observed – though we recognise that a clearer framework for 'patient voice' is being developed by the trust and will be implemented soon. We recommend that the trust continues to work with meeting participants to further embed the principle of outcomes into the mechanics of decision-making and governance to ensure that they are more embedded in the business of the organisation.

March 2025….

This is another area of considerable progress.

The involvement of a patient representative (Glyn) at the Clinical Leadership Executive meeting was hugely impressive for two specific reasons.

1. Glyn was clearly comfortable in taking part in the discussions – he made practical and consequential comments and observations and asked questions which added clear value to the meeting.

2. The involvement of Glyn wholly avoided any semblance of tokenism or gesturing. He was evidently comfortable with his role at the meeting as were the professionals in the room. This signifies a cultural recognition of the importance of patient vice and perspective in the governance of the trust and will benefit it greatly as a result.

In the other meetings we observed, despite there being no patient voice physically in the room, there was a much greater degree of direct referencing than we observed in 2024. Whereas previously this was implied, it is now much more explicit and demonstrates clear progress over the last twelve months.

Review focus 4 – engaging with the system

In April 2024 we said…

The trust's relationship with and standing within the system has shifted considerably over the last twelve months. According to a number of people we spoke to, this has led to a more engaged and according to some more assertive profile for RDaSH in relation to not only the two ICBs, but also the three local authorities and many VCSE organisations it partners with.

As parts of the system are subject to increasing pressure in relation to increasing demand and financial stress, the trust should ensure that its operating arrangements are able to take account of these changes and where possible establish systems to signal and significant changes that might have an impact on the trust itself.

March 2025…

We were keen to pick up evidence of the trust's work on developing an influential relationship with the system – a factor we commented on positively during our initial review.

Clearly the involvement of the chief executive and others in the senior team has increased over the last year. This has had a positive effect on the narrative at the meetings we observed – the operational management group is a good example of a meeting during which we heard considerable evidence of system working and references to system partners during the discussion.

Again, this is evidence of firm progress in line with the goals of the changes made.

Conclusions

We have observed clear progress since our review in December 2024. The trust is more familiar with the operating arrangements introduced in 2024 and as a result presents a more confident grasp of the key issues facing the organisation.

Our observation notes confirm this upbeat assessment:

- *"The meeting papers were concise and have a clear purpose – each contribution is relevant to what is being discussed and clear about the actions expected."*
- *"The introduction of agenda items is impressively brief and to the point – supporting the flow of the meeting."*
- *"Decision-making is clear, with tangible outcomes, an understanding of impact and defined next steps".*

The challenge now is to move towards full maturity. While much progress has been made, there remain areas for improvement:

- *"The chief executive is still the main conduit for all debate (in the CLE meeting)."* This is not a negative, but there is further scope for others to provide more leadership of the debate.
- *"Participation is much wider, but there is a tendency for participants to still stick to their own area of subject matter expertise."* This relates to the point about 'swimming in lanes' and is an area for continued improvement.
- *"Needs to be more of a sense of joint mission and endeavour."* Again, this is a maturity point.

These observations point to the need for further maturation of the operational arrangements, but take nothing away from the impressive shift that has occurred over the last twelve months.

Implications

In the initial review conducted in late 2024 and early 2025, GGI was asked to look at issues such as the effectiveness of the new operating arrangements, the chairing, leadership and effectiveness of meetings, behaviours and focus, and the effectiveness of assurance and performance/operational systems within the operating model. Although not an inspection, the GGI review team used a structure which mirrored some of the CQC well-led key lines of enquiry to frame its findings which will help ensure future improvements are consistent with those expectations.

So, what are the main implications of this refresh?

- In terms of leadership and effectiveness, there is a much clearer sense of the purpose, value and outcomes of the meetings we observed. ***We consider meetings to be effective and supporting the leadership of the trust.***
- Whilst the meetings we observed were operational rather than board or board committees, there was a clear focus on assurance and escalation. ***There is a clear focus on assurance and the need to escalate the outcomes and implications of operational meetings.***
- The concerns and perspective of patients was much more apparent in the meetings we observed, with the CLE meeting benefitting from this directly. ***The trust is much more explicitly focused on the perspective of patients and service users than it was twelve months ago.***
- While much progress has been made, there is still scope to develop the maturity of the operational arrangements further by encouraging wider participation in meetings and encouraging attendees to think and contribute beyond their immediate areas of expertise. ***The implication being, much done, more to do and we recommend that this is a specific focus for further development.***

Recommendations

The trust has made good progress over the course of the last twelve months. This progress must be secured and that rests on three factors:

1. Given the progress made, the trust must avoid complacency and ensure that the progress made is maintained through periodic internal reviews, active reflection during and after meetings to ensure that standards are being observed and maintained.
2. Further progress through ongoing learning and development. Progress is always relative in a dynamic environment and while recognising the progress made by the trust over the last twelve months, that progress has happed in the context of wider political, economic and environmental change. This is no time for senior leaders at the trust to be resting on progress.
3. Specifically in relation to meetings, we recommend that explicit guidance is given to participants prior to meetings to focus on the quality of debate and the individual contribution they can make. At the conclusion of each meeting, a short/pithy quality assessment should be conducted by the chair and these regularly reviewed and fed back. This will help track progress.

Partnerships and collaborations

CIPFA
The Chartered Institute of Public Finance & Accountancy

CLORE LEADERSHIP

Good Governance Academy

SALZBURG GLOBAL SEMINAR

Bloom*
Opening up procurement
Accredited Supplier

podcast the public good

SUPPORTER OF THE TERRA CARTA
For Nature, People & Planet

Association of Mental Health Providers

Living Wage Employer

ONE PLANET STANDARD

bsi. | Membership
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ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Reduction of Inappropriate Out of Area Placements	**Agenda Item**	Paper R
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	29 May 2025

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

Since 2023 the Board has been committed to ending out of area placements. Part of that work is tackling inappropriate out of area placements, for which, in August 2024, we agreed to take fiscal responsibility for from April 2025. This paper outlines the work we have done and will do to achieve this aim.

Colleagues will recognise the difficulty of success in a multi-factorial environment. It will be important to focus effort on the most impactful and quantified changes we can make. Whilst avoiding less purpose admission is part of the work, the disproportionate emphasis in on reducing length of stay – which requires us to safely discharge more patients each week. Across HQTC, we consider that there is opportunity to do so, a view re-emphasised by our divergence from the national 32 day mean LOS aspiration.

Changing our ways of working, and influencing those of partners, will be difficult – hence the focus of half of the executive team, among other resources, on this work this year. It will also involve challenging the practice of some clinical staff to create greater consistency in how we work. A very transparent process to date has been undertaken, but it is important that the Board is aware that not everyone employed within the Trust will welcome or agree with the changes that will be made over the next eight weeks. Whilst every acute ward may not do everything in an identical manner, it seems reasonable and safe that we have a consistent approach to MDTs, plan format, admitting processes and so. Given the restrictive and iatrogenic nature of admission, it is also important that every Responsible Clinician has direct support (and for a period this will come from clinical executives) to make sure that admissions are purposive and length of stay only as necessary for acute needs.

The paper is explicitly linked to our own, and system finances. Should work in Q2 not deliver, we will need to consider bringing forward our 2026/27 cost improvements plans into Q3 25/26.

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

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 is asked to:

X	**ACKNOWLDEGE** the ethical, clinical, and financial case for reducing OAPs
X	**NOTE** and **CHALLENGE** the scale of work undertaken to date

X	**EXPLORE** the highest risk action or confounding factors							
X	**RECOGNISE** the primacy of this work for three of our 13 directorates, associated senior leadership and executive teams							
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register		X	O 10/19					
Strategic Delivery Risks								
System / Place impact								
Equality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	In draft
Quality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	
Appendix (please list)								
N/A								

Eliminating Mental Health Out-of-Area Placements

1. Executive Summary

1.1 Out-of-Area Placements (OAPs) for mental health patients are used when local services are unable to meet individual care needs, for a variety of reasons. While sometimes necessary, OAPs are associated with poorer patient outcomes, increased costs as most OOP are private sector, disconnection from support networks, and delayed recovery as people are away from their loved ones and communities. The reduction of OAP is enshrined in national policy. This report outlines the key steps needed to reduce OAPs significantly, discusses associated complexities and risks, and assesses the potential barriers to success.

2. Context

2.1 While progress has been made, RDaSH continues to rely on OAPs due to local capacity gaps. This paper focuses on **inappropriate** placements—patients who should be within RDaSH beds but are instead placed externally, primarily due to no bed availability.

Out of Area Placements active at the end of the period (inappropriate only) (March 2025 data)

There are still known data quality issues with MHSDS data for OAPs, causing the figures to not report correctly. The information below is sourced from the OAPs monthly report.

MH Provider	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend (from last month)
BDCT	8	16	9	8	14	10	15	15	11	15	23	17	-6
CNTW	0	0	0	2	0	0	0	7	3	1	0	10	10
HTFT	15	22	12	8	8	19	11	8	6	14	18	13	-5
LYPFT	41	27	21	15	20	18	22	20	17	14	24	24	0
NAViGO	0	0	0	0	0	0	0	0	0	0	0	0	0
RDaSH	19	24	24	25	28	29	22	23	13	21	27	18	-9
SHSC	6	9	17	17	22	16	20	30	40	44	31	27	-4
SWYPFT	1	3	4	4	5	4	4	5	4	4	4	5	1
TEWV	1	1	1	0	1	3	3	2	2	3	1	0	-1

Monthly data submission link (by 15th of each month with data as at the last working day of previous month): Monthly inappropriate OAPs stocktake

2.2 There are also "**appropriate**" OAP's. These are patients who are placed in a private provider for a variety of reasons such as patient choice, safeguarding, staff members or require a single sex environment. The position for both these OAPs as of the 16th of May 2025 is:

Out of Area Placements							
	Don		N.Lincs		Roth		
Bed Type	App	InA	App	InA	App	InA	Totals
Acute	3	1	2	11	3	1	21
PICU	2	1	1	5	0	0	9
Older Person	0	0	0	0	0	0	0
Type Totals	5	2	3	16	3	1	30
Combined Totals	7		19		4		30

2.3 There is a third broad category of patients who need complex and **specialist** environments, such as secure, eating disorder or Tier 4 CAMHS. These units are often at a regional level managed through collaboratives.

2.4 There have been several previous papers to Board which have referenced the concerns in relation to patients who are in OAP, and the numbers of these patients are captured in the monthly Integrated Quality Performance Report. These papers have included bed modelling data and current challenges in relation to long lengths of stay (LoS).

2.5 The Board are also aware that from the 1st April 2025, RDaSH has received £6.9 million from South Yorkshire ICB to fund all South Yorkshire inappropriate OAP's. This means that the financial risk and opportunity now sit with RDaSH, which is now the same for most mental health providers. The Board have approved £3m of this as part of the 2025-6 financial efficiency programme. Currently we do not have that arrangement for North Lincolnshire, so the ICB continue to fund all OAP.

3. What are the issues we are trying to tackle?

3.1 There are potentially 5 -6 broad issues we are trying to tackle which are all interrelated. We cannot address one of them without considering and addressing the other elements.

- Limited local capacity to meet daily demand (on average 20 people who are already in an OAP)
- High bed occupancy (98-100%) vs. preferred target (92%)
- Long lengths of stay (median ~60 days vs. national 32)
- Admissions to OAP are often out of hours made by non-RDaSH practitioners
- Inequities in patient location (e.g., North Lincolnshire patients in Rotherham) and in the Place offer in the community
- Variability in ward therapeutic processes

3.2 Simply put the primary objective is that we need to maintain the current 12.16 weekly discharges (including OAP's) and then we require an additional 4.37 (5) discharges per week across the 5 Adult Mental Health wards.

1	Target occupancy %	92			
2		Doncaster	Rotherham	North Lincs	Combined
3	Occupied Bed days Inappropriate OOA	3279	2411	2786	8476
4	Occupied Bed days internal	14713	12859	6447	34019
5	Commisioned Bed Days	14604	13142	6241	33987
6	OBD %	123.20	116.19	147.94	125.03
7	Total Discharges	213	239	182	634
8	Daily Discharges on Our Wards	0.58	0.65	0.50	1.74
9	Weekly Discharges on Our Wards	4.08	4.58	3.49	12.16
10					
11	K	71.89	76.08	73.77	217.18
12					
13	Daily discharge rate needed for target occupancy	0.78	0.83	0.80	2.36
14	Weekly discharge rate needed for target occupancy	5.47	5.79	5.61	16.52
15					
16	Diference in weekly discharge rate to achieve target occupancy	1.39	1.21	2.12	4.37

3.3 The three Clinical Executives, the Chief operating Officer (COO) and the Chief Executive (CEO) have been regularly coming together to start to consider what different workstreams can be undertaken to tackle this complex set of challenges. This is overseen by the High-Quality Therapeutic Care Taskforce (HQTC), set up in February 2025 which was established in order to consider the whole therapeutic offer on the inpatient wards, so that we are focusing on therapeutic patient care, safety and quality along with timely care.

4. Workstreams & Actions

4.1 In this section I will capture some of what we are or will be doing and offering brief actions. This does not capture the detail and depth of each of the workstreams and may mislead by appearing over simplified to enable articulating them. To recapitulate they are interrelated and encompass many variables.

4.2 There are several pieces of work underway or will be progressed in Q1 in preparation for the 1st July onwards.

I. **Complex discharges** (COO and Head of flow) – this work will apply to those patients who require a complex discharge, most likely needing funding and a range of partners to secure a specific placement. This work will only apply to those patients who are deemed clinically ready for discharge (CRFD), so is not about influencing discharges per say. A complex CRFD forum has been set up (in October 24), with terms of reference and attendees are the Assistant Directors of Social Care from each of the 3 local authorities; ICB colleagues and is chaired by the COO. The 6-month review has shown all partners would like it to continue and has reduced the delays in complex discharges.

II. **OAPs sign off process** - will have to be agreed by the Chief Nurse (CN) - This will particularly be out of hours and will have to be discussed with the CN. This will start on the 1st June. This will mean the CN will engage directly with admitting clinicians and front-line teams to discuss cases. The fixed point is that the dialogue will be directly with the decision-making clinician. The purpose is to not necessarily overturn decisions but there will certainly be dialogue and clinical curiosity about decisions made. Clinicians may not be used to this degree of scrutiny, and it may be perceived as challenging or "top down". Successful OAP reduction programmes such as at Sussex Partnership NHS FT have shown OAP need executive sign off for a period of time to help turn the curve.

III. **Patient Reviews** – those patients currently in OAP and so we need to determine next steps for each patient (COO & Head of Flow) – A simple assumption would be that we repatriate these patients. However, for some this could intrude on the patient improvement journey and if we utilise all our available bed capacity, with will mean others going out of area. So, its cyclical. All these patients will be discussed with the Care Group Directors of Nursing on the 21st May. Following this we will then need to cost those who will remain in OAP against the allocated £6.9m

IV. **Standard work** - will be introduced onto the acute wards (CMO & COO) – this means that from the point of admission to discharge the documentation, team process and ways of working will be the same across all the wards. We will be clear about the different team process (i.e. PIPPAS; MDT and ward rounds) with

consistency of definition and purpose; frequency and attendees. What, why, when and who – but consistency is key.

V. **Accountability** reviews at 3 and 15 days (DoP & CMO) – patients will be actively reviewed to ensure there is clarity on purpose of admission (day 3) and what is being considered in terms of their potential discharge process. Start discharge planning on admission. Cleary several cases will be complex that an imminent discharge is unlikely. The 15-day element is a fixed point to speak with the Responsible Clinician (RC) to ensure they are clear on the diagnosis, forward plan and identify barriers to discharge. The DoP and CMO will actively lean into this for an interim period to role model clinical enquiry and clarity.

VI. **Community Services Reconfiguration** - not just investment but how we configure services so that community and acute are less siloed. This will include crisis and home treatment services, including Crisis Houses, along with community mental health teams. With this will be asking partner agencies to work differently with a focus on retaining people in their communities, in advance of any admission; engaging will people who are on the ward and then supporting timely and safe discharges.

VII **Independent Diagnostic Review & Ward Blueprint** - we have commissioned an independent clinical colleague (previously a Director of Nursing) to visit all the wards; speak with a range of ward staff and observe systems and process. This has also included some discussions with those with lived experience, but we need more of this. This has highlighted a wide variation in systems and process across the wards, including clinical engagement and disconnection from community. This will be summarised in a report for the 23rd May and will include a broad blueprint of the rhythm of the ward by day and week.

4.3 Strands 4, 5 & 6 are significant pieces of work – and the standard work is a general title which will either hold or sit alongside all the interventions and change on the wards. Much is coterminous and will be alongside the culture of care work and the safety and quality plan and it metrices. Also, to draw out that this will require a significant level of senior curiosity and intervention from the Executives. For example, the escalation process for the Accountability work stream, will require the DoP and CMO discussing cases with the RC at 15 days. All inappropriate OAPs will need to be reviewed, and those out of hours will again require a direct conversation with RC/admitting clinician with the CNO. Cases with long lengths of stay will require conversations with the COO. This is not to coerce changes in clinical decision making this is about clinical curiosity and ensuring that everything is being considered. By its nature it is *interventionist*. However, this is new, and several clinicians may feel scrutinized and challenged.

4.4 We are then looking in mid-June, before the June HQTC to have a one-day event with key front-line staff from the wards, with representatives from professions, banding and across Care Groups. They will help make selection decisions to the one consistent model. What we have not agreed yet is the deployment model, but this will be discussed and agreed before June's HQTC. This is key as much of the work is focusing on consistency but once agreed we will then have the significant cultural piece of asking people not only working to new systems but also asking them to work differently. This is a hearts and minds thing, and we need to work collaboratively with

front line staff within the wards; in crisis and community teams; wider partners and voluntary organisations.

Some broad principles on how mobilisation may be successful:

- Locally led, centrally supported.
- Inclusive of lived experience.
- Clinically and operationally led.
- One change model implemented consistently.
- Strong rhythm of coaching, accountability, and support.
- Outcome-focused and culturally informed.
- System-wide partnership engagement.

4.5 Length of Stay is a key lever to bring about more capacity on the wards. We would not want that separated from the standard work and doing things once on wards. However, we are currently reviewing what we are doing (so strengthening not anything new) now to try to enhance this focus while the other work develops. We cannot defer this work as it will hopefully bring some of the changes, we need in a timely way and was discussed in a paper at March Board.

5 Complexities and Risks

A. Systemic Complexity

Mental health systems span multiple agencies—NHS, social care, housing, voluntary sector—requiring coordinated and often slow-moving responses. There are also many points of entry into mental health services.

B. Workforce Shortages & capability

National shortages of mental health professionals limit the pace at which services can expand, particularly in rural or deprived areas. There may also be capability issues with staff as we try to adapt to new ways of working.

C. Financial Constraints

Expanding local capacity requires upfront investment even through time and other resources, while OAPs continue to draw down budgets. This creates a tension between short-term cost and long-term value.

D. Complexity of Patient Needs

Some individuals have highly specialised or forensic needs not easily met in general mental health services, requiring bespoke provision. However, a number remain in AMH as there are limited placements across the county

E. Resistance to Change

Staff may be hesitant to change long-standing referral practices or adopt new models of care. Culture change takes time and active leadership.

6. Why the Programme May Not Succeed

6.1. Despite a structured approach, there are several reasons why this programme could face setbacks. A number of these have been captured but it may be useful to recap and add any additional ones.

6.2 OAP arise across the week and weekend and often require decisions 'out of hours." This challenges who does what and how we respond to immediate needs - the 3am on a Sunday morning scenario when a mental health patient is being disruptive in the emergency department.

6.3 OAP patients may be known to services or not known to services. Influencing admitting decisions is often not an RDaSH employees but involve AHMPs, S12 doctors and Police (among others). Part of this will be the shift to manage more risk in the community and that will require RDaSH and partner colleagues anticipating and working with that. We are not sure about the system appetite for this and arguably there is disjointed Governance. If partners (e.g., NHS trusts, local authorities, ICBs, Police) are not aligned, progress will continue to be fragmented.

6.4 Our intended focus relies on having beds available inside RDaSH each day/night. This will be based primarily on reducing amendable LOS. Doing that requires colleagues in wards and community teams to behave and work differently. Risks arise from that ask.

6.5 We have significant Capital plans for this year, such as Great Oaks 3 – 4 and the remaining door replacement programme which will mean we have fewer beds available in 25/26, particularly in North Lincolnshire.

6.6 Existing OAP cannot remain where they are, but we must not simply 'move them' for several reasons. We need to behave therapeutically, and this will also utilise any capacity within RDaSH, so we simply keep continue with the cyclical nature of flow.

6.7 There is a concern from the teams that as we retain more patients it will be the more complex who remain on the wards. This can lead to an increase in acuity including concerns about aggression and violence along with more challenges about patients who are complex but CRFD.

6.8 There is a failure to engage patients and families. A top-down model lacking co-production may miss the mark on what will enables local recovery and addressing this complex set of circumstances.

6.9 All modelling is based on demand over the last 2-3 years. It is not anticipated that we will see spikes in mental health demand, but we need to acknowledge that many young people are still emerging from the impact of COVID as they go into adulthood, and we have a continued impact from increasing austerity and poverty and so demand may outstrip even expanded capacity. For example, what would have happened if the steel works had shut down in North Lincolnshire.

6.10 There are three final risks which I would like to comment on which are leadership, time and financial.

6.11 This programme will require leadership within the Trust and across the system. This is work that require team behaviours and reliance – within the executive group, or a

subset thereof. It will also need our directorates and SLTs to step in. The work may on occasion challenge clinical judgements, but we also require "clinical buy-in" for the changes we make. It is important this change is clinically led and patient focused or again it becomes a view of managerially imposed. We have not yet developed the multi-professional leadership teams proposed for the wards and these will be key to bring about that ward cultural change.

6.12 What time will we need to make these changes but more importantly changes that are sustainable. Many trusts have tried this work with an immediate positive impact but over time they have not been sustainable. We need Trust capability for change which is arguably still developing. For example Sussex took 18 months to achieve their objectives (https://thepsc.co.uk/case-studies/entry/case-study-transforming-mental-health-inpatient-services-with-sussex-partnership-foundation-trust)

7. Financial

7.1 We have committed to £3million from the £6.9million from the South Yorkshire ICB to the cost efficiencies programme. This means we must live within £3.9million to fund SY inappropriate OAP's. For month one we have spent approximately £390k. There are several financial issues to consider.

7.2 It is worth considering that we have a difference in funding so RDaSH now holds the funding for all inappropriate OAP for Soth Yorkshire but that is the case for North Lincolnshire. We enter this work with patients already in OAP. This is currently 3 for South Yorkshire and 14 for North Lincolnshire.

7.3 There has been a marked improvement in the number of people who are from SY and OAP. This needs to be sustained and from July this needs to be 9 patients or less. This is based on a bed price of £760 per day but PICU and enhanced observations cost more.

OAP Budget	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
ICB Transfer	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000	6,900,000
Planned reduction				-333,333	-333,333	-333,333	-333,333	-333,333	-333,333	-333,333	-333,333	-333,333	-3,000,000
Net Budget	575,000	575,000	575,000	241,667	241,667	241,667	241,667	241,667	241,667	241,667	241,667	241,667	3,900,000

7.4 To achieve this the primary lever will be a reduction in LoS. In headline terms this is **16 more discharges per month, or 4 per week**, across the 5 AMH wards. We are excluding older adult as we continue to have capacity and for clinical and ethical reasons then older adults need to remain in their communities, as far as possible.

7.5 From July, the Executive Group and Clinical Leadership Executive meetings will be looking at data that shows how we are doing by reference to these needs, recognising this is not a simple change, but that less impactful Q2 delivery, will steepen the Q3/4 scale of change. We will continue to review those patients who are out of area to consider any opportunities for repatriation, and particularly if any patients do go out of area from the 1st July there will be an active focus on their repatriation in a timely way. A weekly meeting with the Directors of Nursing; Flow and the COO has been established.

7.6 We have done an initial draft of a Quality Impact Assessment which was reviewed on the 20th May 2025 by the Clinical Executive. This is currently getting further risks and opportunities added and will be discussed again. This will be signed off by the 31st May.

8. Conclusion and Recommendations

8.1 Reducing out-of-area mental health placements is both clinically and ethically necessary. It improves patients' recovery, maintains connection to their support systems, and aligns with national policy objectives. However, success hinges on sustained investment, integrated working and significant change, and clear leadership some of which will be directly interventionist.

8.2 We ask the Board to:

ACKNOWLDEGE the ethical, clinical, and financial case for reducing OAPs

NOTE and CHALLENGE the scale of work undertaken to date

EXPLORE the highest risk action or confounding factors

RECOGNISE the primacy of this work for three of our 13 directorates, associated senior leadership and executive teams

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – April 2025	**Agenda Item**	Paper S
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	29 May 2025

The report illustrates a number of areas of delivery. Physical Health Services are performing well across a range of their metrices, but important to note their achievement of the 18-week RTT compliance. This has been mirrored in Mental Health RTT and is the first time we have had compliance across RTT Trust-wide. There are no 52-week breaches. This does not negate the position in terms of neurodiversity, with 4,994 patients waiting.

For the first time we have zero breaches over 24 hours for the s136 in April. May is seeing improvement on out of area placements from 21 for April. We did have 2 patients abscond but following review these have been managed appropriately. There has been a reduction in the number of ligature incidents.

Data associated with establishments and budgets is not yet updated to accurate planned month 2 figures. However, it is clear we have more work to do to convert dated PDR commitments into closer to 100% appraisal. In advance of the launch of our wider safety work it is encouraging to see VTE Assessments improve further to 95.77% & MUST Assessments improved to 79.86%. The Falls Assessment measure shown is a reflection of a new reporting standard and improvement in June is anticipated.

Alignment to 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 addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X

Previous consideration

Clinical Leadership Executive and relevant committees of the Board

Recommendation

The Board is asked to:

	NOTE reported delivery 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, O 4/24, NF 1/20 NF 8/24, NLCG 4/20,NLCG 1/23, F 1/25, NLCG 11/23, RCG 8/24, CCG15/24, CCG 3/22, PCG 28/24, PCG 10/24, PCG 9/24, DCGP 2/22, PCG 23/24						
Strategic Delivery Risk	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: N/A

Integrated Quality Performance Report

May 2025 Review

Data as at the 30th April 2025

Contents

1.0 Executive Report

This report presents the Month 1 April 2025 performance across operational efficiency, quality, workforce, and financial metrics.

Performance Highlights and Areas for Improvement:

Children and Young People (CYP) Services: The metric for Children and Young People (CYP) receiving one clinical contact within a 12-month rolling period (OP13a), from April 2024 measures the contribution of RDaSH towards the place target. The rate for April remains below the required target reporting month rolling period (OP13a), with 9,217 CYP accessing services, remaining below the target of 9,424. The expected rise in Neurodevelopment activity from the digital providers which is not currently flowing through the clinical system will bring the activity to the required level. The Children's Eating Disorder service continues to perform exceptionally, with 100% of the most urgent cases seen within one week across the full year (OP15) and 93.02% of referrals seen within four weeks (OP14), just short of the 95% target. It is noted that the 6 breaches over the 12-month rolling period (May 2024-April 2025) relate to the period May-July 2024 and since this time all children have been seen within 4 weeks of referral.

Physical Health Services continue to perform well across all metrics: The 18-week referral to treatment metric (OP08b & OP08C) continue to perform well and the position of OP08C has recovered from the March 2024 position and is now meeting the target to ensure as a minimum that 92% of patients are seen and treated within the 18-week period. The proactive monitoring of assessment and treatment waits provided by the Deputy Care Group Director supported by the performance team has had a positive impact. There were also no 52 week waits in Physical Health (OP10c). The Virtual Ward (LTP06), an initiative providing patients with care at home rather than requiring hospitalisation has seen occupancy rates remain above the 80% target have remained consistently above the 80% target reporting 93.33% on the 1st of the calendar. For patients experiencing a physical health crisis (OP05), where assessments are required within two hours of referral, performance has exceeded the 70% target in month, reaching 77.42%.

Adult and Older Adult Mental Health Services perform well across all metrics: The Trust continue to exceed the target for the 18-week referral-to-treatment metric (OP08d) demonstrating the continuing focus on waiting times to ensure that patients are assessed and treated in a timely way and to improve the quality of care provided. It is also noted that the services have no 52-week breaches (OP10d). The services have also managed the Section 136 suites well in April ensuring that there are no individuals remaining in the 136 suites for longer than 24 hours (OP73a).

Talking Therapies Directorate: The Access Rate Performance for the month of April is reported as 1520 against the target of 1915. When compared with activity in the same period last year we are reporting 156 above last year's actual which was 1,362. This demonstrates that the service is starting to see a gradual and sustained increase in the number of patients entering treatment: There remains a significant number of further actions to embed and sustain this change whilst also further building capacity and demand to deliver the target as we move into 2025/26 period. The current forecast for when capacity will reach the required level based on trainee completion dates is September 2025. For the reliable recovery performance for April 2025 was 47.61% however still demonstrates sustained improvement from the year-to-date position and the period during summer of 2024 when performance was consistently significantly below target.

Inappropriate Adult Acute OAPs (OP17C): There were 21 inappropriate out-of-area placements in March, which remains below the trust target of 30. A multi-phase improvement program is in development, led by the Executive Team.

Neurodevelopmental Services: March saw a deterioration in those waiting for an Adult ADHD assessment when compared with the trajectory. This primarily due to a number of assumptions used to inform the original trajectory that have not been possible to translate into practice in the original timescales for example issues in recruitment, implementation of new systems etc. A new model of service delivery has been designed to maximise efficiency and will help inform changes to the trajectory. We are reporting 4,994 adults waiting against a trajectory of 4,184 for this metric. The CYP Neurodevelopmental waiting list reported 2,937 against a target of 2,329, primarily due to delays in recruiting additional staff required to meet demand. A revised trajectory has been developed to support compliance with the four-week target and is pending approval.

1.0 Executive Report

Quality and Patient Safety: The Trust drive to prioritise quality and patient safety has seen an improved position against the metrics reported in the dashboard. the percentage of VTE assessments completed within 24 hours has achieved the target reporting 95.77% against the 95% target. Care groups are continuing to conduct daily deep dives, weekly audits and exploring transfers with the acute trust which are acted on if the VTE assessment is not fully complete, the services continue to feed back to doctors to sustain this level of performance.

Absconded Patients (QS20) The number of detained patients who absconded from acute adult and older people's inpatient mental health units (QS20) was 2 in April. Following a deep dive one patient failed to return from unescorted section 17 leave. The patient was subsequently returned by police. The second patient went home when on leave from the ward and was taken to A&E with police on a S 135 before being returned to the ward.

Racist Incidents: Six racist incidents in April from the 7 reported in March the Acceptable Behaviour Policy has now launched Trust Wide and continues to be used to support colleagues and re-enforce zero tolerance. IR1's are reviewed and actioned when they arise, and staff involved are contacted for support. The expectation is that tolerance remains high, and we should expect a higher number of incidents to be reported.

MUST : We are reporting an increase in April to 79.86% (115/144) from the 77.30% (126/163) in March of the % of Inpatients that have a completed MUST assessment. The alert is now embedded in all inpatient records so that when retrieved the alert will notify when the assessments are uncompleted to assist with completion within timeframe. There is also an exemption for hospice patients in the last 24 hours of life. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers.

FALLS: This new metric is reporting 68.24% (58/85) in April of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. This is the first month reporting this new metric moving from 72 hours to a 12-hour reporting window. There have been some errors in recording this month due to moving to the new template, these have been addressed with the staff concerned. We anticipate this compliance level improving month on month as becomes business as usual.

Workforce Development: The percentage of employees receiving a performance and development review (PDR) has increased to 89.67% from 87.84%, reflecting improved support for staff development, feedback, and engagement, in addition, the year-to-date sickness absence rate has decreased in month from 6.39% to 4.97% achieving the <5.1% target. The revised policy launched in April, following manager training will hopefully support with maintaining compliance against the metric.

Consultant vacancies: The number of vacancies has increased this month to 11 due to colleagues leaving the Trust, however two candidates have been offered posts which they have accepted (currently subject to pre-employment checks) which will return the vacancy level to within its Target range.

Safeguarding Compliance: Adult and child safeguarding compliance (POD26 & POD27) is currently below the 90% target. Targeted actions, including bespoke sessions for the half-day LEARN event calendar, are underway to improve compliance. Any non-compliance will be shared with Directors of Nursing for targeted improvements.

Vacancy Rate: The vacancy rate increased from 148 to 162 vacancies in April, currently standing at 4.37% against a target of 2.5%.

Finance : The month 1 finance position is in line with the plan with all directorate budgets now signed off and delegated by the CEO and CFO. Detailed reporting of the financial position will resume from May in line with NHSE reporting timescales.

2.0 - Performance – In Focus

Indicators for April 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)		People first episode in psychosis started treatment in 2 wks		13/13	100.00%		100.00%	>= 60%	100.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1520		1520	>= 1915	1520
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		299/628	47.61%		48.00%	>= 48%	48.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		437/650	67.23%		67.00%	>= 67%	67.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		24/31	77.42%		77.00%	>= 70%	77.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			604		604	>= 598	604
OP08b (L)		18 wks RTT for AHP led Physical Services		308/309	99.68%		100.00%	>= 92%	100.00%
OP08c (N)		18 weeks RTT for consultant led Physical Health services		52/54	96.30%		96.00%	>= 92%	96.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		218/226	96.46%		96.00%	>= 92%	96.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			0		0	= 0	0
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			0		0	= 0	0
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		65/69	94.20%		94.00%	>= 60%	94.00%
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			9136		9136	>= 9424	9136
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		680/4882	13.93%		14.00%	>= 20%	14.00%
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		80/86	93.02%		93.00%	>= 95%	93.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		2/2	100.00%		100.00%	>= 95%	100.00%

Narrative

OP03a – Reporting 1,520 for the month of April 2025 against a target of 1,915. When compared with activity in the same period last year we are reporting 156 above last year's actual which was 1,362.

OP03c – Performance reported as 47.61% for April 2025 slightly below the 48% target.

OP7b – PLACE TARGET ACHIEVED -a rolling 12-month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (604) and Maternal Mental Health Service (SHSC) (255) is counted the number of women receiving support is 859, remaining above the target of 598.

OP13a – The RDaSH contribution to the place target is reported as 9217 (9136+Healios 81) against a target of 9424

OP13b – The CYP access 2 contacts and a paired scored has seen a downturn in performance from 14.53% in March to 13.23% in April 2025.

OP14 - Children and young people with routine eating disorders seen within 4 weeks is reporting 6 breaches from May and June of 2024 in the rolling 12 month period and is reporting 93%, just below the 95% target.

2.0 - Performance – In Focus

Indicators for April 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			21		21	<= 30	21
OP54a (L)	LTO 06 a (i)	Virtual ward occupancy - on day 1		56/60	93.33%		93.00%	>= 80%	93.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			4994		4994	< 4184	4994
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			2937		2937	<= 2329	2937
OP60 (L)	LTO07	Dementia Diagnosis rate		7417/9734	76.20%		76.00%	>= 67%	76.00%
OP61a (L)	LTP08a	Place target for SMI		3735/5490	68.03%		68.00%	>= 75%	68.00%
OP61c (N)	LTP08c	Patients with SMI having full annual physical health check		2621/3546	73.91%		74.00%	>= 95%	74.00%
OP73a (L)	LTP 10 a	Section 136 Breaches – Occupancy hours lost to breaches			0		0	= 0	0

Narrative

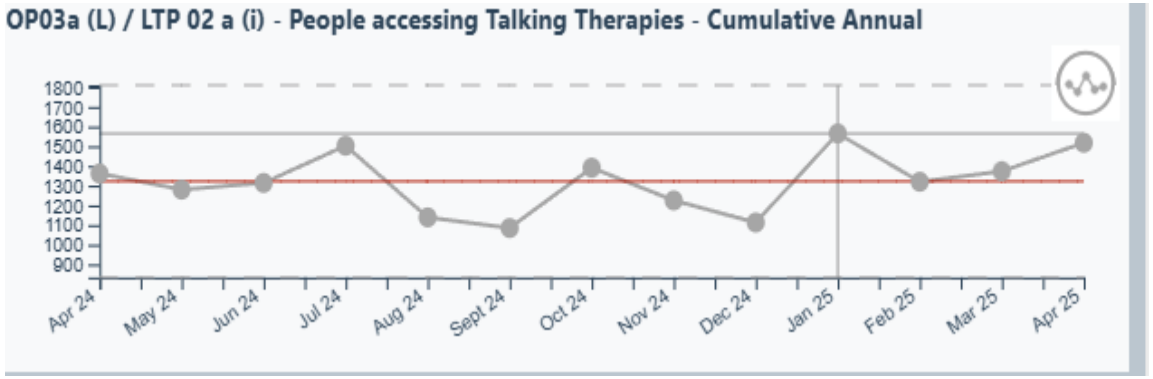
OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 4,994 adults waiting for assessment against the target of 4,184. The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual for April is 2,937 CYP waiting against the target of 2,329. The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

OP61a – The metric for individuals receiving an annual health check and is the national place target measuring 6 checks (performance is reported by NHSE so is reporting as at the Q3 position) against the QOF , performance is reported as 68.03% against the 75% target.

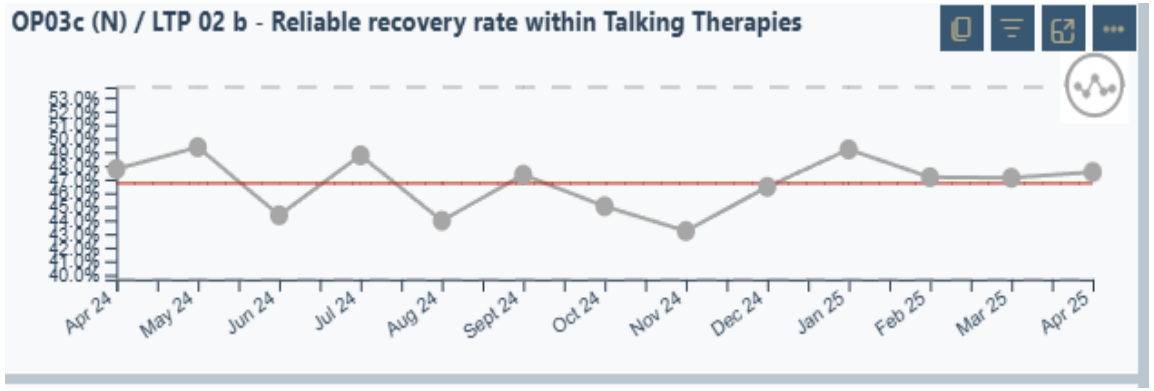
OP61c – The new metric is measuring the RDaSH performance against the QOF with declines excluded. Performance is reported as 73.91% against the 95% target.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

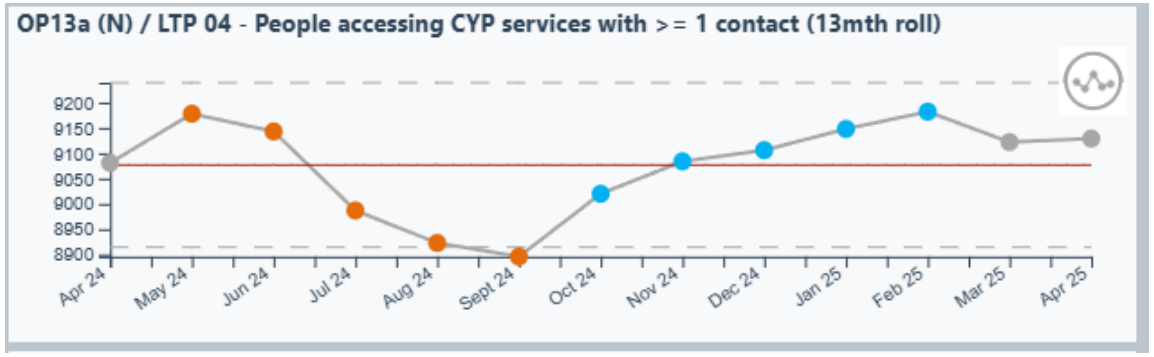
OP03a The Access Rate Performance for the month of April is reported as 1520 against the target of 1915. When compared with activity in the same period last year we are reporting 156 above last year's actual which was 1,362. This demonstrates that the service is starting to see a gradual and sustained increase in the number of patients entering treatment: There remains a significant number of further actions to embed and sustain this change whilst also further building capacity and demand to deliver the target as we move into 2025/26 period. The current forecast for when capacity will reach the required level based on trainee completion dates is September 2025.



Trend, Reason and Action

OP03c Performance for April was 47.61% which was an increase from March 2025 which was reported as 46.86%. This demonstrates sustained improvement from the year to date position and the period during summer of 2024 when performance was consistently significantly below target.

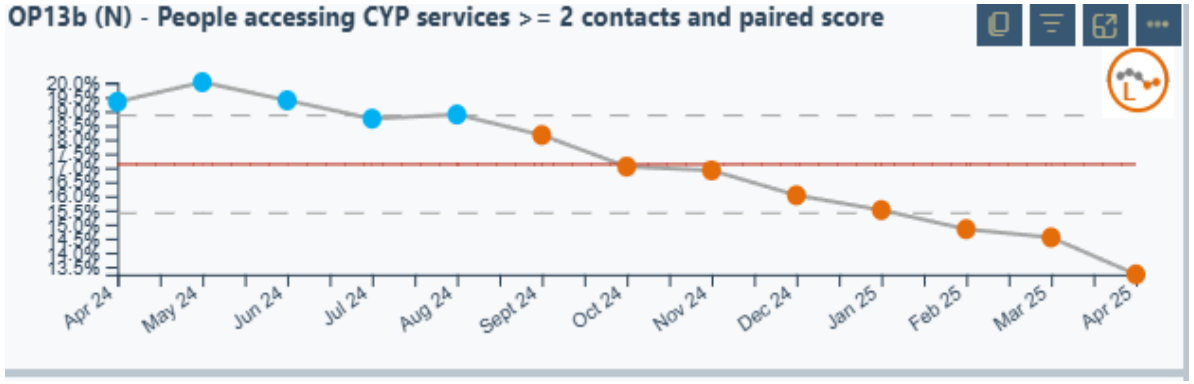
The breakdown between services for April 2025 shows that Doncaster fell slightly short of the target reporting 47.54% and North Lincolnshire were above, reporting 48.36%. The Rotherham service saw a improvement on performance reported in March reporting 46.44%.



Trend, Reason and Action

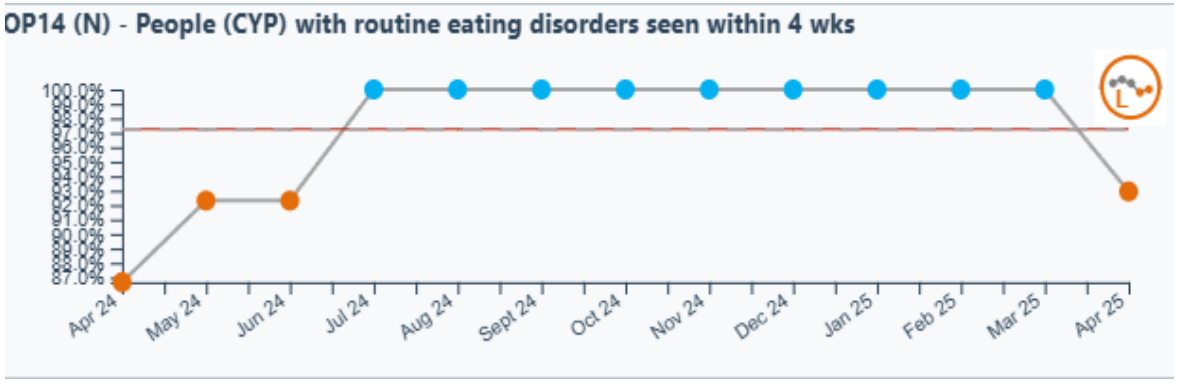
OP13a The children and young people access rate (OP13a) is the RDaSH only target across the 3 places. The graph represents the RDaSH contribution and is reporting 9,217 against the target of 9,424. It has been determined that the Neurodevelopment activity from the digital providers is only manually factored in up to 81 children, the service are working towards getting all activity flowing into SystmOne in order for the reporting to flow.

2.1 Performance In Focus - Exceptions



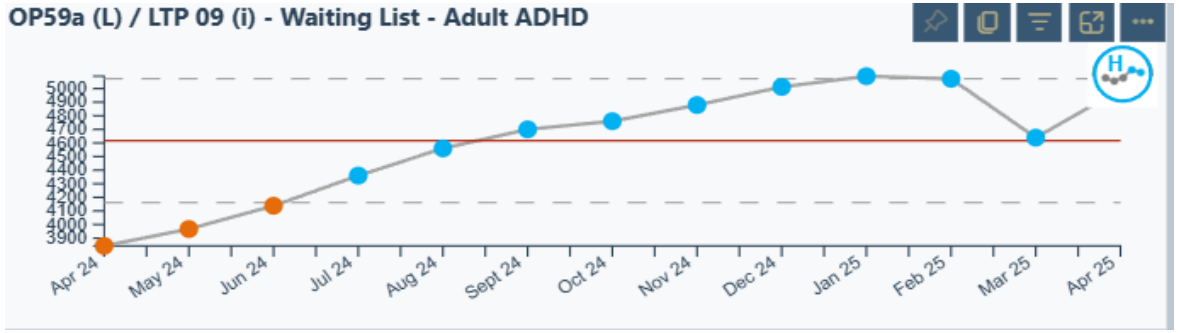
Trend, Reason and Action

OP13b - The CYP access 2 contacts and a paired scored has seen a downturn in performance from 14.53% in March to 13.93% in April 2025. CYP do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with CYP planned to see transition to this tool from January – March 2025, with all staff to be trained by April 2025.



Trend, Reason and Action

OP14 - Children and young people with routine eating disorders is reporting 6 breaches in the rolling 12 month period. This is a rolling 12 month target with appointments offered slightly over the 4 weeks primarily due to service capacity issues within the April-June 2024 period. Current wait times within this pathway remain below the 4 week wait target.

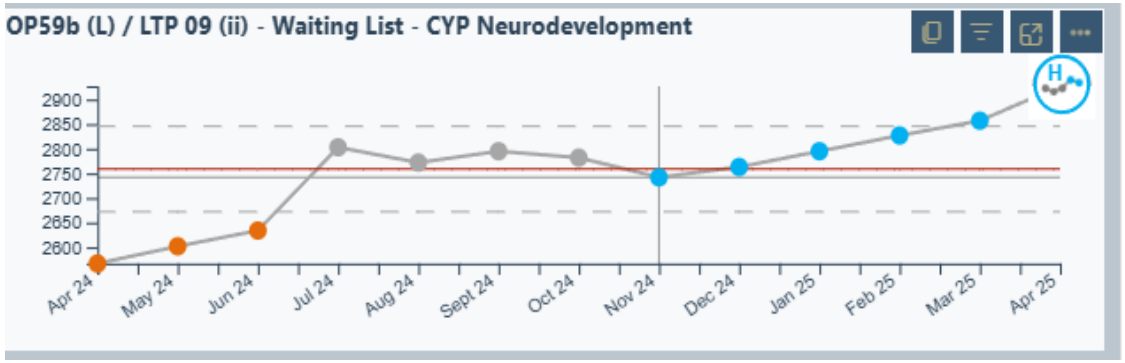


Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 4,976 adults waiting for assessment against the target of 4,184.

The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

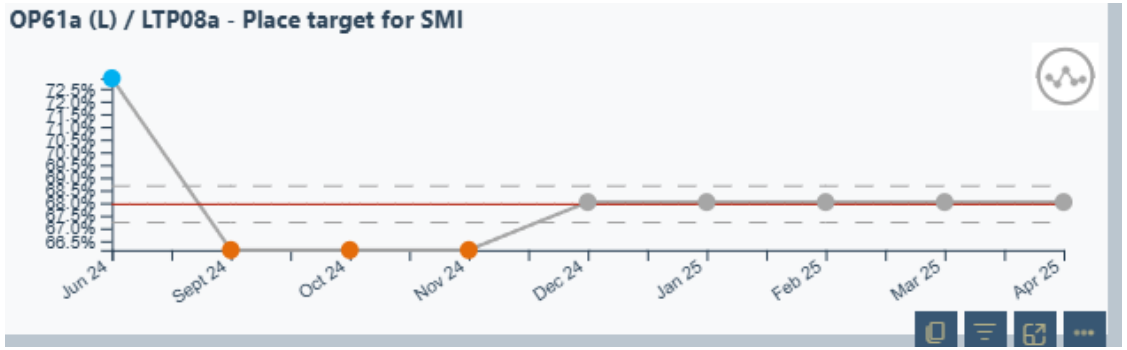
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting 2,929 CYP waiting against the target of 2,329.

The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.



Trend, Reason and Action

OP61a – Reporting against the QOF for the place target. Performance is reported only as of December 2024. This is due to the availability from NHSE where the metric is provided a quarter in arrears. Continued focus is being placed on reducing the number of patients who decline elements of their health check such as BMI and blood tests. Work is ongoing with GP surgeries in the three localities to cleanse and cross-reference the registers with the goal of having 1 register per place which can be kept accurate and up to date.

Trend, Reason and Action

OP61c - This metric measuring the number of SMI patients having a full annual health check against the RDaSH QOF excluding declines reporting 75.29% against the 95% target. Continued focus is being placed on reducing the number of patients who decline elements of their health check such as BMI and blood tests. Work is ongoing with GP surgeries in the three localities to cleanse and cross-reference the registers with the goal of having 1 register per place which can be kept accurate and up to date.

3.0 Quality & Safety In Focus

Indicators for April 2025/2026 TRUST — Quality & Safet

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS05 (N)	Number of MRSA infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS07 (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	136/142	95.77%	Q1 >= 95%	96.00%	>= 95%	96.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		16/16	100.00 %		100.00%	>= 90%	100.00%
QS19 (L)	Number of AWOL's from low secure units (Amber Lodge)			0		0	= 0	0
QS20 (L)	No detained patients absconded acute adult/OP inpatient MH			2		2	= 0	2
QS21a (L)	Physical aggression incidents mod or above to staff (%)		1/119	0.84%		1.00%		1.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats (%)		2/119	1.68%		2.00%		2.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		0	Q1 = 0	0	= 0	0
QS27 (L)	Ligature incidents mod or above all inpatient areas		2/28	7.14%		7.00%	<= 10%	7.00%
QS29 (L)	Number of racist incidents against staff members			6		6	= 0	6
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		5/5	100.00 %		100.00%	= 100%	100.00%
QS36 (N)	Inpatients that have a completed MUST assessment		115/144	79.86%		80.00%	= 100%	80.00%
QS37c (L)	Inpatients commenced falls assessment in 12 hrs		58/85	68.24%		68.00%	= 100%	68.00%

Narrative

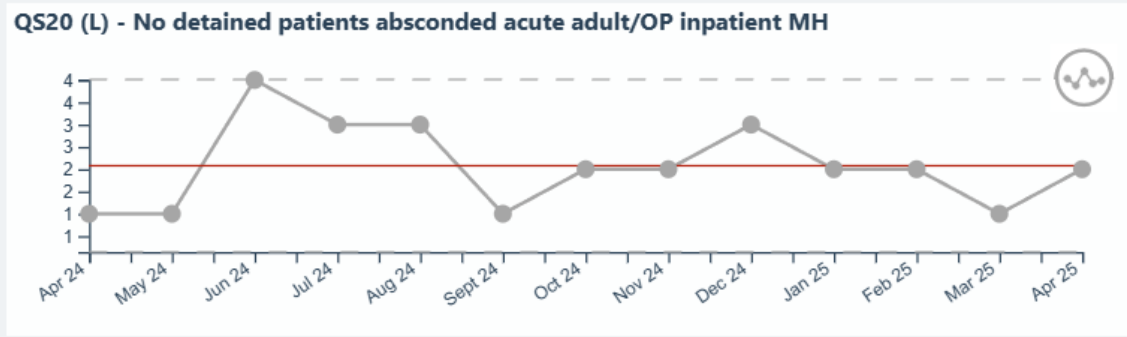
QS20-An increase to 2 patients reported as absconding in April from acute adult and OP inpatient mental health units from the 1 reported in March.

QS29 –The Trust is reporting a decrease to 6 incidents from the 7 incidents reported in March.

QS36 -- Reporting an increase in April to 79.86% (115/144) from the 77.30% (126/163) in March of the % of Inpatients that have a completed MUST assessment.

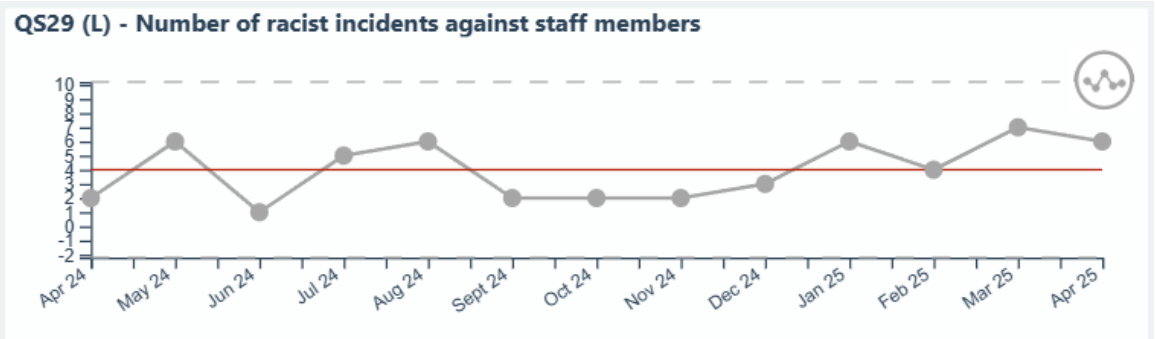
QS37 – This new metric is reporting 68.24% (58/85) in April

3.1 Quality and Safety In Focus - Exceptions



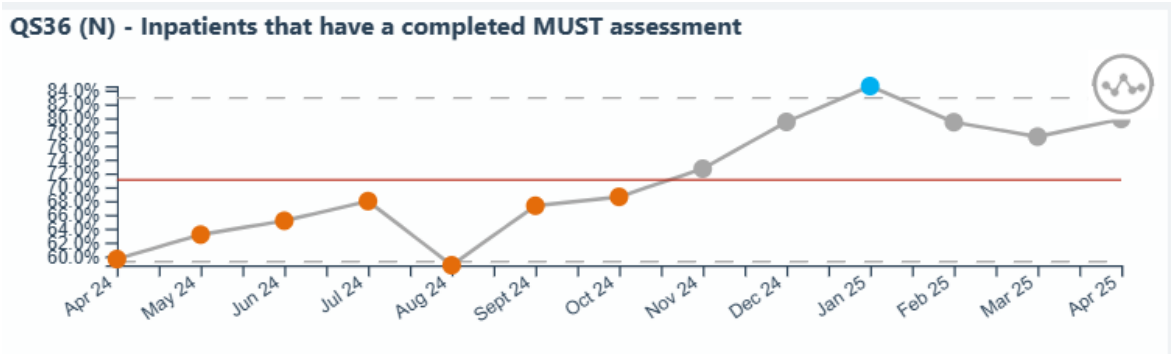
Trend, Reason and Action

QS20- An increase to 2 patients reported as absconding in April from acute adult and OP inpatient mental health units from the 1reported in March. Following a deep dive one patient failed to return from unescorted section 17 leave. The patient was subsequently returned by police. The second patient went home when on leave from the ward and was taken to A&E with police on a S 135 before being returned to the ward.



Trend, Reason and Action

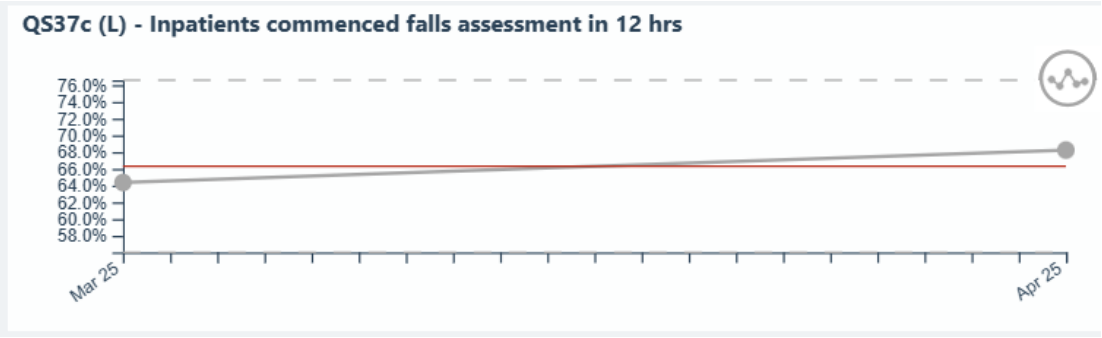
QS29 – The Trust is reporting a decrease to 6 incidents from the 7 incidents reported in March. The Acceptable Behaviour Policy has now launched Trust Wide and continues to be used to support colleagues and re-enforce zero tolerance. IR1's are reviewed and actioned when they arise and staff involved are contacted for support. The expectation is that tolerance remains high and we should expect a higher number of incidents to be reported.



Trend, Reason and Action

QS36 – Reporting an increase in April to 79.86% (115/144) from the 77.30% (126/163) in March of the % of Inpatients that have a completed MUST assessment. The alert is now embedded in all inpatient records so that when retrieved the alert will notify when the assessments are uncompleted to assist with completion within timeframe. A change request has been made for an amendment to the MUAC template to include step 4 completion to ensure this is clearer. There is also an exemption for hospice patients in the last 24 hours of life. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS37c –This new metric is reporting 68.24% (58/85) in April of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. This is the first month reporting this new metric moving from 72 hours to a 12-hour reporting window. There have been some errors in recording this month due to moving to the new template, these have been addressed with the staff concerned. We anticipate this compliance level improving month on month as this becomes business as usual.

4.0 People and Organisational Development – In Focus

Indicators for April 2025/2026 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	0.81%		1.00%		1.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	4.97%		5.00%		5.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	11		11		11
POD16 (L)	Qualified nursing vacancies	<= 2.5%	5.71%		6.00%		6.00%
POD17 (L)	Support worker vacancies	<= 2.5%	7.08%		7.00%		7.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	89.67%		90.00%		90.00%
POD19a (L)	Individuals completed mandatory/statutory training	> 90%	93.91%		94.00%		94.00%
POD23 (L)	Number of individuals currently suspended from employment		0				
POD24 (L)	Average suspension length in calendar days	<= 150	0		0		0
POD25 (L)	Recruitment completed within 12 weeks	>= 95%	97.67%		98.00%		98.00%
POD26 (L)	Compliance for safeguarding children's training		95.16%		95.00%		95.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		94.82%		95.00%		95.00%
POD28 (L)	Total Vacancies		162		162		162
POD29 (L)	Total Vacancy Rate %		4.37%		4.00%	<= 2.5%	4.00%

Narrative

POD15 – Consultant vacancies have increased to 11 breaching the target of 10.

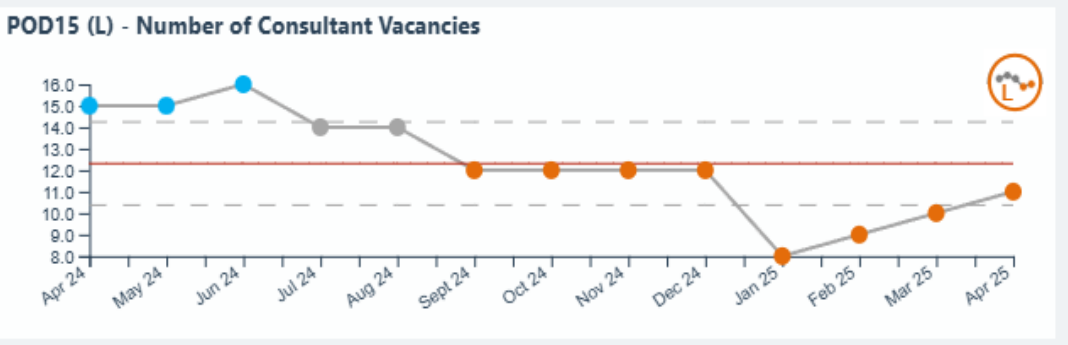
POD16-17 – Reporting against the revised target of 2.5% both qualified and support worker vacancies are above.
All 2025/26 budget changes will be enacted in May 2025 which will then amend the vacancy position. A full review of all vacancies will be undertaken and presented at the June People and Teams meeting to ensure there is a clear trajectory to deliver the 2.5% vacancy factor across staff groups and roles.

POD18 –The Trust continues to experience challenges maintaining PDR compliance and there has been an improvement from 87.84% to 89.67%. A revised approach to appraisal is being developed during Q2. The new approach will improve the quality of experience/outcomes, which should drive an improvement in compliance. PDR completion rates was discussed at People and Teams on the 8 April 2025 and the list of outstanding PDR's will be shared with all Directorates as Care Groups have provided assurance at Delivery Reviews in March 2025 that all outstanding PDR's would have been completed by the end of March 2025 and the current reporting doesn't demonstrate this.

POD26 and POD 27 - Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance.

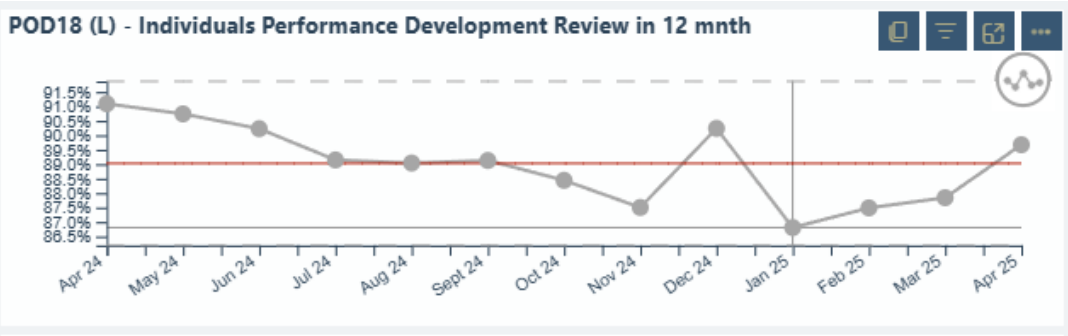
POD29 – reporting as 4.37% against the target total vacancy rate percentage of less than or equal to 3.3% (2024/25) with 162 vacancies currently across the trust (increased from 148).

4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

POD15 – The number of vacancies has increased this month to 11 due to colleagues leaving the Trust, however two candidates have been offered posts which they have accepted (currently subject to pre-employment checks) which will return the vacancy level to within its Target range.



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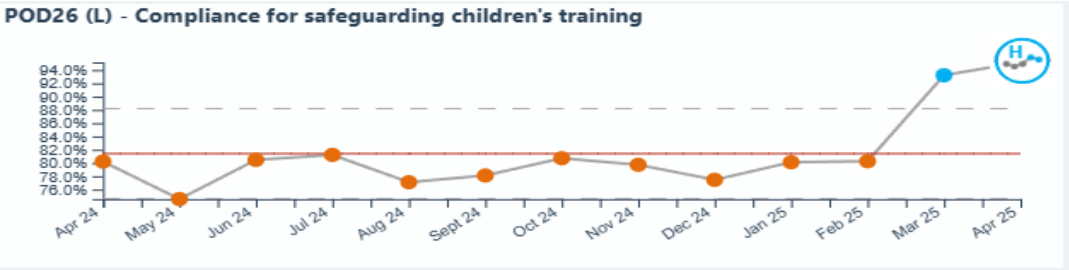

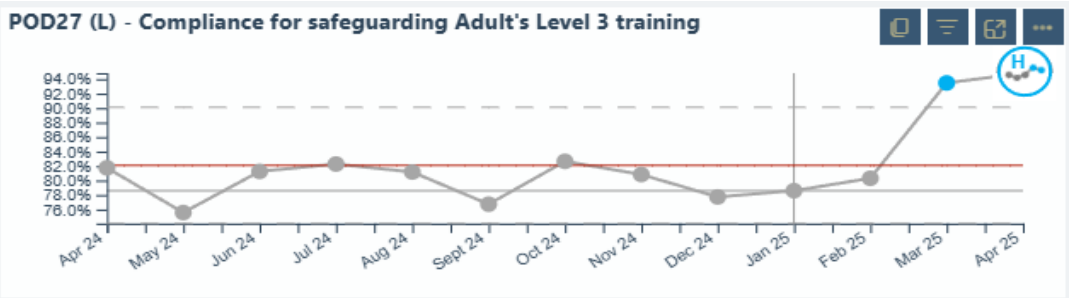

Trend, Reason and Action

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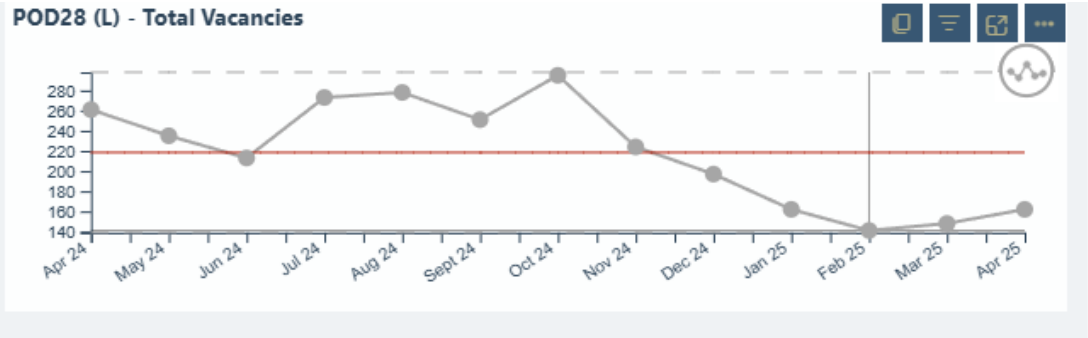
4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

POD28 and POD29 - reporting as 4.37% against the target total vacancy rate percentage of less than or equal to 3.3% (2024/25) with 162 vacancies currently across the trust (increased from 148).

4.0 Finance – In Focus

The month 1 finance position is in line with the plan with all directorate budgets now signed off and delegated by the CEO and CFO. Detailed reporting of the financial position will resume from May in line with NHSE reporting timescales.

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.
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(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Annex 1
Proof of Concept
HI Analysis

Trust IQPR KPI with Health Inequalities Analysis – Proof of Concept

Introduction:

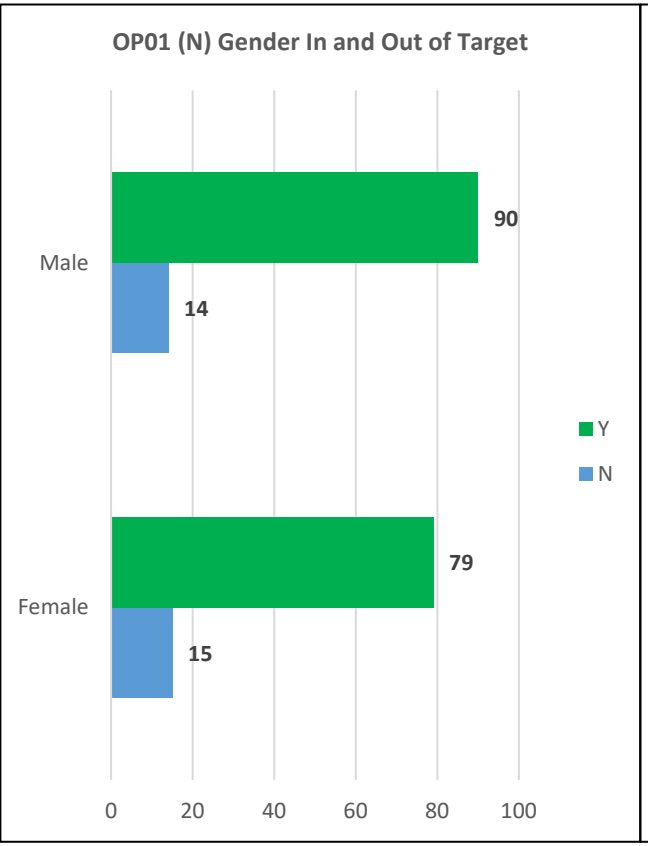
- Trust requirement to breakdown IQPR and other measure down to key Health Inequality elements (age, gender, ethnicity, deprivation) and supporting visual analysis.
- Current IQPR BI product is not fit for purpose for this level of breakdown and detailed analysis.
- PoC using IQPR KPI OP01 (N) “People first episode in psychosis started treatment in 2 wks” with a >60% compliance target.
- Proposed design suggests 4 table based KPI matrix pages, one for each HI element providing highlight figures for each KPI with ability to drill to individual HI visual analysis.
- 12mths Trust level 24/25 data used for PoC analysis to ensure adequate sample size for low monthly activity.
- HI data is available for each IQPR measure at patient level via report 458.
- Analysis highlights a balance between genders for meeting KPI target and age group, predominantly white ethnicity, and higher proportion of black and mixed males. Slightly higher female representation from lower deprivation areas, and increased males from higher deprivation areas. Increased ethnicity representation in lower deprivation areas

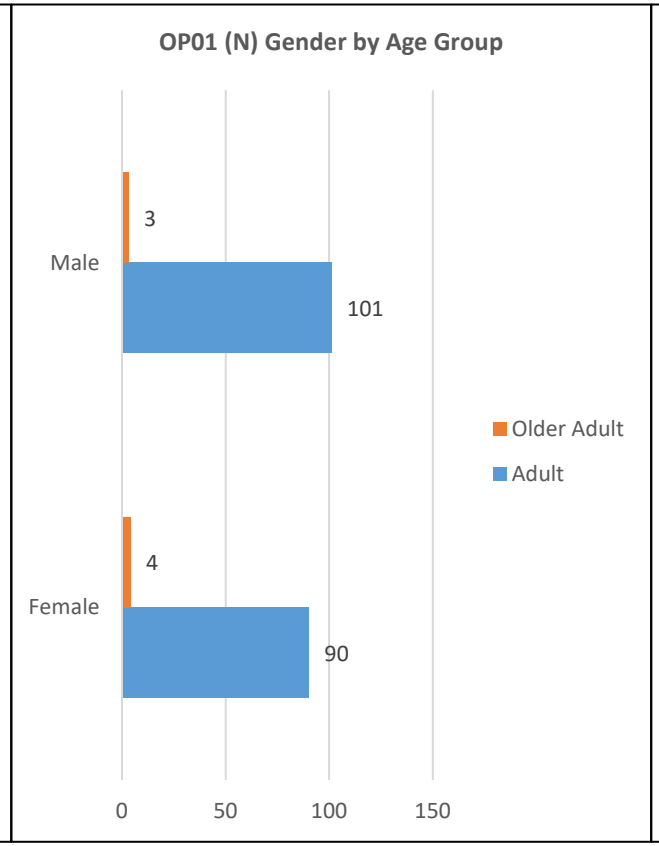
Next Steps:

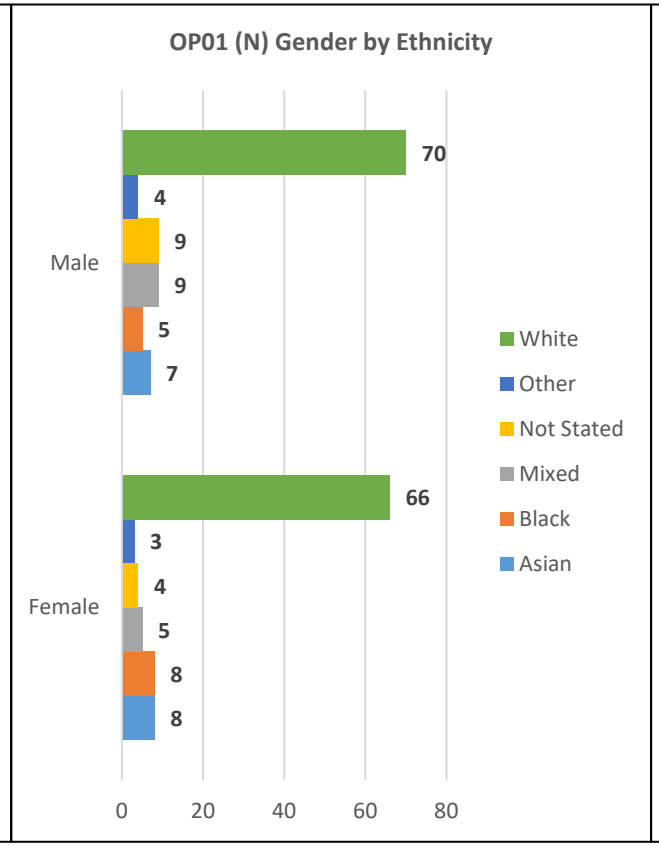
- Agree standard visualisation, analysis, and level of granularity required to support regular monitoring.
- Fully automate within a new KPI management BI product which includes standard Health Inequalities analysis breakdown.
- Potential to add year on year comparison and further population analysis techniques where appropriate.

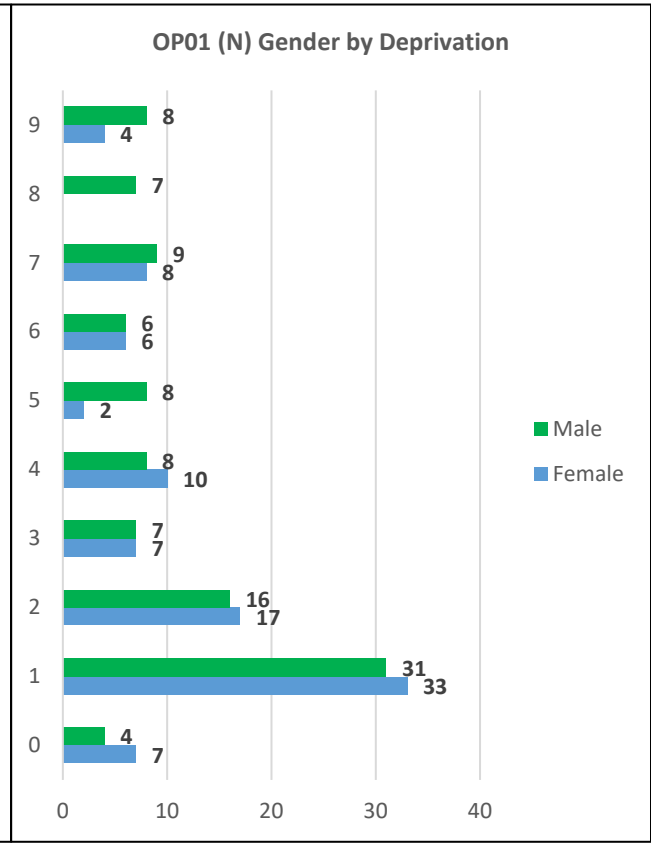
Measure by Gender

			Measure			Gender	
Indicator	**Alt Ref**	**Metric**	**Target**	**Actual**	**Value**	**Male**	**Female**
OP01(N)		People first episode in psychosis started treatment in 2 wks	>60%	84%	155/184	52.53%	47.47%



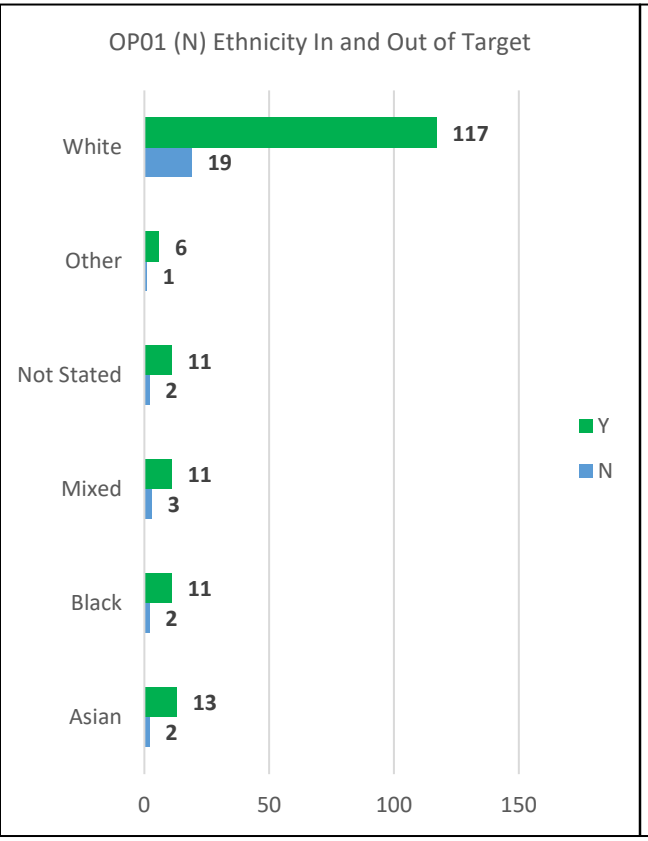


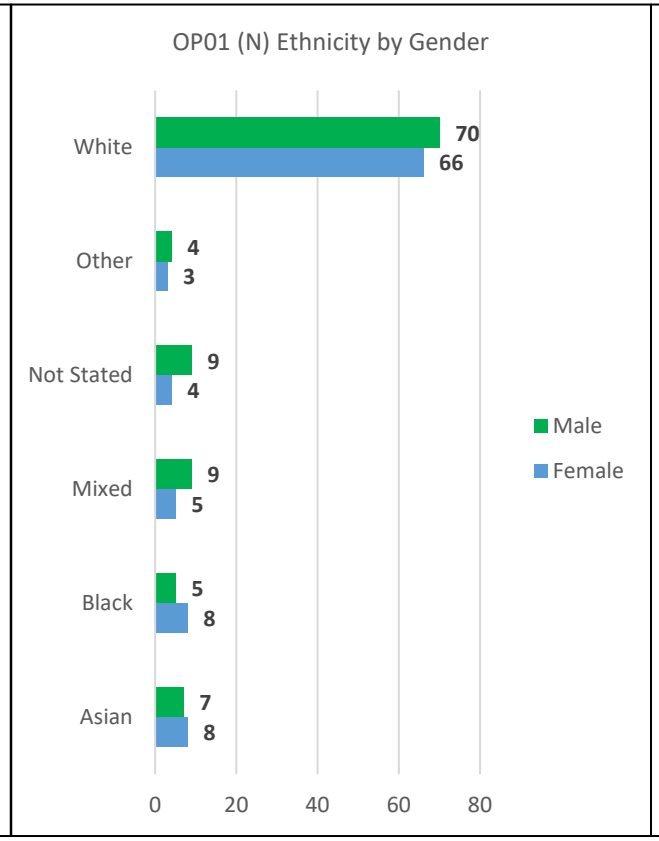


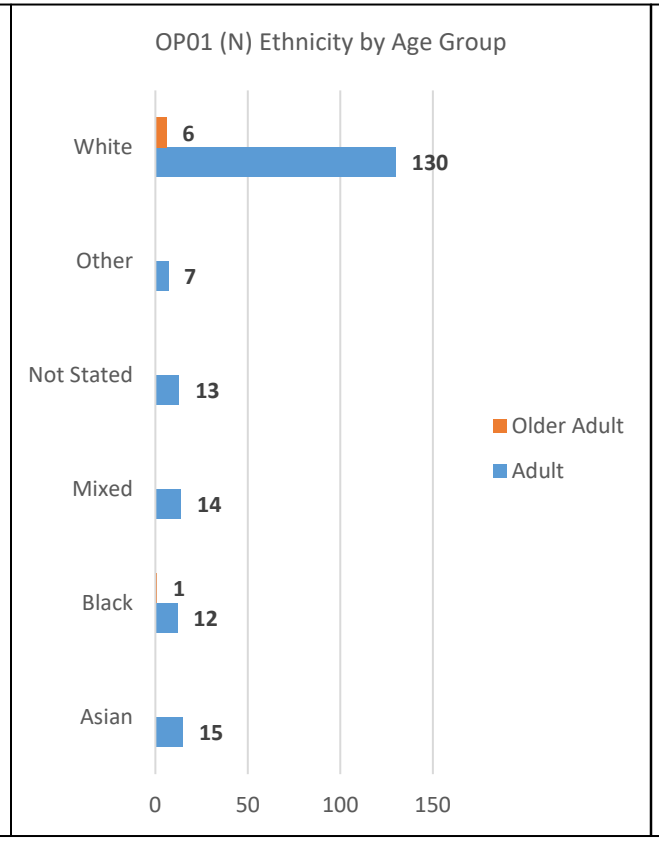


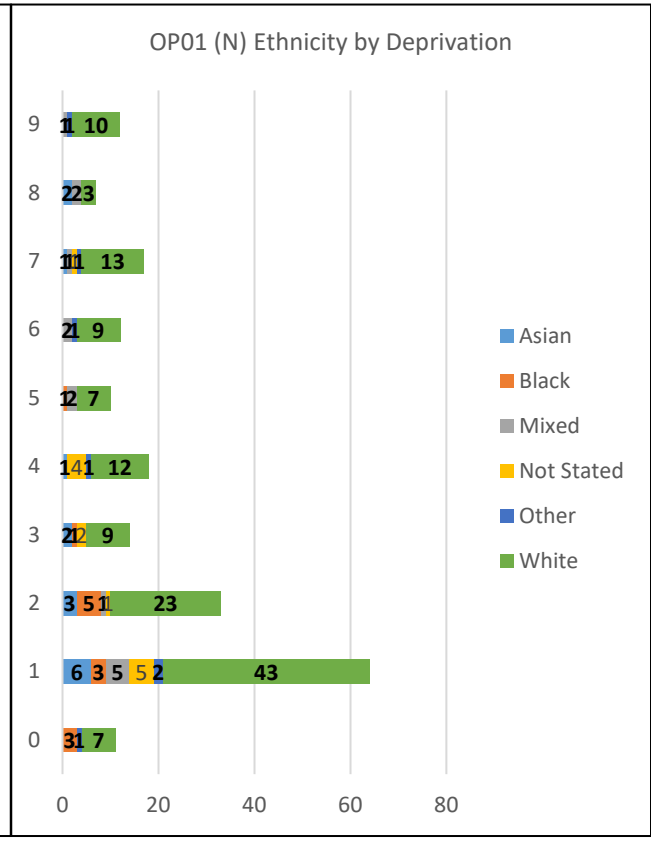
Measure by Ethnicity

			Measure			Ethnicity					
Indicator	**Alt Ref**	**Metric**	**Target**	**Actual**	**Value**	**White**	**Black**	**Asian**	**Mixed**	**Other**	**Not Stated**
OP01(N)		People first episode in psychosis started treatment in 2 wks	>60%	84%	155/184	68.69%	6.57%	7.58%	7.07%	3.54%	6.57%



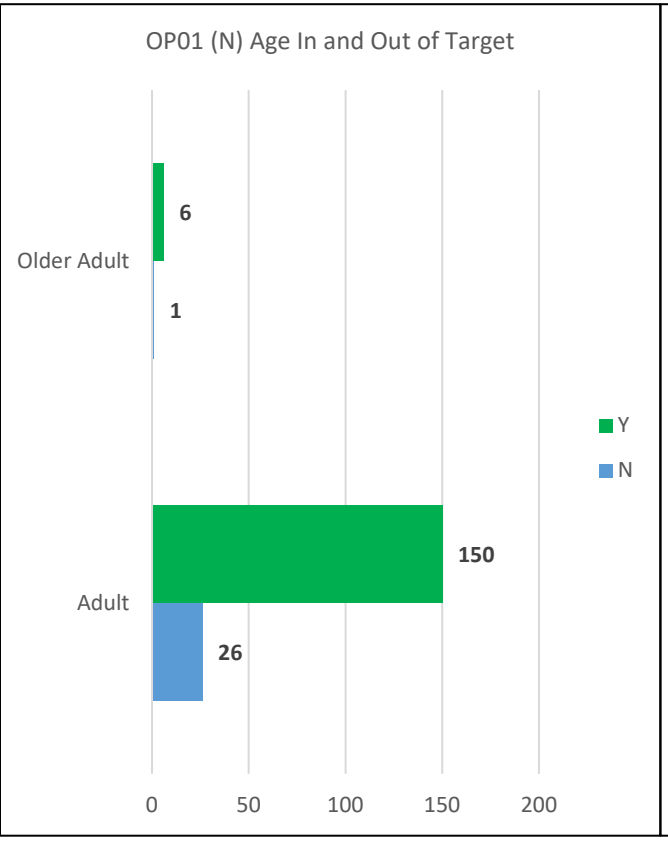


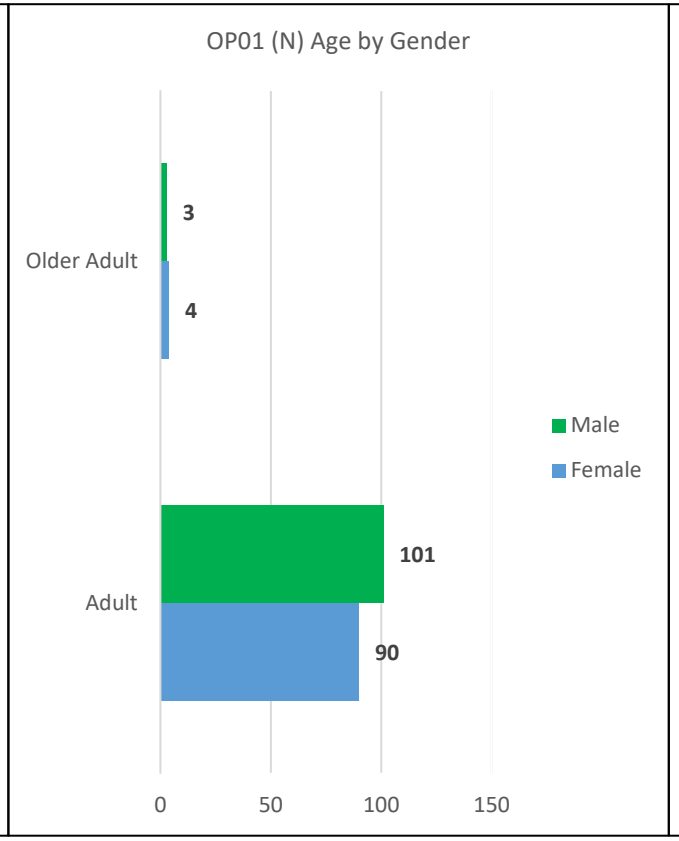


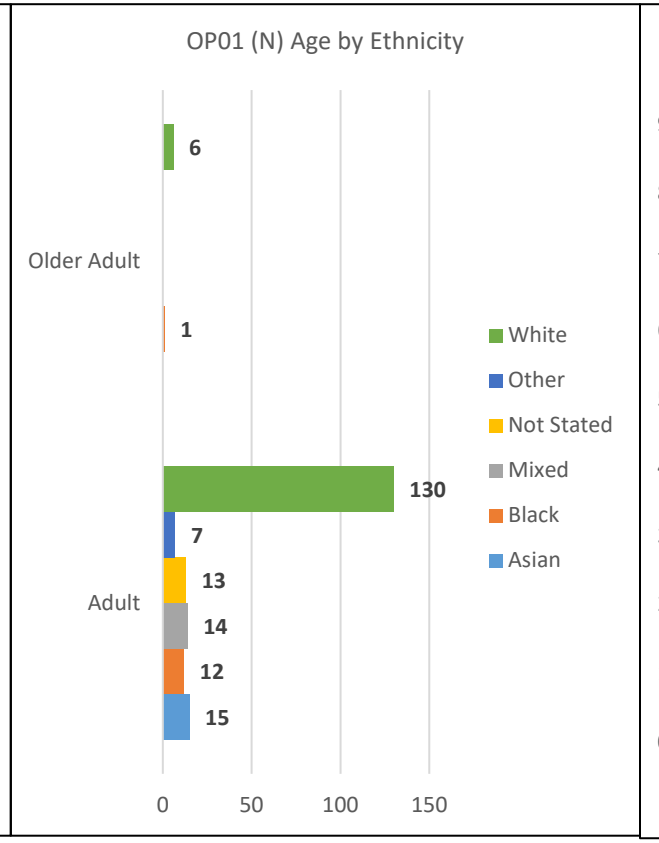


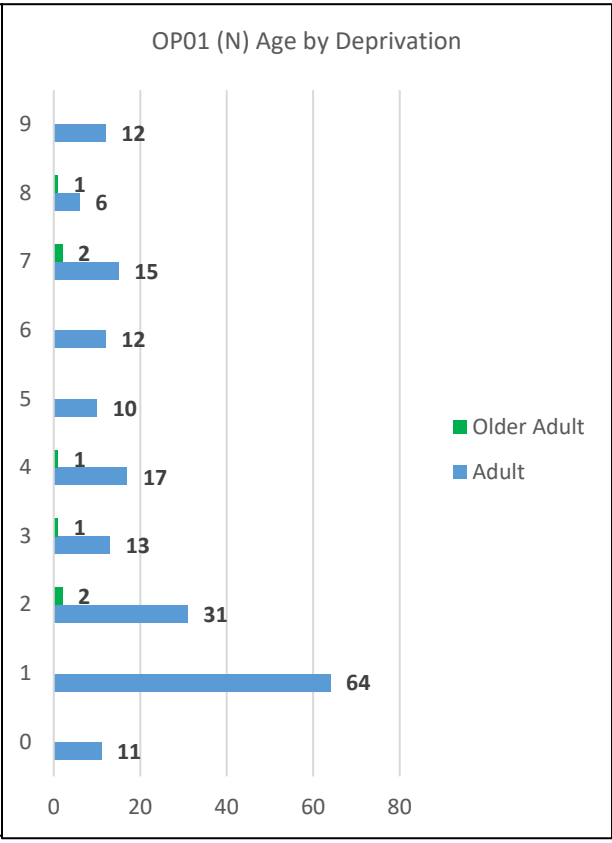
Measure by Age Group

			Measure			Age Group	
Indicator	**Alt Ref**	**Metric**	**Target**	**Actual**	**Value**	**Adult**	**Older Adult**
OP01(N)		People first episode in psychosis started treatment in 2 wks	>60%	84%	155/184	96.17%	3.83%



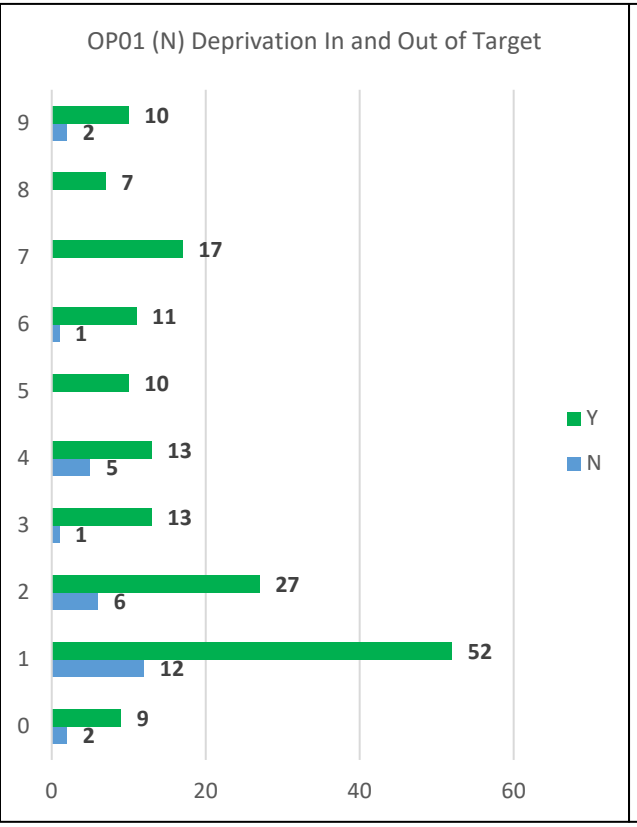


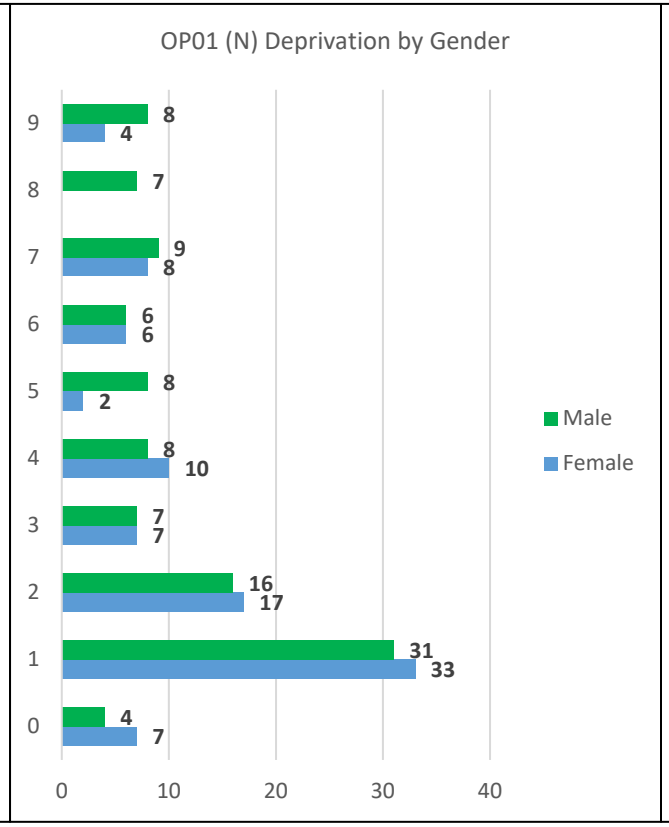


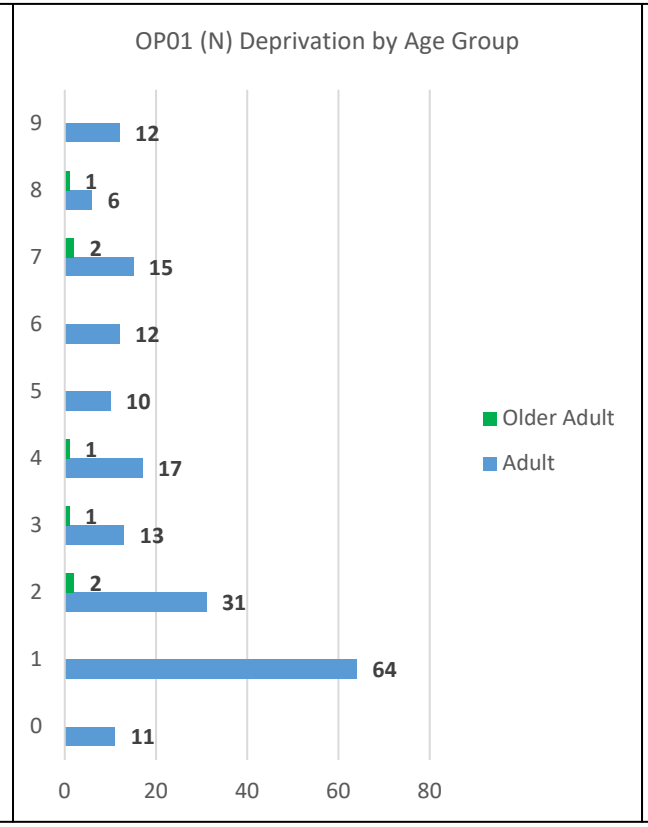


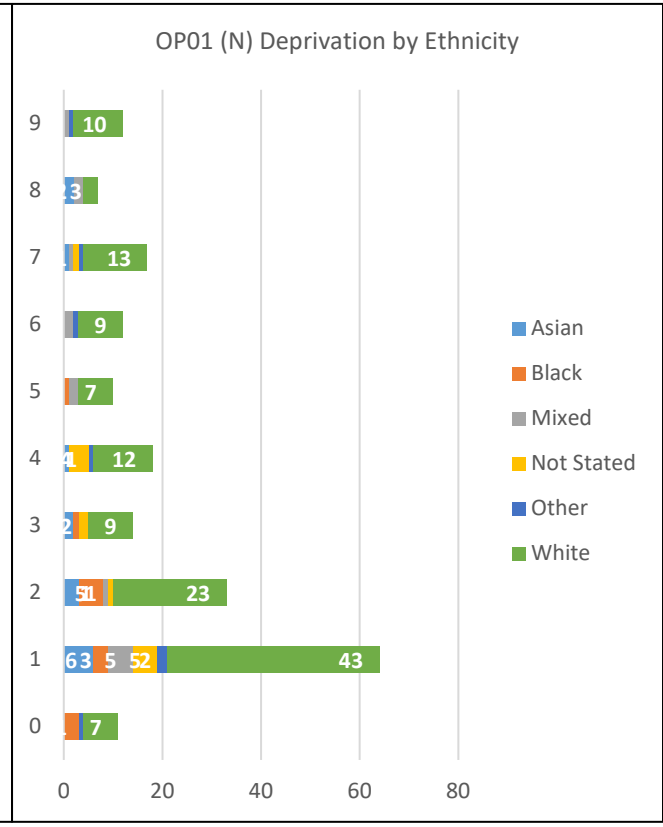
Measure by Deprivation

			Measure			Deprivation Indices										
Indicator	**Alt Ref**	**Metric**	**Target**	**Actual**	**Value**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
OP01(N)		People first episode in psychosis started treatment in 2 wks	>60%	84%	155/184	5.46%	31.69%	18.03%	7.10%	9.29%	4.92%	6.01%	8.20%	3.83%	5.46%	0.00%









ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Priorities and Promises Scorecard as at May 2025	**Agenda Item**	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 May 2025

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

In March the Board considered a YTD position for 24/25, and it is that which will be used as the basis for our Promises Report into the annual members meeting in July 2025. A parallel patient-led report will accompany this.

In February the promises were 'segmented' as part of the operational planning for 25/26: the detail of that was explored in the last Board report and remains unchanged. CLE in June, assisted by the scorecard here, will discuss in particular what is needed to achieve segments 1, 2, and 3 promises over the balance of the year.

Our Promise 2 [carers] delivery plan will be finalised by the start of August.

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

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

Previous consideration

n/a

Recommendation

The Board is asked to:

X	**NOTE** the self-assessment provided, which will go to the CLE in June
X	**DISCUSS** specific updates offered in the report itself
X	**RECOGNISE** the intention to hold 'success events' for promises 25/3 if achieved in H1

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

Trust Risk Register	X	RMG has been asked to reconsider whether promise delivery is well reflected in our risk register					
Board Assurance Framework	X	SDR 3 vs promise 15/21					
System / Place impact	NA						
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)

Annex A – May promises scorecard

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 Accompanying the scorecard, which follows the format agreed by the Board in September 2024, is a commentary here on key matters arising over the past 8 weeks together with any new risks to delivery which the Board needs to be sighted on.

1.2 Challenge on the pace and depth of progress is welcomed, and the report should provide a basis for that to happen.

Key updates from April and May

2.1 We have finalised work to complete our Promise 8 set of 'five'. Alongside work on dementia diagnosis, health checks for people with a learning disability, older adult access to talking therapies, and work on neurodiversity, we have **agreed to focus on perinatal mental health**. Sustained support to execute these commitments will be needed in each care group, through the E&I group, even as the clinical champions continue their role for each project.

2.2 Within our delivery review cycle we have focused this month on the planned care element of **Promise 14**. The final data work on trajectories is being completed, mindful of review at July's Board meeting. We are targeted in many cases initial delivery of four weeks during Q3, providing opportunity in Q4 to stabilise the position. This work does rely on altering how we communicate and in many cases book patients, and Richard Banks is now leading work in that regard.

2.3 With the publication shortly of the Ten-Year Plan, we are seeing real energy locally in relation to **Integrated Neighbourhood Teams**. This should allow us during H2 to make progress with this otherwise delayed promise, where we had chosen not to rush ahead without partners, including local communities. In related vein we have now proposed, and agreed in the Equity and Inclusion Plan, a set of success measures for Promise 21 about hyper local working.

2.4 For the first time in May, care group teams have been working to present their **research performance** within delivery reviews. As we take forward promise 28 (and then in parallel promise 24 on education) we are seeking this year to deliver on our tripartite mission. The transition path to directorates and care groups working across all three areas, normal and routine in much of the NHS, will be a development journey over the balance of 25/26.

2.5 June will see our Pathway event in relation to **Homeless Health**, as part of Promise 10. As outlined in the Equity and Inclusion plan forward look section for this promise this cannot be all of our efforts. For a variety of reasons, including how public health funds have been accrued, there is a risk that our

focus is too Doncaster centric, and we will take active steps from Q3 to redress that balance.

Getting close to delivery

3.1 Over the course of this year, we are **seeking to 'deliver'** at least four of our promises – starting with accreditation for promise 25, then the milestone associated with promise 3 – and then year end delivery of promises 14 and 19. We would all recognise that delivery is an ongoing activity, needing maintenance as well as milestones, but it will be important to celebrate, recognise and learn from the work done.

3.2 The forthcoming audit report on Promises 3, 4 and 5 appears encouraging. We would all recognise that Promise 5 will need further work. The shadow CLE is due to kick off during Q2, and over the latter part of the year Glyn Butcher and Jude Graham will undertake work reviewing how we support co-production. **Delivery of our Community Involvement Framework** cannot be successfully achieved without a more structured relationships between the Trust and voluntary sector partners, and we are actively considering presently how best to do that, acknowledging that the intention is for Care Group "cakes" to hold lead responsibility for VCSE partnering at place.

3.3 In September, as a Board we are aiming to spend time considering further progress so far, learning from and the forward trajectory in relation to Promise 1. This deliberately chosen first commitment, and the largest beneficiary of financial investment since 2023, needs to deliver full value for patients, to alter patterns of care, and to plausibly reach across all services. As with volunteers, there is an inevitable risk that adoption is in places of enthusiasm, but may not yet reach into places of greatest need. We also intend by that date to have completed work on our wellbeing framework and wider support offer for peers.

Conclusion

4.1 It remains the case that our promises are widely acknowledged. There is work for us to do to begin to keep the organisation as a whole updated on how far we have come (where we have) and how far we have to go. This summer we will consider the most impactful, yet sustainable, way to do this. By that point we will be able to reassure colleagues that the Ten Year Plan is a national rendition of much of what the Trust has been trying to achieve for two years – assuming that the plan is published and contains the long term narrative that we expect.

Toby Lewis, May 23rd 2025

Promises and priorities – delivery plan and delivery self-assessment

Annex 1

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
1. Employ peer support workers at the heart of every service that we offer by 2027.	Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Amber red	We have a baseline understanding of our current position, and a credible plan for inpatient coverage: establishing how community coverage is achieved will need us to broker 'sharing' agreement between service teams to become affordable	Amber red	This work will require the focus learnt on promises 3 and 6 in recent weeks if we are to purposefully introduce PSWs at twice or more the scale of neighbouring Trusts: the next few months will set a critical platform for a 26-28 funded plan of growth
2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	Assessing the trajectory for this application was delayed from February to May owing to pressure of other work, so no change to planned rating.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence. The positive 'aura' created by the Carers Network will help – as will the impetus to improve flexible working arising from the staff survey.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	There is now an understanding that we will have 'a common' Trust-wide approach' to this. Implementation planning will follow via HQTC in Q1.	Amber green	Carer feedback will be critical, as we implement a new approach – and gather insight into what works (critical too with changes to MHA)
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber red	We would expect plans to move this forward to be developed via our new network over coming weeks.	Amber red	This cautious rating reflects the hidden scale of need and the work required to match that with support
	Identify all-age carers that use our services and ensure their rights under the carers act are recognised.	Red	The plan for this work will delivered by 22nd July 2025	Red	Until the planning work is done it is impossible to meaningfully estimate the LOD.

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3. Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer	Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.	Amber green	The final trajectory will come to the public health, patient involvement and partnerships committee in July.	Amber green	Until we hit 350 in October, we have to remain cautious. Considerable effort has been expended to move towards 250 – and impetus needs to sustain.
	For that body of volunteers to reflect the diversity of our populations.	Amber green	There remains work to do to reach across all protected characteristics. Hence the move to ESR entry.	Amber green	There is now clear focus on this aim, and with more people entering volunteering on a career-development pathway there is a route apparent to delivery.
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.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Green	Both via Care Opinion, and bearing in mind other routes, we can see that the scale of feedback we have in place will continue to expand.	Green	This scale measure we would expect to meet during 2025/26.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	The pilot for this work has proved successful and has been assessed by the Board's MHAC: we now need to sustain the work over time.	Green	We will track this work in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received.
	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Amber green	Most directorates can evidence how this feedback is influencing their work: we need to ensure all 13 can do so when Delivery Reviews occur in May (and this is being validated).	Amber green	Recognising that feedback is not all about 'change' – we need to be able to evidence a small number of meaningful impactful changes in our 25/26 Quality Account.
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.	Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work continues and has been evaluated for further improvement. The remaining step planned is to create communities of practice among those involved, for example through our shadow CLE.	Green	As the work continues, the need to ensure accountability from representatives back to the local community will grow. The route and agency through which to do that remains to be established.

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	Deliver the Board's community involvement framework in full.	Green	This CIF has broad support (and is now approved) but needs operationalisation plans to deepen with Care Groups, supported by a revised VCSE register (new received).	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Amber green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming weeks.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.
	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Green	Council of Governors has approved the approach, but there is a need for Nursing and Facilities to now systematically deploy it in Q1.	Green	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 2025 we would expect to meet the measures we set in 23/24.
6. "Poverty proof" all our services by 2025 to tackle discrimination, including through digital exclusion	All our services to have completed poverty proofing and be able to evidence resultant change (including digital).	Green	Directorate level deployment is agreed and a revised 'approach' is being taken learning from pilots. There is a good 'buy in' now from those involved.	Amber green	It will be important before July 2025 to be able to evidence real changes from the 24/25 deployment – with funding for the transport changes put into place.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	Our current plan is to poverty proof. It remains to be established in early 25/26 what other interventions are needed to achieve this measure.	Amber green	The lack of a final timescale for this improvement explains the positive rating – there is time in 2025 to iterate delivery over following months/years.
	Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'.	Amber green	Teams have begun to describe how this will be integrated within their DIALOG+ deployment: more detail is needed on how patients will experience this access before the plan goes green.	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.

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7. Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: **achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.**	Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026/27.	Amber green	The last report flagged a concern of this plan deteriorating owing to data reporting gaps: there is confidence that this can be resolved.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.
	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber red	There has been some fantastic work done to move this measure forward. However, the gap from our/PCN registers is sizeable and GP contract changes may have an impact on partner engagement and on our approach.	Amber red	For SMI registers it is apparent we do have the scope to do this work. This is less clear for LD registers (where the GP listed popn is significantly larger). We need to resolve in Q2 a trajectory to achieve coverage *or revise our aim.*
8. Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality (“the RDASH 5”). (next report will include neurodiversity measure and peri-natal MH)	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Amber red	There is not yet a cogent plan to address this (and the investment fund bid proved unaffordable). A reset of approach needs to be undertaken considering what can be achieved (and what problem we are trying to solve)	Amber red	The LOD has deteriorated in view of the plan being unaffordable, and the wider challenges for this AHC approach outlined under promise 7 reporting.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green	A strong proposal to make progress with this is funded for 25/26, rooted in evidence from elsewhere. We need to ensure all 3 memory services are engaged with the Rotherham led work.	Amber red	The LOD is improved based on a emerging and coherent plan. As waits for diagnosis reduce, we have capacity to reach into communities and work at pace (as we evidenced in NL).
	Improve access rates to talking therapies among older adults.	Amber green	There is a plan (to increase access by 1500 slots). A combination of data-mining among exists caseload and new referrals exists – there	Amber green	The tangible plan, and clear clinical commitment, exists to make this happen – what is now needed is measurable

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			remains some doubt over whether the grip needed is in place (which is also a broader TT concern for the care group).		change over Q1/2 to reinforce confidence in our ability to deliver.
9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.	Achieve the levy requirements in 2024/25 and thereafter.	Amber green	The Board has received the plan of action for this measure: It is now being enacted.	Amber green	We remain confidence of meeting the measure in 25/26 but need to see an upswing in enrolment during Q1 to be confident after falling short in 24/25.
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber red	A detailed plan is due by July for this measure.	Amber red	Whilst there are differences between these three ambitions they currently have in common delivery doubts based on a lack of oversight and cogent approach. This is being urgently addressed – as schemes exists elsewhere and deploying them to the Trust is entirely possible with focus in Q2.
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Red	A detail plan is due by July for this measure.	Amber red	
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	Learning from what is above, we need to start work now on the scheme for twelve months hence. Working with our ID/LD teams, we need to consider how best we can establish a targeted programme.	Amber red	
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	Comparison vs. standards will go the July E&I sub group.	Amber red	It is possible to meet the standards in time, with rapid use in 25/26 of the funds set aside with partners. This will require concerted work to make ‘mainstream’ services available, as well as to develop specialised services.

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misusing substances, and forced migrants.	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	This access plan will rest on ensuring mainstream services thresholds for exclusion are changed in theory and practice: initial discussions to this effect have begun. A more organised and concerted approach will be needed (with new resource in place to move this forward).	Red	Until a baseline plan is in place it is not possible to offer a more optimistic view of changes needed – nor how much resistance in practice could be experienced in developing TIC models in this field.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	The Trust has invested in GRT specialist service support. Service offers for sex workers and those experiencing homelessness are developing – there remains work to do in considering how best to ensure refugee access.	Amber green	Most inclusions health groups can benefit from revised access arrangements, and some element of specialised support, over the next two years. But only if organisation and emphasis is stepped up in H1.
11. Deliver in full the NHS' commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and trauma responsive services	Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place.	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.
	Introduce peer-led service support offer for local residents.	Amber green	This offer is in place in trial and further expansion is being into place. We'd expect this to be live at full scale during 25/26.	Amber green	This input and effort measure can be met, and is in fact ahead of expectations.

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12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.	Green	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams.	Amber green	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into early 25/26.
	Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated in the context of the digital transformation plans we have during the balance of 25/26.	Amber red	Rating reflects planning comments made.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Amber green	A strong plan exists, has been peer reviewed, and is being delivered. However, national funding and narrative is now uncertain for virtual ward services.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We need to agree a final plan with the Care Group, and crucially with DRI, for the service's further growth.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Green	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Green	Funding, some centrally pumped, much recycled in now in place to move these services forward in H1 25/26
	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…	Amber Green	This measure is ours, and others, and will see substantial emphasis in coming years – no doubt.

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14. Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Meet four hour wait standard in 2025/26, where it applies.	Amber green	This measure applies in only a handful of defined services. Monitoring suggests room for improvement but strong performance – focus on this is likely to yield delivery.		A delivery priority for next financial year.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Amber red	Thinking about routes to success has taken place and CLE is moving to define what this promise in practice means in July and August.	Amber red	Until we commence implementation it is too early to be confident we do not have glitches, notably in relation to MDT decision making
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Green	Strong consistent work has taken place to understand our waiting lists and demand/supply in relation to waits themselves. Investments reflect only areas where productivity cannot meet the measure.	Amber green	Delivery relies on both supply side change and some stability in demand, both across a year and by month (as a proxy for four weeks). We will use 25/26 to identify difficulties with that assumption.
	Meet 4 week standard from April 2026 across all services.	Amber green	There is increasing confidence that this measure could be met: the cultural shift doing so requires is not inconsiderable and weariness with the ask will need to managed.	Amber green	Neurodiversity remains the greatest single challenge to the measure, and adult ADHD services are very substantially behind the agreed trajectory going into Q1.
15. Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Red	Positively, the Trust is at the forefront of 'neighbourhood health' conversations across the ICB: but a cohered plan remains elusive (and we cannot plan alone). We might reasonably expect the Ten Year Plan to again reemphasis the requirement.	Red	Time passes and 26/27 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings on a pilot or targeted basis.
	Restructure Trust services into those INTs during 2025/26.	Red	This rating reflects the lack of a plan – our community based teams, in the main reflect PCN groupings – not neighbourhoods.	Amber red	Discussions over children's services less well developed than for adults: will require a move towards generalism

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					which may not be easy to lead professionally.
	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!
	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	Needs a clear frame of year end analysis in ‘washing up 24/25’.
16. Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	We are moving from training to use and support teams to doing: led by Jude Graham.	Amber green	This remains a challenging programme and one that can deliver, but will face competition from other priorities.
	Report and improve patient recorded outcome measures (PROMS) supported nationally.	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber red	An improvement trajectory remains to be understood and defined, but data is beginning to be shared to build it.
	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red	This forms part of our Q&S plan but may take us into 2026/27.	Amber red	See comments to the left.

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17. Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	Narrow the school readiness gap between our most deprived communities and average in each place in which we work.		A challenging plan exists, which has strong support from across corporate functions and is led through the Children's Care Group.		Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan. This feels feasible, if difficult, in Doncaster and North Lincs.
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber green	Establishing this data feed is taking time and requires stem a deteriorating position. May move to Amber red	Amber red	It is much easier to be confident of the inputs than the results in this field: the Trust has developed and is implementing a clinically led hypothesis which may transpire to make a difference.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.		Current analysis for this measure appears positive. Work to improve MHA compliance is showing promise. We know what to do, we need to do it – with Q1 25/26 seeing some better real time data available to teams, for instance in relation to S17.		With continued focus we have some confidence that this can be met over the balance of the year.
	Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment.	Amber red	Baseline data is being put into place. But it is taking time to agree how to accomplish change inside each ward. Medical engagement remains a significant challenge to implementing this plan, albeit among acute psychiatrists there is some enthusiasm.	Amber red	Mobilising this work will be a significant endeavour in 25/26, after pilot phases over next two quarters.

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	Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams are able to act on that feedback and those evaluations.	Green	This work has progressed strongly through 2024/25, including now on an OOH basis. Peer involvement has added greatly to the product.	Green	We do need to be able to show impact from the work done, and this will be reflected in our QA for 24/25.
19. End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Cease to place patients out of their home district except where that is their choice or in their best interests.	Amber green	The plan of action is before May's Board.	Amber red	The scale of change required remains immense. Substantial improvement is possible, a revised timetable for elimination will be assessed in Q1 25/26. Our general 25/26 plans assume sizeable change from July 2025.
20. Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	Deliver over 130 care packages through our physical health virtual ward service working. with partners.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Red	AOT work has taken primacy. An assessment is being made of how/when this is best mobilised. It may be that it can support the LOS work referred to under Promise 19.	Amber red	This rating reflects comments on the left.

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	Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Amber red	The intent and commitment to do this is clear from the leadership team – but a tangible plan to trial this is not yet visible and did not come forward within planning for 25/26. Discussions will continue with the CCG.	Amber red	Evaluation in that time period may not be feasible, but deployment, if funded, will be.
21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness.	.			
	Contribute actively to the city-wide Thrive programme within Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced.				
	Implement anticipatory preventive care models supported within the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care.				
	Understand and act on local research into patterns of referral, cross referral and best fit services for mental health in adults and older adults linked to general practice.				

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes.	Not yet reviewed			
22. Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).	Amber green	This is not P14! This measure is mostly met in Trust delivered/commissioned services. The intention is to use the MHLDA programme for 25/26 to influence configuration.	Red	This is rated red to reflect the reality our patients face – where there is substantial variety in non-Trust services which we need to now influence. There is also a fragility to crisis services which needs continued attention.
	Support substantially increased discharge and admission capacity over weekends.	Red	This will be an important part of our work on promise 19, and efforts to reduce LOS. We do not have a defined plan, delivery chain or implementation model in place as yet but need to have such for May.	Amber green	There is very substantial executive emphasis on this work and over coming months we'd expect to see change.
	Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber red	This is not currently our priority, and we'd anticipate baseline data is scarce. N&F resourcing this work during 25/26 – due in July.	Amber green	By the end of 2025 this input measure can be met.
23. Invest in residential care projects and programmes that support long-term care outside our wards: specifically supporting expansion of community forensic, step-down and step-up services.	Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations.	Amber green	We have made a start in Rotherham, and are trying to define final work packages elsewhere. Turning these opportunities into bed flow that impacts acute care needs further grip.	Amber green	Strong buy in from clinicians and partners – and work can be taken forward within the auspices of HQTC. Will need diligent oversight to avoid atrophy.
	Expand the scale of our residential forensic rehabilitation service.	Green	Work has already taken place with this in mind. Further plan exist in our community teams, with scope for work alongside Cheswold.	Amber green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support. Bid submitted for national frailty monies.	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 3 years to deliver.
24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.	Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. Some uncertainty over what drives positivity.	Green	If we retain good infrastructure and support our supervisors with time then performance is expected to be sustained
	Trust workforce plan for 2028 on track to be delivered.	Amber green	Plan, notwithstanding item below, developing well. Fully staffed is year 1.	Amber green	Persistent vacancies are not out principle difficulty (retention exemplar work needs to be effective to sustain seniority within disciplines over time) ie retirement risk.
	Trust meets expectations applied through national Long Term Workforce Plan roll out.		We may pause monitoring of operating plan guidance sheds light on the national		Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)
	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received). Social work assessment due in 2025.	Amber green	No identified reason why assessment outcomes would change over coming period, albeit some emerging concerns among postgraduate medical education.
25. Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	Obtain Real Living Wage Foundation accreditation in first half of 2025.	Green	Engagement started some time ago. Components required all being taken forward and visible within corporate delivery reviews.	Green	For summer 2025 we are confident of achieving accreditation unless external intrusion into our pay plans.

Promise		Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Red (R) – Not constructed yet		Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	
26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We have completed the work on both back pay and RLW for implementation to the timetable agreed with the Board.	Green	As above.
	Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).	Amber green	Clear plans developed during 2024. Implementation deadlines are clear and being met but some supply chain issues to resolve in Q1.	Green	Measure defined, suppliers aware. Food and travel most challenging areas to execute, albeit both consistent with P27 agenda.
	Implement suite of policies and practice to Kick Racism Out of our Trust.	Amber Green	The agreed plan has had difficulty being deployed, and audit review criticised the diversity of approaches taken. This is largely addressed but rapid action is needed in Q1.		Practice as well as policy change needed, but visible start made and weaknesses caught in time.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber green	Some positive movement within the 2024 staff survey results when compared to 2023 and to peers. Further 2025 survey on which the our recent quarterly HR data.	Amber red	A complex and longstanding issue, which, as August 2024 illustrated, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues.
	Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Amber green	There is strong commitment to the measures contained in NW accreditation: work needed now to look across excluded groups for relevant assessment tools.	Amber green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Tackle our gender pay gap.	Amber green	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Green	We are increasingly confidence of delivering this measure moving into 2025/26.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Amber Red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our estate plan.	Red	Estimated £18m investment is not entirely foreseeable, and we are working through what may be possible as an alternate to the heat pump route to gas reduction.
	Agree and deliver specific contribution to local authority climate change plans.	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in due course this work will need to be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are doing what is asked. The plan may give rise to a larger ask in time.
	Change service models for patients and staff to reduce travel required by 2027.	Amber red	A plan to achieve this, and to scale ‘this’, is being developed during Q1. Our ‘remote’ policy and practice will be crucial to success. A positive climate adaptation day has moved forward thinking inside teams as well as at corporate level.	Amber green	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 25-26-27.
28. Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring	Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Amber green	This is very much a well led measure and we would expect to succeed again in 2024/25

		Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet		**Likelihood of delivery** Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	**Comments on likelihood of delivery**
investment and employment to our local community.	Deliver metrics contained in the Trust's Research and Innovation plan.		Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups	Amber red	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together
	Work to further increase the reach of research into excluded communities locally.		This is a longstanding programme of work for grounded research. A more detailed delivery plan may be needed going into 25/26. This may include developing a community researchers' programme. The Trust is now hosting EMRI, which further contributes to our aspirations.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**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**	29 May 2025

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

The Board agreed a revised approach to the management of five newly agreed strategic delivery risks (SDR) some twelve months ago. Via an internal audit (Q3 24/25), it received significant assurance on that new approach, but agreed to further reflect on the report format, action plans to reduce risk scores and to have further consideration that the SDRs in place remained those most likely to impact on the delivery of the Strategy.

A revised format is included in this paper and via individual lead Executives, Committees and in conjunction with the Audit Committee Chair / Director of Corporate Assurance tri-annual reviews, further refinement and clarity will be achieved in delivering mitigating and impactful action to these risks. The Trust's Strategy remains the clear focus of the Trust until 2028. We anticipate that the NHS's 10-year plan will be published in the coming weeks and the Trust will need to carefully reflect and respond to both. In doing so, there will be a timely opportunity to consider and confirm the ongoing SDR in Q3.

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

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

The Board receives regular report on SDR throughout the year and last did so in March 2025.

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

The Board of Directors is asked to:

RECEIVE and **NOTE** the update position reflected in the revised (format) SDR.

NOTE the next steps outlined in the report to further refine and enhance plans to mitigate these risks

NOTE the intended review of SDRs following the publication of the NHS 10 year Plan

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

Trust Risk Register		
Strategic Delivery Risks	x	SDR1, SD2, SDR3, SDR4 and SDR5
System / Place impact	x	All SDR in the paper are set within an external (system/place) impact / requirement for engagement.

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)

Individual Strategic Delivery Risk forms are in the Annex to the Report.

Strategic Delivery Risks

1. Background

1.1 The Strategic Delivery Risks are those risks that the Board has determined as having most potential to disrupt the delivery of the strategic objectives. These are different from the risks manged via the range of risk registers (operational risks). 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 SDRs focus on factors which could interrupt delivery of the organisation's objectives over the medium term. These are also risks that the Board has a unique ability to solve.

1.2 The Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect.

2. Strategic Delivery Risks (SDR)

2.1 The five risks, each aligned to a strategic objective are:

- 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 (links to SO1)
- Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)
- Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies (links to SO3)
- 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 (links to SO4)
- The Trust lacks the cultural capability and competence on wider issues (links to SO5)

2.2 Papers to the Board throughout the 24/25 featured the five SDRs and respective Committees received frequent reports on progress with mitigation. Furthermore, the Audit Committee remained sighted on the progress with the overall SDR management at each of its meetings and the Chair of the Audit Committee held meetings, alongside the Director of Corporate Assurance, with each of the respective Executive leads.

2.3 The Trust's new approach to strategic risk management was subject to an internal audit review in Q3 by 360 Assurance and received a positive (significant assurance) outcome with recommendations to the Trust, relating to format, actions, version control, review of the risks and link to the Risk Management Framework.

2.4 The Board of Directors will recall the staged process through which it identified and agreed the five strategic risks – the risks that most significantly could impact on the ability of the Trust to deliver its Strategy (and its strategic objectives). Essentially a 'long list' of some forty plus risks were initially identified and subsequently reduced in number to the final five. The second audit recommendation seeks to afford the opportunity for the Board to review the risks and to ensure they remain those that most

significantly could impact on the ability of the Trust to deliver its strategy (and its strategic objectives) Whilst opportunistic to consider the risks, the process of identification was robust and comprehensive and the five risks were identified against the long term delivery of the strategy, that is to say they were the most significant and they were expected to take time and effort to address. In the coming months however, the NHS 10-year Plan will be published. Its impact on the Trust and its strategy needs to be considered and there will be time afforded to considering whether that 10-year plan impacts on the Strategy or the current risks to our achievement of that Strategy.

2.5 Review and monitoring work will continue through
- 2.8.1 Individual executive leads
- 2.8.2 Board Committees
- 2.8.3 the tri-annual reviews with Executive leads by the Audit Committee Chair and Director of Corporate Assurance.
- 2.8.4 Board of Directors

2.6 The current position in respect of each SDR is presented in Appendix 1 in a revised format. The work to address the audit recommendations has afforded an opportunity to review the content such that it is now a priority action, to be concluded by the end of Q2, that actions / controls are confirmed and the respective assurance process is identified to demonstrate that those controls are operating. Once this is complete a more insightful assessment of the risk score, the next actions and path towards mitigation will be achieved, in line with a specified risk appetite level. A further report to the Board of Directors will be made in July 2025.

3 Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the update position reflected in the revised (format) SDR.

NOTE the next steps outlined in the report to further refine and enhance plans to mitigate these risks

NOTE the intended review of SDRs following the publication of the NHS 10 year Plan

Philip Gowland, Director of Corporate Assurance
23 May 2025

SO1: Nurture partnerships with patients and citizens to support good health											
What could get in the way? **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**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027									
	because	of the leadership's inability to identify, communicate and engage								SF	PHPIP
	then	it will lead to a loss of confidence locally and likely non-delivery of SO1									
Risk Score	Current (May 2025)					Target (March 2026)					
	I	4	L	3	12	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – however. The report noted some further work (Gap) to finalise and embed stakeholder management processes and reports.
Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power' — Both cohorts now launched.	Feedback loop: Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026. Of particular relevance is the response to two questions: 1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities? and 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community (Gap) – outcome of the first evaluation
Educating our Staff: Induction - Revised induction process; 5-day event that includes a focus on introducing colleagues to the Trust and its communities.	Feedback loop: Evaluation of induction asks for participants to respond to the question, *'I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) – outcome of the evaluation

Educating Our Staff: Learning Half Days (Gap) *forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the mitigating actions needed.*	(Gap) – agreed mechanism for capturing the outcome and evaluation of activities that feature within the LHD programme.
Cultural Shift: Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed.	The LDO features as learning outcome *2: Enhance our ability to lead change and deliver improvements (Gap) Clarity over how this will be recorded and reported or evaluated.*
Cultural Shift: Recruitment and appraisal processes that focus on the appointment based on alignment to the Trust's Values	*(Gap)* Confirmed process to ensure processes effectively include this 'test' to ensure colleagues have values that align to those of the Trust
Representation within our colleagues: A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve – this would include number of as well as diversity and representation within these cohorts.	*(Gap)* Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities Improved WRES data
Engaging our communities – seeking feedback Care Opinion launched (patients and carers)	Care Group Delivery meetings in 2024 and in May 2025 featured Care Opinion and Care Opinion within February 25 Board Timeout Led by CEO of Care Opinion (Gap) Overarching analysis of responses via Care Opinion including those leading to action – confirmation of method and frequency
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 4 (Quality – Quality and Safety Plan) o Promise 5 (Board – Quality and Safety Plan) o Promise 6 (PHPIP – Equity and Inclusion Plan) o Promise 8 (PHPIP – Equity and Inclusion Plan) o Promise 10 (PHPIP – Equity and Inclusion Plan) o Promise 11 (PHPIP – Equity and Inclusion Plan) o Promise 26 (POD – People and Teams)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing Board of Directors – March 2025 – Promise 26
PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion – Significant Assurance

SO2: Create equity of access, employment and experience to address differences in outcome										
What could get in the way? **Challenges generating data and / or evidence to support interventions to address Health Inequalities**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	we do not execute plans to consistently create, use and respond to data inside our services and with others								
	because	our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities							RB	FDE
	then	this will lead to a lack of precision in how the Trust reshapes services								
Risk Score	Current (May 2025)					Target (March 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Data Availability: Health Inequalities – Reportable Data Sets of data relating to Promises. Identify a baseline position and detail planned further work across a range of data points including the establishment of targets (via Reportal 521 Health Inequalities Dashboard) (Pointed towards health inequality related promises 6, 7, 8, 10, 11, 12 and 17)	Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities.
Data Quality	Information Quality Programme and reports to FDE noted structured and demonstratable process was in place. Kitemarking – (Gap) Current position Internal Audit report of IQPR (Significant Assurance) Internal Audit report on Waiting Lists (Significant Assurance – waiting list management / Limited Assurance – waiting list validation) Audit on Clinical Coding (Feb 25) FDE assured by the Clinical Coding Audit Report that robust processes are in place to facilitate the accurate application of clinical coding.
Educating our leaders: Digital Needs Survey (completed in Q2)	Summary outcome reports provided to Digital transformation Group and used to inform both the Data Saves Lives programme and also considerations for both bespoke and broader training, particularly

Data Saves Lives Campaign (Launched 26 November 2024) – 'Giving health and care professionals the information they need to provide the best possible care'. Series of posters have been distributed and series of three Vlogs launched (December 2024) Key messages in December including Improving trust and transparency; Accurate and timely recording of data / Knowledge is Power; The benefits of using the Yorkshire & The Humber Care Record; How data flows through the system/organisation. An 'Ask me anything' session took place in January 25. Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities. Specific related events to date: October 2024: establishing mental health and community use cases associated with the use of the Yorkshire & The Humber Shared [clinical] Record; November 2024 : New personalised care visualisation (20 attendees in total). The personalised care visualisation is a new development for PROMs and 4ww / Saving events in SystmOne (14 attendees in total). Accurately recording both clinical consultations of different types, as well as administration events / Communicating with patients digitally (40 attendees in total). Use of health inequalities data for frontline staff: Jan 2025: SMI physical heath checks new visualisation overview (joint session with Change & Transformation) / Feb 2025: shared care records, patient care access considerations (joint session with Information Governance); SystmOne roadmap 25/26	associated with aspects around the requirement to interface with our electronic patient record, SystmOne. (Gap) Identification of key responses from colleagues to the educational efforts to demonstrate learning and great understanding. Board Timeout June 2025 – inc Data Saves Lives / Making Data Count sessions
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: ○ Promise 6 (PHPIP – Equity and Inclusion Plan) ○ Promise 8 (PHPIP – Equity and Inclusion Plan)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing
FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	

SO3: Expand our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services.				
What could get in the way? **Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies**	As a Strategic Delivery Risk:		**Lead Exec**	**Board Committee**
	If	we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level		
	because	there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive	TL	PHPIP
	then	we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.		

Risk Score	Current (May 2025)					Target (March 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – report noted some further work (gap) to finalise and embed stakeholder management processes and reports.
Regular and well established touchpoints within each of the three places with GP representatives: • Individual Practices • PCNs • Federations Via GP Liaison Role – programme of visits established to every practice with touchpoints into PCNs and the local Federations.	Feedback mechanisms with GPs are established and embedded – these will be used to confirm strong alignment on Primary and Community MH services and adult and children's community nursing. Engagement (differing levels) with circa 80% of practices. Initial survey how practices rate the current level of integration, collaboration and partnership with

	RDaSH of practices identified score of 2.52 (out of 5) – benchmark to assess future progress.
Facilitate insight into General practice within: 1. Senior individuals: via Dr Richard Falk – Non-Executive Director / Dr Dean Eggitt – GP Partner Governor / Laura Sherburn – Primary Care Doncaster Chief Executive (route to CLE) / GP Liaison role (within the Strategic Development Team) 2. *Care Groups:* GP related appointments into Care group structures (7 / 13 Care Group Directorates are community based – these leaders are especially important in the development and work supporting the mitigation f this risk.)– 2 Medical Leads and the Nurse Director in the Physical Health CG appointed. *(Gap) Appointment to Physical Health Care Group Medical Director of Primary Care / GP* 3. Wider Workforce: A: Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care. LDO Launched. Cohort 1 commenced January 2025; Cohort 2 launched in April 2025. B: Learning Half Days (LHD) programmed to align to known GP training schedules such as 'Target' in Doncaster (i.e. Wednesday afternoon training sessions across GPS in the city to afford joint training and engagement)	(Gap) Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) Cohort 1 launched January 2025 / Cohort 2 launched April 2025 This feedback will secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care and other partners in particular via the following research and evaluation question. *Has the LDO improved RDaSH Leaders' engagement with each other and the community* Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026.
Practical Programme of Change: Agreed programme of change with Primary Care Colleagues that addresses the issues that they raise via other routes, in particular via GP Liaison Role. CLE (Dec 24) identified four areas of focus + additional fifth subsequent. 1. Remove any and all practices which prevent our clinical teams within RDaSH making cross referrals or transferring care. 2. Move to simple electronic forms for all referrals, with prompts which ensure that mandatory information is provided: 3. Introduce simple, coherent routes of communication to our clinical teams from primary care, and provide 'backdoor' contact models to permit escalation senior clinician-senior clinician for any patients where there is a concern.	(Gap) Comprehensive action plans within Care Groups and reporting mechanism to ensure agreed timescales are achieved and have the intended benefits.

4. Audit and justify any practices which tend to pass work or tasks to GPs that could be done by the secondary care team. 5. Waiting time information – Providing up to date waiting time information and making it simple to patients to find out their place in queues to reduce purely administrative appointments in primary care.	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 12 (PHPIP - Equity and Inclusion Plan) o Promise 15 (PHPIP - Equity and Inclusion Plan) o Promise 21 (PHPIP - Equity and Inclusion Plan)	Via Promises and Priorities Scorecard Paper E (Nov 24 PHPIP) – set out (for P12) – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – verbal item linked to P21 PHPIP Committee – March 2025, presentation GP Liaison role and work to date Board Timeout – April 2025. GP Liaison role and work to date
PHPIP Strategic Delivery Risk Report relating to the oversight and management of SDR3	

SO4: Deliver high quality and therapeutic bed based care on our own sites and in other settings											
What could get in the way? **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**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	Seven day working and other bed based service alterations are not implemented fully									
	because	of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring)								RC	QC
	then	we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.									
Risk Score	Current Score (May 2025)					Target Score (March 2026)					
	I	4	L	3	12	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Staff Engagement (linked to necessary change and impact on staff) Unions and Staff Side – consultation / engagement processes with union and staff side reps to discuss and agree. (This will likely include revised 'standard' terms and conditions to create opportunity for more flexibility, changes to JDs to reflect new ways of working.) Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety	(Gap) Comprehensive mechanism for collation and reporting of feedback gained via: ○ Staff Survey ○ Pulse Check ○ Peer Reviews ○ Consultation responses ○ Responses via Unions and Staff Side Employee Relations indicators
Service provision (RDASH) Newly established High Quality Therapeutic Taskforce from January 2025 to take forward a range of issues and significantly support the delivery of 7-day therapeutic services within an inpatient and acute context. Data • Base line developed of number of discharges in relation to days of the week, and timing of discharges by wards	IQPR reporting improvements in • Waiting times • Out of Area Placements • Delays in discharges • Utilisation of talking therapies

• "live" Flow Dashboard in place Enhance the Current Offer • enhanced discharges during weekdays using current infrastructure - includes using EDD's more consistently and appropriately • weekly meetings with senior nurses to review EDD (Q2) • complex CRFD forum with the 3 Local Authority Partners and 2 ICB Developing New Models • To ensure therapeutic discharges 24/7 are part of the inpatient improvement programme "the middle bit" (Q3 onwards) • Consider Pilot programme on one ward to test the ability, capacity and affordability of proposed changes.	And via 'live' Flow dashboard
Service provision - Alternative (others) Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis. (Gap) This will likely be in the form of an options paper to go to CLE in Q1, 2025/26) to consider below. - This may include better provision of the current crisis provision as a potential step down using 2 additional beds in Rotherham to test this - Co locates with partners who are already 24/7 (i.e. LA, acute, police) or extend hours (GP's) - Expansion of virtual offer, AOT and "remote working" - Outsourcing to community partners to abridge to RDaSH services - Future investment in a needed "step down provision" - Offer A Service With A 24/7 Assistant (expansion of virtual; apps?) Increase self-help services - with swift access to advice and support – enhanced community support and offer for those discharged in first 72 hours	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: This will include all linked to SO3 – Promises 13 to 17, but more specifically those linked to SO4 – Promises 18 to 23	Promises and Priorities Scorecard P19 Out of Area Placements – Board of Directors May 2025
QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk	

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations											
What could get in the way? **The Trust lacks the cultural capability and competence on wider issues**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027									
	because	We do not develop and practice the skillsets required to make change occur								CH	POD
	then	The Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees									
Risk Score	Current Score (May 2025)					Target Score (March 2026)					
	I	4	L	3	12	I	3	L	3	9	

Developing our Leaders Leadership Development Offer – circa 130 individuals inc 15 community leaders Leaders Conference – circa 130 staff as the Top Leaders Cadre – September 2024 Learning Half Days for every member of the Trust commenced in September 2024. Induction (all new starters) – RDASH and our communities – Launched 28 October 2024 First Line Managers Training Scheme – Launches April 2025 'Wider leadership' proposals – B5+ / Very Senior Clinicians Revised appraisal process developed and implemented – Q4 24/25 People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly	Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) - This feedback will secure confirmation that our leaders have the necessary skillsets linked to the partnership work LEIPA Response LDO participant Self-assessment Induction Feedback and Evaluation - Specific question: *I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) Other mechanisms of feedback from leaders to demonstrate their increased competence and confidence regarding making change occur and adding social value.
Increased Capacity	

Fully utilising the apprenticeship levy (delivery of Promise 9) Fully recruiting to all posts – 97.5% Commitment to designated training budget – demonstrate increase in spending year on year Re-development of the Change function - complete	May 2025: 80% utilised in 24/25; Forward plan developed to increase spend including levy transfer to community partners. May 2025: Current vacancies in CEX Report Annex (recruitment at 96.44%) May 2025: Ringfenced training budget in 25/6
Feedback Mechanisms From stakeholders regarding the approach of the Trust	Gap – structure, frequency of collation of related feedback mechanisms including: o Staff Survey / Pulse Check o 'Voice' Scorecard o Care Opinion o LEIPA (part of LDO) assessment o LDO participants self rating Reduction in Employee relations cases / matters
Consistent timely exit and delivery of **time bound projects**, and achievement of key measures with respect to the wider issues within the Strategy – inc the delivery of 'social value' and implementation of P25 where the use of local suppliers will contribute.	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 9 Apprentice Levy (PHPIP - Equity and Inclusion Plan) o Promise 26 Anti-Racism (POD – People and Teams Plan)	Promises and Priorities Scorecard P26 – Board of Directors March / May 2025
POD Strategic Delivery Risk Report relating to the oversight and management of SDR5	

,,ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper V
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 May 2025

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

The Operational Risk Report provides an update to the Board of Directors on the current extreme-rated risks. Each risk has undergone review through the Risk Management Group and has been reported to the Clinical Leadership Executive (CLE) during May 2025.

In addition, this report includes the updated Risk Management Framework and the refreshed risk appetite categories and levels. These were discussed with Board members during the time-out session in April and reflect ongoing efforts to strengthen the Trust's approach to risk oversight and improve consistency in risk assessment. Documents are presented for approval by the Board of Directors and will set the backdrop against which risk will be continue to be managed and from July 2025, this will via the new RADAR system.

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?)

Risk Management Group (RMG), Board Timeout & CLE have considered the matters within the paper

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

The Board of Directors is asked to:

x	**RECEIVE** and **NOTE** the current extreme risks.
x	**RECEIVE** and **APPROVE** the updated Risk Management Framework
x	**RECEIVE and APPROVE** the update risk appetite levels

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

Trust Risk Register	x	As detailed in the report						
Strategic Deliver Risks								
System / Place impact	x	O10/19						
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

1. EXTREME RISKS

There are now five extreme rated risks on the register, one fewer than reported at the last Board meeting. One risk has been deescalated from extreme status, and no new risks have been escalated to extreme.

These risks have been reviewed by the Risk Management Group (RMG) and the Clinical Leadership Executive (CLE), both of which continue to support their current classification.

1.1. De-escalated Extreme Risks

O 5/24	SMI Register Duplication Risk	**I X L 4X 3 = 12**
Description	If there continue to be multiple registers for SMI patients across GP surgeries and RDaSH there is a risk of patients coming to avoidable harm due to being missed and not being offered an annual SMI health check.	
Accountable Director	Deputy Director of Operation	
Updates	Work to consolidate and cross-reference the registers is well underway and expected to conclude by mid-June. The level of discrepancy between registers across Places has already reduced significantly, with most areas now closely aligned. Doncaster still needs to reach 718 additional people, about one third of its target, North Lincolnshire has 180 people left to capture, roughly fifteen percent of its goal; and Rotherham faces the largest gap, with 1,051 people outstanding, almost half of its target.	

1.2. Previously Reported Extreme Risks

O 10/19	Management of Out of Area Placements	**I X L 3 X 5 = 15**
Description	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.	
Accountable Director	Chief Operating Officer	
Updates	The High-Quality Therapeutic Taskforce is continuing its work, with current attention focused on tackling issues around Length of Stay. Alongside this, a formal approval process for Out-of-Area Placements (OAP), covering both in-hours and out-of-hours decisions, has now been developed. The process will go live in July 2025, with June being used as a set-up and preparation period	

PCG 10/24	Implementation of New ADHD Model	**I X L 3 X 5 = 15**
Description	If patients are left unassessed for ADHD due to capacity not being able to meet demand, then this will impact on RDaSH patients and their family's wellbeing and health outcomes, service delivery, staff health and wellbeing, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Care Group Director – Physical Health and Neurodiversity	
Updates	Front-end data suggests the number waiting has exceeded 5,000 and continues to rise. Additional staff have recently started and are undergoing induction, which, while temporarily reducing capacity, is expected to enhance capacity in the coming weeks. Local working processes are being reviewed to improve alignment and support cross-team working. Two Band 5 triage staff have left, although both posts have already been recruited to, with anticipated start dates in July. Their absence will temporarily affect capacity as other team members cover triage duties. Additionally, AI software has been introduced and is being trialled over the next month, with expectations that it will improve report-writing efficiency and support overall capacity-building within the team.	

PCG 9/24	Diagnosis of ASD Patients	**I X L 3 X 5 = 15**
Description	If Doncaster and Rotherham patients are left undiagnosed for Autism then this will impact on patients and their family's wellbeing and health outcomes, staff health and wellbeing, is in breach of NICE guidance, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Care Group Director – Physical Health and Neurodiversity	
Updates	There are currently 1,934 individuals on the waiting list, which continues to grow. The trial of supporting diagnosis through staff already known to other services is due to conclude this month and will undergo a full evaluation. This approach has already enabled several patients to receive a timelier diagnosis while reducing demand on the Autism Service. If successful, plans are in place to roll out this model across both Doncaster and Rotherham.	

CCG 3/22	Neuro Waiting Lists	**I X L 3 X 5 = 15**
Description	If the waiting times for assessment of ASD and ADHD remain above target, this will impact on CYPF, their educational and health outcomes, service delivery, staff health and wellbeing, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Children's Care Group Director	

CCG 3/22	Neuro Waiting Lists	**I X L 3 X 5 = 15**
Updates	Weekly meetings continue to monitor current trajectories and area-level performance. Digital procurement has been successfully completed, with contracts awarded to three providers. A revised trajectory is in development and a draft will be shared with TL and RC.	

DCGMH 6/23	Medical Staffing	**I X L 5X 3= 15**
Description	Due to the inability of the care group to recruit and retain enough medical staff and the emergence of new vacancies, particularly within the acute directorate there is a risk that patient care and safety will be compromised. Additionally, the limited availability of consultant psychiatrist functions (including Responsible Clinician roles and meeting legal professional requirements) may result in a lack of clinical leadership across the care group, further impacting the quality of clinical care.	
Accountable Director	Care Group Director – Doncaster	
	There are currently five vacant clinical consultant posts and a number of unfilled leadership roles across the care group. While active recruitment is ongoing and some progress has been made, the situation will be further assessed at the next Risk Management Group (RMG) meeting against the extreme risk threshold. An update will be provided in the next reporting cycle.	

The Board of Directors is asked to RECEIVE and NOTE the current extreme risks.

2. Updated Risk Management Framework

2.1 The Board ratified the Risk Management Framework in January 2024. Since then, we have reviewed its application across the Trust and, based on feedback and learning from practice, have made a few focused refinements to ensure it continues to meet the organisation's needs.

2.2 The refreshed framework provides greater clarity on how risks are identified, assessed, managed, and governed across all levels of the Trust. The updates were informed by consultation with stakeholders across the organisation to ensure the framework remains practical, proportionate, and aligned to operational realities.

2.3 These changes are now being presented to the Board for review, as part of our continued commitment to strengthening risk oversight, enhancing accountability, and embedding a consistent and transparent approach to risk management throughout the Trust. A summary of the key updates is provided below, with the full framework included in Board Pack B for reference.

Introduction of the PACED principle for managing risk
The PACED principle which stands for Proportionate, Aligned, Comprehensive, Embedded, and Dynamic, has been incorporated to strengthen the Trust's approach to risk management. It ensures that our responses are scaled appropriately to the level of risk, aligned with organisational priorities, and supported by a comprehensive understanding of our context. PACED also reinforces the need for risk practices to be embedded in everyday processes and remain responsive to change, helping to ensure that risk management is both practical and forward-looking.

Enhancing risk culture and aligning it to the trust's core values
This update defines our risk culture by aligning it with the trust's core values. Unlike the PACED principle which focuses on the structured processes for managing risk this change centres on the attitudes and behaviours that drive our decision-making. In essence, while PACED provides a clear operational framework, our defined risk culture captures the spirit behind risk management, ensuring that our actions reflect our values. Establishing a clear risk culture reinforces that every decision is guided by our core principles. It fosters consistency, ethical behaviour, and accountability in how we manage risk across the trust.

Enhanced Risk Classification
We have refreshed the risk classification system to give us a clear, structured way to identify and assess risks. The revised categories reflect the distinct nature of each risk and provide a solid foundation for applying our risk appetite framework.

Standard Operating Procedures for Opening and closing Risk
We introduced standard operating procedures for opening and closing risks, which now include a formal approval process for entering and removing risks from our systems. This ensures that every risk is reviewed and authorized before being recorded or closed. This change brings greater accountability and control to our risk management process. The approval step helps prevent errors and unauthorized changes, ensuring that risks are only opened or closed after thorough review. This structured approach leads to more consistent risk tracking and better overall protection for the trust.

Introduction of Control Types
We introduced control types to clearly define and categorize the different measures used in our risk management framework. Defining control types brings clarity and precision to our risk management process. It ensures that we apply the right control measures to specific risk areas, improves evaluation of their effectiveness, and enhances communication and decision-making across teams.

More Frequent Review of Tolerated Risks: From Annual to Quarterly
The review cycle for tolerated risks has been shortened from once a year to every quarter. This change is intended to end the habit of letting these risks sit unchallenged. Quarterly review keeps them visible, prompts ongoing discussion, and ensures they are reassessed in a timely manner

Introduction of Assurance Over Controls
Assurance over controls was introduced to directly answer the question of how we know that the action plans we have set will work and effectively mitigate the stated risks. This independent review process verifies that our control measures are functioning as intended. By implementing assurance, we gain confidence in the effectiveness of our risk mitigation efforts. It ensures that our action plans are not just theoretical but are proven to work in practice.

Integration of Other Risk Registers
Integration of other risk registers was introduced to bring into our risk management process other risk registers from across the trust not just those in our core operational set. This change ensures we capture diverse risk insights from all areas of the organization. This is essential because it provides a completer and more accurate picture of the risks we face.

2.4 As earlier noted, the changes outlined are reflected in the updated Risk Management Framework included in **Pack B**. This revised framework will underpin the next phase of our risk management improvement journey and will be implemented through RADAR, the Trust's new risk management system. We believe these improvements will not only strengthen our overall approach but also support our progression toward a higher level of risk maturity.

The Board of Directors is asked to RECEIVE and APPROVE the updated Risk Management Framework

3. Refreshed Risk Appetite Framework

3.1 As part of the broader update to the Trust's Risk Management Framework, the Risk Appetite Framework has also been reviewed and refreshed. This work is intended to ensure that risk appetite is not treated as a standalone concept, but is meaningfully embedded into how we assess, escalate, and respond to risk across the organisation.

3.2 The refreshed framework provides clearer, more practical guidance on the levels and types of risk the Trust is willing to accept in different areas of activity. It introduces a set of defined risk categories and associated appetite levels, supporting more consistent decision-making and improving alignment between strategic priorities and operational risk management.

3.3 To apply the framework effectively, it is important to review the definitions of each risk category, these are included in the full Risk Appetite Framework accompanying this report. Understanding the intent and scope of each category is key to ensuring consistent interpretation and application.

3.4 Below is the risk appetite scale and a summary of the Trust's agreed risk appetite categories, along with the appetite statement for each. These are presented for Board review and approval prior to formal implementation within the wider risk management process.

1. **Averse** - We will not accept this risk under any circumstances; immediate mitigation or avoidance is required.
2. **Low Tolerance**- We accept only a small, tightly controlled exposure where benefits are essential, and controls are proven.
3. **Moderate Tolerance** - A balanced position, we will accept risk when the benefit clearly outweighs it, and effective controls are in place.
4. **High Tolerance**- We are willing to take a sizeable, well-understood risk in pursuit of significant benefit, provided controls are monitored

Summary of the Trust's agreed risk appetite categories and appetite statements

Risk Category	Sub-category	Appetite	Narrative statement
People Risk *The risk of not having a sufficient, healthy, capable and appropriately deployed workforce to deliver services safely and sustainably.*	Planning & Supply	High Tolerance	We will take calculated workforce planning risks such as new recruitment pipelines or international sourcing when they secure sustainable staffing and keep patients safe.
	Capacity	Low Tolerance	The Trust accepts only minimal risk in having the right mix of staff in the right place; any unsafe rota gaps must be escalated.
	Well-being & Retention	Low Tolerance	We have low appetite for working practices that erode staff well-being or retention.
	Capability & Performance	Low Tolerance	We accept minimal risk that colleagues lack the skills, training, or supervision required to meet standards.
Financial Risks *The risk of financial loss, mismanagement, or unsustainable planning that impacts the Trust's ability to deliver services, invest in future priorities, or comply with financial and regulatory expectations. This includes planning, oversight, control, and fraud-related exposures*	Financial Planning CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement; budgets must stay balanced, and sustainability protected.
	Counter Fraud	Averse	We have adverse tolerance for fraud bribery or corruption.
	Financial Control & Oversight	Averse	We do not tolerate breaches of financial control or external reporting requirements.
Patient Care Risks *The risk that care delivered fails to meet required safety, quality, and experience standards. This includes risks of clinical harm, ineffective improvement efforts, poor learning systems, or suboptimal patient involvement*	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement accepting some controlled risk for better outcomes.
	Learning and	Low Tolerance	We accept minimal risk in the governance audit and

Risk Category	Sub-category	Appetite	Narrative statement
that compromise outcomes or regulatory compliance	Oversight		learning systems that assure care quality.
	Patient Experience	Moderate Tolerance	We will take limited risk to improve experience where dignity communication and outcomes remain protected.
Performance Risk *The risk that operational systems and support infrastructure fail to meet service, resilience, or compliance expectations. This covers emergency preparedness, demand-capacity mismatch, estates and equipment, digital infrastructure, information governance, and overall delivery capability.*	Emergency Preparedness	Moderate Tolerance	We tolerate limited well managed risk to improve resilience and emergency response through learning and stress testing.
	Capacity & Demand	Moderate Tolerance	We accept some risk of demand exceeding capacity; access delays must be actively managed.
	Estates, Equipment & Supply Chain	Moderate Tolerance	We will maintain resilience yet tolerate limited risk while upgrading infrastructure or supply models provided patient safety and continuity plans stay robust.
	Information Governance	Averse	We do not tolerate breaches of information confidentiality integrity or availability.
	Digital Infrastructure & Cyber Security	Averse	We accept minimal risk to the availability reliability and security of core digital infrastructure.
External and Partnerships Risk *The risk arising from the Trust's interface with external stakeholders, legal frameworks, strategic partners, and regulatory bodies. This includes the risk of failure to comply, collaborate, deliver agreed outcomes, or influence change in ways that affect strategic goals or reputation.*	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering transformation provided governance remains effective.
	Legal & Governance	Low tolerance	We do not tolerate breaches of legal duties regulatory obligations or governance standards.
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations accepting uncertainty, where aligned to strategic goals and public benefit.
	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards or reporting obligations.
	Delivering Our Promises	Low Tolerance	We accept minimal risk of failing to meet agreed commitments to partners and communities; delivery must be reliable and transparent.

3.1. Applying the Risk Appetite Framework in Practice

This section sets out how the refreshed Risk Appetite Framework will be applied across the Trust. Risk appetite plays a critical role in shaping strategic planning, guiding decision-making, and supporting the delivery of programmes and projects. It provides a consistent reference point for determining how much risk the Trust is willing to accept in different areas of activity and ensures that decisions at all levels are made with a clear understanding of acceptable boundaries.

Operationally, when a new risk is entered into RADAR, the owner selects the relevant risk category together with the appetite level approved by the Board for that category. This appetite level sets the tolerance band (the acceptable range within which a risk can be managed without triggering escalation).

At each review, the residual risk score is assessed against the upper limit of the tolerance band. If the score sits within this band, the risk is considered within tolerance. In these cases, the owner continues to monitor progress, update controls as needed and provide assurance through RADAR and routine reporting to the Risk Management Group (RMG).

If the residual score exceeds the upper threshold of the tolerance band, the risk is flagged as out of tolerance. The owner must then draw up an action plan to bring the score back within acceptable limits. RMG reviews the plan, and if the risk remains out of tolerance for two consecutive review cycles, it is escalated to the Clinical Leadership Executive (CLE).

The Risk Management Group (RMG) will play a key role in reviewing such risks to ensure that any breach of appetite is understood, justified, and actively managed. This approach promotes proportionate oversight and ensures that the Trust's risk-taking remains consistent with its defined appetite, supporting a more mature and transparent risk culture.

The insights from the reporting will feed into improvements in controls, refresher training, and, where necessary, a review of the underlying appetite and tolerance settings.

The full Risk Appetite Framework, including definitions, tolerance thresholds, and supporting guidance, is available in **Board Pack B**.

The Board of Directors is asked to RECEIVE and APPROVE the update risk appetite levels.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Fit and Proper Person Test (FPPT)	**Agenda Item**	Paper W
Sponsoring Executive	Kath Lavery, Chair		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 May 2025

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

Fit and Proper Person Test (FPPT) guidance came into force from 1 April 2024. It is a key requirement for all members of the Board. When the guidance was issued, an initial assessment of the then members of the Board concluded that everyone met or exceeded the FPPT requirements.

An internal audit during 24/25 that sampled the checks undertaken within a number of recent appointments to the Board concluded that there were improvements needed in the compliance process and record keeping. The recommended improvements have been addressed and the annual review against FPPT requirements for all current members of the Board has been completed. As a result, a revised internal audit report providing significant assurance (that the system and controls in place are working as designed) has been received; and the Chair has concluded 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 this topic in March 2024 when all the then members of the Board were deemed to meet the FPPT requirements.

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

The Board of Directors is asked to:

x	**RECEIVE** and **NOTE** the update that confirms the process followed to undertake the test and the assurance received from internal audit.
x	**RECEIVE** and **NOTE** the concluding statement from the Chair that, following the receipt and review of self-attestation statements and where applicable, the checks undertaken during recent appointments, she has deemed all members of the Board to meet the requirements of the fit and proper person test.

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
Fit and proper person test framework for board members

1 Background

1.1 NHS England published updated guidance, effective from 1 April 2024, *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.

1.2 The FPPT requirements sits alongside the NHS Leadership Competency Framework (LCF) and the recently issued NHS Board Member Appraisal Framework as key documents pertinent to members of the Board of Directors.

2. Fit and Proper Person Test (FPPT) in 2024/25

2.1 An assessment undertaken, and reported to the Board in March 2024, concluded for those individuals who were on the Board of Directors at that time, that all met the requirements of the fit and proper person test. Since then there have been a number of new appointments to the Board of Directors - during each appointment process the requirements need to be achieved and relevant records maintained.

2.2 In Q3 24/25 **internal audit** undertook a review of the processes deployed by the Trust. This reflected on the previous year end review and the recent appointments to the Board of Directors. It concluded that there was an opportunity to enhance the process and after identifying a number of gaps, it highlighted the need to ensure all relevant documentary evidence was retained on file. The trust has addressed and responded to both elements of this feedback and following an audit follow up review in March 2024, has received a final report confirming the enhanced process and closure of identified gaps and providing significant assurance in respect of the system of control linked to FPPT.

2.3 Also during Q4 24/25, every member of the Board of Directors was asked to submit a self-attestation statement confirming their compliance with the FPPT requirements. In support of this the Trust commissioned a number of checks – to gain assurance on elements such as disqualified directors, disqualified charitable trustees, insolvency register, and a social media check.

2.4 The chair has considered all responses and supporting documentary evidence for the individuals listed below and has concluded that there were no matters of concern and that all current members of the Board of Directors meet the requirements of the FPPT.

Kathryn Lavery	Dave Vallance	Pauline Vickers
Sarah Fulton Tindall	Kathy Gillatt	Rachael Blake
Richard Falk	Maria Clark	Toby Lewis
Richard Chillery	Steve Forsyth	Carlene Holden
Izaaz Mohammed	Diarmid Sinclair	Richard Banks
Judith Graham	Jo McDonough	Philip Gowland

2.5 The conclusion will be included within a declaration to the NHS England Regional team (due 30 June 2025) by the Chair.

The Board of Directors is asked to:

RECEIVE and NOTE the update that confirms the process followed to undertake the test and the assurance received from internal audit.

RECEIVE and NOTE the concluding statement from the Chair that, following the receipt and review of self-attestation statements and where applicable, the checks undertaken during recent appointments, she has deemed all members of the Board to meet the requirements of the fit and proper person test.

Philip Gowland, Director of Corporate Assurance
12 May 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	IPC Annual Report 2024/2025	**Agenda Item**	Paper X
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Jim Cooper, Deputy Chief Nursing Officer IPC Team		
Meeting	Board of Directors	**Date**	29 May 2025

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

This report has not serviced the usual governance process that is seen historically in the NHS for annual reports. The data contained within this report has however been via the internal corporate processes and serviced via the sub structure of the CLE, originating from the subcommittee of Quality and Safety Group

This report outlines our continued commitment to promoting the best practice in infection prevention and control and maintaining low incidents of healthcare associated infections, the BoD are asked to focus on these key issues:

1. **Compliance Standard 1**

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

2. **Compliance Standard 3**

Noting significant achievement in ensuring appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

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

SO1: Nurture partnerships with patients and citizens to support good health	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	X
Business as usual.	X

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

No Previous Consideration

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

The Board of Directors is asked to: Receive and note IPC Annual Report 2024/2025

X	**NOTE** the work undertaken in 2024-2025 and agree that the trust is meeting its statutory duties and required national standards regarding Infection, Prevention and control

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

Trust Risk Register	X	N&F 21/24 - If a highly transmissible and impactful pandemic emerges and the Trust's pandemic preparedness and response plans are insufficient, there is a risk that the Trust will be unable to effectively manage patient care demands and protect staff, which may result in overwhelmed healthcare services, compromised patient outcomes, staff burnout, and operational disruptions.
Board Assurance Framework	X	
System / Place impact	N/A	

Executive Summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HCAIs) within Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust. This report acknowledges the hard work and diligence of all our colleagues who play a vital role in improving the quality of patient care and experience, as well as helping to reduce the risk of infections.

In addition, the report demonstrates the continued commitment of the Trust to IPC and provides evidence through the delivery of the national IPC Board Assurance Framework (BAF) and aligns with the Trust's six values. Our ambition is to continue to provide high quality care, drive innovation and deliver the best possible outcomes for our patients. Our organisational values seek to ensure we provide safe, effective, and compassionate care through a well-supported and developed workforce. The IPC work programme, as set out in the BAF, aims to deliver our objectives.

The IPC team, Care Groups and corporate colleagues work in close partnership to provide strong leadership and support, ensuring compliance with guidance and legislation relating to the prevention and management of infections.

The key achievements of 2024/25 are:

- Continued low rates of healthcare associated infections (HCAIs)
- Dedicated IPC link champions (IPCLCs) providing support to their peers and colleagues to deliver safe care
- Completion of an external sharps safety audit on the physical health wards following the introduction of Sharpsmart containers on these wards
- Collaboration with the inpatient Matrons through the completion of supportive visits and walk rounds with a focus on IPC elements
- Participation in the influenza vaccination campaign
- Review and update of the IPC audit tools
- Audit programme completed on inpatient areas and participation in the pilot programme to implement Radar mobile app/web portal system
- The visible, proactive and supportive approach of the IPC team.

Introduction

The aim of this report is to provide information and assurance to the Board that the IPC team and all staff within the Trust are committed to maintaining low levels of Healthcare Associated Infections (HCAIs) and that RDaSH is compliant with current legislation and evidence based best practice. The report covers the period 1 April 2024 to 31 March 2025 and provides information on IPC activities across the three geographical localities covered by RDaSH services: Rotherham, Doncaster, and North Lincolnshire, and demonstrates the governance arrangements and assurance that good IPC practice is consistently implemented across all Care Groups thus ensuring our patients and service users receive safe effective care.

This document provides evidence that effective IPC systems and processes are in place to support the delivery of the national Board Assurance Framework (BAF). The purpose of the BAF is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). This document also provides evidence that effective IPC systems and processes are in place to support the delivery of the Trusts strategic goal to deliver safe, effective and compassionate care.

Governance Arrangements

Safe, effective IPC remains a top priority for the organisation. It acknowledges that avoidable infections can be devastating for patients and their families and can have a detrimental impact on patient care delivery. The Chief Executive holds ultimate responsibility for providing effective IPC arrangements, with the Chief Nurse / Director of Infection Prevention and Control (DIPC) holding the portfolio for IPC. The Deputy Chief Nurse (Deputy DIPC) is responsible for the operational leadership of IPC provision and the backbone Nurse Director provides direct line management of the IPC team.

The Care Group Nurse Directors and Corporate Service Leads are responsible for the operational delivery of IPC in all Care Groups and are supported by the Deputy Chief Nurse. IPC reports are received by Trust Board via the Sub CLE Quality and Safety Group.

Operational Delivery

Infection Prevention and Control Team

The IPC Clinical Nurse Specialists provide advice and support to colleagues across the organisation. The IPC team has a proactive and supportive attitude with an emphasis on being visible and approachable across all clinical settings. The team works closely with colleagues from Estates, Facilities, Learning and Development, the Safety Team, Emergency Planning and Patient Safety as well as colleagues/peers locally, regionally and nationally.

Two of the team are members of the Infection Prevention Society (IPS) and attend meetings of the Yorkshire branch of the society, contributing to national guidelines, research and educational events. Membership of the society provides useful resources and support networks with colleagues from other organisations. Both nurses are also members of the mental health and learning disability special interest group, a subgroup of the IPS. The team utilised social media platforms for IPC specialists including WhatsApp and Facebook closed groups for additional support and to share information nationally and across the region.

Trust wide IPC Annual Work Plan

Compliance Standard 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention and Control Committee (IPCC)

The aim of the Infection Prevention and Control Committee (IPCC) is to:

- Receive assurance of an effective framework for IPC and antimicrobial resistance (AMR)
- Provide strategic leadership and direction on IPC activities across the Trust to ensure that the risks posed by transmission of avoidable infection is minimised
- Ensure that the Trust provides and maintains a safe environment and safe practices for patients, colleagues and visitors
- Provide assurance to the Trust Board via the DIPC.

Key Outputs:

- To oversee compliance with national standards/targets in relation to the prevention and HCAIs, including the Health and Social Care Act 2008, NHS Litigation Authority (NHSLA), the Care Quality Commission and any other relevant legislation pertinent to IPC
- To oversee the implementation and the ongoing monitoring of the IPC Board Assurance Framework
- To receive assurance reports from the Ventilation and Water Safety Group to ensure water safety is monitored and reported
- To provide assurance via healthy check and challenge to Care Groups to present their Alert Advise and Assure (AAA) report and report by exception
- To receive assurance reports from the Tuberculosis (TB) and Viral Hepatitis services for governance purposes
- To influence and support the Trust with any Emergency Preparedness, Resilience and Response (EPRR) arrangements, relating to infectious diseases
- To receive assurance from Occupational Health Services that the needs of the Trust are met.

Ventilation and Water Safety Group

The Water Safety Group (WSG) formerly convened as part of the IPCC, however in 2022 this was recreated to ensure the membership was more appropriate to the subject matter and legislative requirements. An Authorised Engineer for Water (AEW) was appointed to the group to ensure Trust compliance with current guidance and legislation and Terms of Reference have been reviewed to reflect the changes. Members of the IPC team have undertaken specialist water safety training as part of the requirements of the WSG. This group reports to the Sub CLE Estates and sustainability Group. Key areas for priority action:

- Legionella sampling detected a number of low-level positives in various locations identifying <100 colony forming units (cfu). Mains flushing and resampling was undertaken in accordance with HTM 04-01. Resamples were clear indicating these were not systemic issues.

- Legionella sampling detected >5000 cfu in a hot water tap in a salad preparation kitchen sink in the hospice. Disinfection and thorough flushing was instigated before a resample was taken. This was then clear with no detectable Legionella. Non systemic.
- To continue to raise awareness of water safety in relation to flushing infrequently used outlets. Records were monitored, managed and reviewed by the IPC team via Tendable.
- Continue learning and development for existing Responsible Persons (Water Quality) appointed in estates to manage the engineering and monitoring systems.

The Ventilation Safety Group (VSG) was established in February 2022 and was incorporated with the WSG to form the Ventilation and Water Safety Compliance Group (VWSCG).

The aim of the group is to ensure the safety of all ventilation systems used by/for patients, residents, colleagues and visitors, and to minimise the risk of infection associated with airborne pathogens. This group will undertake the commissioning, development, implementation and review of an operational procedure for the management of ventilation systems as part of the Trusts governance. Key areas for priority action:

- Involvement in capital building projects to ensure appropriate ventilation systems are incorporated. The IPC team have liaised with Estates and Capital Projects colleagues to provide expert advice and oversight on a number of refurbishments:
- Great Oaks derogations from *HTM 03-01 Specialised Ventilation in Healthcare* will need approval by the VSG
- Elizabeth Quarter refurbishment ventilation providing 6 air changes per hour to treatment rooms. Also, design providing ventilation to non-clinical areas. Non-openable windows mean mechanical ventilation and a fresh air supply is required. CIBSE guidelines recommends 10l/s per person. The design is to meet the guidelines and is required for non-elevated CO2 levels
- Authorising Engineer (ventilation) has recommended appointment of Authorised Person after successful interview and competence review. Estates Engineer appointed by Estates Director.

Operational Water Safety Compliance

Due to the risks associated with water systems there is a legal requirement for all healthcare facilities to have water safety plans (WSP) in place. This is overseen by the VWSCG. One key component of the WSP is the flushing of infrequently used or unused water outlets. To reduce the risk of exposure to water-borne infections such as Legionella and Pseudomonas aeruginosa water flushing must be undertaken twice a week and spread out evenly over 7 days. The main achievements related to water safety compliance in 2024-25 are:

- A robust programme in place to monitor water safety and take appropriate action where required
- Collaborative working between IPC team, Estates and Authorised Engineer.
- Transition from paper records to Tendable mobile app/web portal system in Q3
- Analytics around compliance monitoring were shared with ward managers weekly.

Water Flushing Compliance Figures

Rotherham Adult Mental Health Care Group - Acute Services Directorate			
Ward	Q3	Q4	Overall compliance
Kingfisher Unit	62%	75%	68%
Osprey Ward	54%	75%	64%
Sandpiper Ward	31%	92%	60%
The Glade	31%	58%	44%
North Lincs Adult and Talking Therapies Care Group - Acute Care Services Directorate			
Laurel Ward	62%	75%	68%
Mulberry House	15%	67%	40%
Doncaster Mental Health & Learning Disability Care Group – Acute Directorate			
Brodsworth Ward	46%	17%	32%
Cusworth Ward	15%	33%	24%
Skelbrooke Ward	62%	75%	68%
Windermere Lodge	62%	92%	76%
Doncaster Mental Health & Learning Disability Care Group –LD & Forensics Directorate			
Amber Lodge	69%	83%	76%
Doncaster Mental Health & Learning Disability Care Group – Community Directorate			
New Beginnings	92%	75%	84%
Physical Health & Neurodiversity Care Group – Rehabilitation Directorate			
Hawthorn Ward	8%	67%	36%
Hazel Ward	100%	67%	84%
Magnolia Lodge	100%	83%	92%
Physical Health & Neurodiversity Care Group – Rehabilitation Directorate			
St Johns Hospice	69	92	80

Audits

The IPC team have utilised the Tendable mobile app/web portal system to audit practice and staff knowledge of procedures in the Trust IPC Manual. The audit tool provides the reports, analytics and insights to improve performance and compliance. All 19 inpatient areas were audited:

- 1 area rated amber for sharps management. Main areas of concern were around contamination injury management and safe use and labelling of sharps containers.
- 2 areas were rated amber for the infection prevention and control audit. Key concerns were around gaps in the completion of discharge and terminal clean checklists and knowledge of appropriate products for decontamination.

Audit Results

Care Group	Directorate	Area	Infection Control %	Sharps %
Rotherham Adult Mental Health	Acute Services	The Brambles	84.2	94.4
		The Glade	96.2	93.3
		Sandpiper Ward	92.7	88.9
		Osprey Ward	100	100
		Kingfisher Unit	96.2	94.4
North Lincs & Talking Therapies	Acute Services	Laurel Ward	94.5	100
		Mulberry House	98.2	94.4
Physical Health and Neurodiversity	Community & LTC	St Johns Hospice	98.2	94.4
	Rehabilitation	Hawthorn Ward	91.7	94.1
		Hazel Ward	96.5	100
		Magnolia Lodge	91.2	100
Doncaster Adult Mental Health and Learning Disability	Acute Services	Skelbrooke Ward	92.6	94.1
		Brodsworth Ward	87.3	100
		Cusworth Ward	92.6	70.6
		Windermere Lodge	100	94.4
		Emerald Lodge	92.7	94.4
	Learning Disability & Forensics	Amber Lodge	100	100
	Community	New Beginnings	100	100

Ward Managers produced action plans and progress was supported by the IPC team. Action plans were followed up to ensure the audit cycle was completed. All actions have been completed. The IPC team were involved in piloting a new auditing and reporting system prior to being introduced in 2025/26. Collaborative work with Inpatient Matrons was undertaken to review IPC practices through the completion of quarterly supportive visits and walk rounds.

External Sharps Audits/Reviews

The representative from Sharpsmart completed sharps audits on the physical health wards in February 2025. Feedback was positive with the following observations:

- Sharps segregation overall was impressive
- All wards had spare containers available
- Feedback from colleagues around the use of the containers was positive
- Discussions held around using temporary closure mechanism and point of care disposal
- Ongoing support being provided by Sharpsmart and the IPC team

Post Infection Reviews (PIRs)

Post Infection Reviews (PIRs) are required for HCAIs that are subject to mandatory reporting. The PIR process relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to the patient's infection. The outcome of the PIR is to determine clinical learning and attribute responsibility for the infection. One case of Clostridioides difficile infection (CDI) was investigated by the IPC team and a PIR completed. The team also provide information to Doncaster and Bassetlaw Teaching Hospitals (DBTH) for the community PIRs where some involvement from RDaSH services has been identified. There have been zero cases of Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection (BSI), Methicillin-susceptible Staphylococcus aureus BSI or Gram-negative BSI.

Outbreak Management

During 2024/25 a total of 6 outbreaks were identified. The IPC team provided support and guidance daily to affected inpatient areas via face-to-face visits/meetings, telephone updates and emails. Outbreaks were managed locally with meetings held where any lessons were identified or where there were any business continuity concerns. Any actions were followed up during clinical visits. At the end of the outbreak summary reports were completed if learning actions were identified and these were distributed across the Care Groups for sharing.

Outbreaks of Infection

Care Group	Directorate	Area/Service	Month	Type
Physical Health & Neurodiversity	Rehabilitation	Hawthorn Ward	June	COVID-19
Rotherham Adult Mental Health	Acute Services	The Glade	July	COVID-19
Doncaster Adult Mental Health & Learning Disabilities	Learning Disabilities & Forensics	Amber Lodge	July	COVID-19
North Lincolnshire Adult Mental Health & Talking Therapies	Acute Services	Laurel Ward	July	COVID-19
Physical Health & Neurodiversity	Rehabilitation	Hawthorn Ward	September	COVID-19
Physical Health & Neurodiversity	Rehabilitation	Hazel Ward	March	COVID-19

Compliance Standard 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.
The organisation follows "The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes" and there is an audit programme is in place to monitor compliance.
The organisation follows appropriate Heath Building Notes and Health Technical Memorandums in relation to new builds and refurbishment of premises.

Cleanliness

The Trusts cleaning services works to the National Standards of Healthcare Cleanliness 2021. Clinical areas are monitored monthly and non-clinical areas are monitored quarterly, with performance indicators set higher than those in the national standards. Each audit was followed up with an action plan for the support staff, nursing staff and estates team to address as required and a 'star rating' poster displayed at the entrance to the premises. A Domestic Cleaning Audit Report is produced and presented at each IPCC. Collaborative work is undertaken between the support service manager and IPC to undertake further monitoring on inpatient units to provide assurance with the standards.

New Builds and Refurbishments

The IPC team have worked in partnership with Estates and Facilities, Capital & Planning and Care Group representatives to provide specialist IPC advice based upon current Health Building Notes and Health Technical Memorandum's across several planned refurbishments. Representatives from estates and the IPC team met monthly to share information on current and upcoming projects to ensure IPC advice and input was sought at each stage of the planning, construction and commissioning process. IPC team involvement included the review of building plans and consultation on fixtures and fittings as well as advice

on the location of key IPC facilities and equipment. Refurbishment projects overseen this year included:

- Great Oaks
- Elizabeth Quarter
- Completion of the adult mental health wards in Rotherham
- Changing Lives

Compliance Standard 3
Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Statement:
The Trust uses appropriate local guidance to inform antibiotic prescribing decisions.
Antibiotic prescribing for inpatient units is routinely reviewed for adherence to guidance in line with PHE guidance.

Antimicrobial 5 Point Plan

The Antimicrobial 5-point plan is a review process applied by the Trust pharmacists to all inpatient prescriptions for antibiotics. It consists of reviewing the process for antibiotic prescribing and administration against the standards described in Public Health England's guidance "Start Smart then Focus", namely that all prescribing is:

- Based on national and local guidelines (see reference section)
- Not initiated in the absence of clinical evidence of infection.
- Accompanied by swabs or cultures, which are taken and acted on where appropriate.
- Reviewed 48/72 hours after initiation against the patient's condition.
- Complete with the duration of treatment, review date, stop date and indication clearly recorded on the medication chart, in the patient record, complete with accurate administration records

The Pharmacy Department have a manual electronic data capture tool to support the systematic recording of data where the Pharmacist is aware of the use of an antibiotic (there may be occasions when a patient may have been started on an antibiotic and discharged between pharmacy visits). A quarterly report is presented to the Trust Medicines Optimisation Group (TMOG) and the IPCC. The main observations included:

- Overall compliance with audit standards continued to improve over each quarter of this year. Current compliance is 98.9% compared to the previous capture of 96.5% (range 96.5% - 96.8%). It is worth noting that this is quite an achievement, as the scope of the data collection has broadened to cover additional ward areas, as it had been identified part way through the annual audit period that there were in-patient areas
- Compliance has improved steadily over several years since this data was first recorded, in 2016 compliance was recorded as 83.0%
- The current locally agreed formulary guidelines are available for all localities
- Appropriate levels of swabs and cultures are being done 2024/25 results are 96.2% in comparison to the previous result in 2023/24 report of 90%
- Indications for use and appropriately timed reviews are being recorded in patients notes 99.3% compared to previous result in 2023/24 report of 93%
- The administration record was fully completed on all occasions with avoidable dose admissions on 1.2% of courses. 24/2025 – 100% complete administrations.

Actions to be completed:

- The reports are discussed and circulated to all relevant wards.
- Plans to develop a protocol on SystmOne to force relevant data input to automate a reportal dashboard has proven unsuccessful. An alternate way of automating a report continues to be explored. Data was manually collected for this report – no further development around the automated reported due to prioritisation of other projects and workload in data warehouse.

Compliance Standard 4
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
Statement 1:
All IPC information leaflets and posters are to be co-produced with service users, friends, family and carers and are compliant with national guidance.
IPC information and guidance is published on the Trust public website.

The Trust website contains relevant IPC information and is updated regularly. Colleagues are also signposted by the IPC team to national websites such as NHS Choices, UK Health Security Agency (UKHSA) and NICE guidelines for the most up to date and evidence-based information.

The IPC link champions (LCs) are encouraged to provide information at ward/clinic level using information boards. A wide range of information is displayed and disseminated to patients, visitors and colleagues. IPC LCs are encouraged to update the IPC information board content on a quarterly basis and to consider any seasonal or current IPC issues such as measles, influenza, norovirus and good food hygiene in relation to barbeque season in summer months.

The IPC team have been central to producing and disseminating information around HCAIs, including measles information, to all colleagues, using different media formats via daily communications and clinical learning briefings.

International Infection Prevention Week

Our focus for this year's campaign was to raise awareness of inappropriate glove use. The overuse of disposable gloves can have a detrimental effect on healthcare workers skin, increasing the risk of sensitivity and dermatitis. There is also a risk of an increase in healthcare associated infection rates as colleagues become over-reliant on gloves by using them for multiple activities and then failing to decontaminate their hands as per the WHO 5 moments for hand hygiene.

The overuse of gloves also contributes to additional product cost as well as increased waste disposal which negatively impacts the environment and adversely affects the sustainability agenda. Our IPCLCs raised awareness with colleagues through discussions and by updating notice boards. Amber Lodge patients participated in a fun awareness session around glove usage and developed a poster around when they think colleagues should wear gloves. A glove quiz was also held along with hand hygiene assessments using the glow and tell machine.

Karen Foltyn (IPC Nurse) with Sam Taylor at Amber Lodge

Karen Foltyn and Chris Tomes (IPC Nurses) with Wendy Edmondson at New Beginnings

IPC information noticeboard Windermere Lodge

Karen Foltyn (IPC Nurse) with Jackie Nelson at Windermere Lodge

Compliance Standard 5
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
Statement 1:
Risk assessments for HCAI are completed for all inpatients on admission.
Statement 2:
The IPC team provides advice and support to clinicians to reduce the risk of transmission.

The Healthcare Associated Infection Risk Assessment form located on SystmOne must be completed for all patients on admission to a ward, to ensure prompt identification of patients who have or are at risk of developing an infection. The target for completion was 100% and compliance is shown below:

Healthcare Associated Infection Risk Assessments	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Total Admissions	485	457	458	493
Total admissions with Infection Control Risk Assessments completed	455 (94%)	438 (96%)	438 (96%)	479 (97%)
Admissions without Infection Control Risk Assessments	30 (6%)	19 (4%)	20 (4%)	14 (3%)

In February 2025 the IPC team initiated a prevalence audit to evaluate the HCAI document to determine whether MRSA swabbing was indicated and performed correctly at the appropriate sites. The findings from the audit identified that MRSA screening was not always completed when indicated. Learning opportunities were highlighted and training around this will be delivered in 2025/26.

Compliance Standard 6
Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Statement 1:
Personal responsibility for compliance with IPC is identified in the job descriptions of all Trust staff.
Statement 2:
Develop a knowledgeable and skilled workforce to deliver a safe, high-quality service.
Develop and deliver a level 2 IPC training programme.
IPC link champions to be in all clinical areas/teams.

Mandatory Training

Standard Precautions Training:

- **Level 1** is for all non-clinical staff and is required every three years.
- **Level 2** is for all clinical staff and is required annually.

The training is completed by eLearning. A paper-based version of the training is available for staff groups unable to access e-Learning. This has been utilised primarily by colleagues from the Estates and Facilities Departments with limited access to Information Technology. For these groups of colleagues, the knowledge and learning post training was assessed by the individual's line manager. Compliance is monitored monthly by the IPC team and data is sent to Care Groups so gaps can be addressed.

Standard Precautions Training Compliance	Level 1 Compliance		Level 2 Compliance	
Care Group	23/24	24/25	23/24	24/25
Children's Care Group	97%	99%	92%	95%
Doncaster AMH & Learning Disabilities	93%	92%	90%	95%
Physical Health & Neurodiversity	99%	100%	95%	94%
Rotherham AMH	96%	98%	93%	92%
North Lincs & Talking Therapies	97%	99%	93%	95%
Corporate	93%	95%	100%	93%
Overall Trust Compliance	95%	97%	93%	94%

Additional Training

- Attendance at both the Community Nurse conference and the Healthcare Support Worker conference provided an opportunity for colleagues to talk to the IPC team about their work, raise the profile of IPC and discuss any current issues of concern
- Delivery of an education session around end-of-life care and specimen samples to colleagues at St Johns hospice
- Continuation of the rollout of a reusable tourniquet in clinical services
- Partnership training with the Physical Health Community Practice Teachers around central venous access devices, infections and sepsis
- Collaboration with the Physical Health Community Practice Teachers in the development of a training video for the management and maintenance of Peripherally Inserted Central Catheters.

Infection Prevention and Control Link Champions

Our IPC LCs have a role profile that describes their role and responsibilities to support patient safety strategies through the dissemination of IPC knowledge and best practice in their clinical areas. Both ward and community settings have nominated IPC LCs who are supported by the IPC team. They are passionate and enthusiastic and are invaluable role models for influencing knowledge and best practice within the workplace. Meetings are held every three months by MS Teams to share information and guidance and provide a platform for the link champions to raise concerns and share good practice.

A celebration was held for colleagues, including three IPCLCs, who successfully completed the Florence Nightingale Foundation course 'Developing Health Care Support Workers to be Infection Prevention Control Champions'. This course is recognised and supported by NHS England. The purpose of the course was to develop nursing, midwifery and allied health professional leadership to influence organisational and patient outcomes at a local, national and international level of healthcare. A WhatsApp group was set up for the IPC LCs and has proved to be a valuable communication tool prompting useful conversations between peers. Every week a "Friday Thought" has been shared by the IPC team which has prompted discussion between the group members.

Measles Resilience

Due to an increase in measles cases nationally a resilience plan was required. In response, a great deal of work was undertaken especially around filtering face piece (FFP3) plans. An external company was sourced to fit test patient facing colleagues across all localities and increased numbers of fit testers in each care group. Priority groups were identified in the care groups for fit testing with records maintained by the Workforce team.

The measles immunity status was reviewed for all inpatient admissions and patients were offered the vaccines if they had incomplete or unknown status. Medicines Management supported with the distribution of MMR vaccines to all localities. Colleagues were encouraged to find out their own immunity status with each care group collating information for their teams. Occupational Health offered to set up vaccination clinics for any colleagues wanting their MMR vaccines. A plan for rapid antibody testing for contacts of suspected or confirmed cases was established for all localities. This supported colleagues to be able to remain at work and reduced the impact on service delivery and business continuity.

Information was communicated to all colleagues with guidance and procedures updated or formulated as and when required. Relevant documents for colleagues to view and utilise when required were made available on the Trust intranet. Measles awareness has been raised by the IPC team during clinical visits, safety huddles, team meetings and drop-in sessions. These have enabled colleagues to ask questions and clarify the importance of measles immunity and the need for up-to-date vaccination status. An interactive measles awareness session was held on Amber Lodge with patients and colleagues that highlighted how infectious measles is and the importance of vaccination. Attendance at several community team meetings. This has provided a focus on IPC within community services and has built supportive relationships with frontline colleagues.

Compliance Standard 7
Provide or secure adequate isolation facilities.
Statement:
- All inpatient areas apart from physical health wards (Hawthorn, Hazel and Magnolia Lodge) and drug and alcohol services (New Beginnings) provide single room en-suite accommodation.
- All inpatients requiring isolation are appropriately managed.

The IPC team reviewed patients that had or were at risk of infection in order to support clinicians around the isolation and cohort nursing of patients where clinically indicated.

Compliance Standard 8
Secure adequate access to laboratory support as appropriate.
Statement:
- The Trust has contracts with acute NHS providers in Doncaster, Rotherham and North Lincolnshire to deliver laboratory services across all localities.

The Trust is compliant with Criterion 8. There has been provision of seven-day 24-hour access to laboratory support through contracts with The Rotherham Foundation Trust (TRFT) and DBTH. The laboratories operated according to the requirements of national accreditation bodies for the investigation and management of disease/infections.

Compliance Standard 9
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Statement:

- There is an IPC Manual incorporating up to date IPC procedural documents available on the Trust website.

The Trust adopted the National Infection Prevention and Control Manual (NIPCM) and associated A-Z of pathogens, supported by several quick guides and supporting documents. These incorporated local policy and procedure and provided colleagues with the information required for the initial management of a patient with a specific organism or for a particular process.

Compliance Standard 10
Providers have a system in place to manage the occupational health (OH) needs and obligations of staff in relation to infection.
Statement:
- The OH service is contracted out to an external provider.

People Asset Management (PAM) provided the occupational health service for the Trust. The IPC team signposted colleagues to PAM for advice where infection risks were identified.

Conclusion

The content of this report details the broad range of IPC activity across the Trust and highlights that preventing and reducing the risk of preventable infections/harm to colleagues and patients has remained a priority. The DIPC recognises and acknowledges the breadth and depth of work undertaken by all colleagues across the Trust working together to reduce the incidence of preventable HCAIs and enhancing patient safety.

The high visibility and availability of the IPC team, to facilitate effective IPC standards across all areas of the Trust, is key to the delivery of safe effective care and our vision ***"that no person is harmed by a preventable infection"*** remains consistent. This report demonstrates assurance that the standards in the Code of Practice in the Health and Social Care Act 2008 are being implemented and where necessary, actions have been put in place to mitigate against any exceptions, and we continue to be compliant against national standards.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Safeguarding Annual Report 2024/2025	**Agenda Item**	Paper Y
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Louise Bertman, Head of Safeguarding		
Meeting	Board of Directors	**Date**	29 May 2025

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

This report has not serviced the usual governance process that is seen historically in the NHS for annual reports. This is why the forward look of work for 2025/26 is removed until it has been signed off within the RDaSH governance framework.

The data contained within this report has however been via the internal corporate processes and serviced via the sub structure of the CLE, originating from the sub committee of Quality and Safety Group – Safeguarding Assurance Group.

This Annual Report provides a detailed review of safeguarding practices and learning across the organisation, the key areas the BoD are asked to note are:

1.Improvement in Safeguarding training compliance.
2.Learning from safeguarding incidents and reviews.

The Safeguarding processes received limited assurance from the 2024/25 360 audit, this was based on its review on the 2023/24 Q4 submissions and noting some of Q1 2024/25 showed that we had not learnt from the practices and processes that needed immediate attention. These have been actioned and addressed this year.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	
Business as usual.	X

Previous consideration (where has this paper previously been discussed – and what was the outcome?)
No Previous Consideration

Recommendation (indicate with an 'x' all that apply and where shown elaborate)	
The Board of Directors is asked to:	
X	**NOTE** the work undertaken in 2024-2025 including the work to tackle limited 360 audit assurance report 24/25.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)		
Trust Risk Register	X	N&F 2/25, N&F 8/25
Board Assurance Framework	X	

Introduction

This Annual Report highlights the work undertaken by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) in respect to its commitment and responsibilities in maintaining the safety and protection of those at risk of abuse and neglect. The report covers both adult and children safeguarding and the Mental Capacity Act (MCA) (2005). The responsibility to safeguard adults and children and promote their welfare is more comprehensive than just protection. To be effective, this requires staff members to recognise their individual responsibility to safeguard and promote the welfare of children and adults who are vulnerable as well as the commitment of Trust management to support them in this.

This report covers the period April 2024 to March 2025 and provides assurance that RDaSH is meeting its statutory obligations by ensuring staff are equipped to respond appropriately to safeguarding concerns when they arise. The purpose of this report is to:

- Provide an overview of safeguarding children activity within RDaSH
- Provide an overview of safeguarding adults activity within RDaSH
- Provide assurance that RDaSH is compliant with its statutory duties
- Identify emerging risks and trends in relation to safeguarding
- Summarise the work undertaken in relation to the MCA (2005)
- Outline the key priorities for 2025/2026

Safeguarding is a complex and challenging area of work, however, our plans are underpinned by the RDaSH values and supports the 28 promises set out in our Clinical and Organisational Strategy for 2023-2028. The safeguarding teams workstreams link to the following promises:

Promise 4 puts patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.

Promise 5 systematically involves 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.

Promise 6 states that we intend to poverty proof all our services by 2025 to tackle discrimination, including through digital exclusion.

Promise 26 is to become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.

Governance and Leadership within the Safeguarding Team

The safeguarding leadership and governance structures are well established with the Chief Nursing Officer being the Executive Lead with responsibility for Safeguarding and the Medical Director being the Executive Lead with responsibility for Mental Capacity Act (MCA). The Head of Safeguarding provides strategic direction for both adult and children's safeguarding, with the Named Nurses/Professionals and MCA lead providing expert advice, guidance, and leadership. The MCA lead also reviews the quality of applications to the Supervisory Bodies for authorisations under the Deprivation of Liberty Safeguards (DoLs).

The team prides itself on ensuring that the person at risk of or suffering neglect, harm or abuse always remains in our 'line of sight', and that we 'hear their voice' and they remain at the centre of all we do.

Quality Assurance

Challenge is offered by the quarterly Safeguarding and MCA Group which is a sub-group of the Quality and Safety Group. The purpose of the Safeguarding and MCA Group is:

- To provide operational guidance around the strategic direction of safeguarding and MCA across the Trust in relation to safeguarding children and young people, adults at risk, PREVENT and victims of domestic violence and abuse.
- To provide assurance that statutory requirements and national guidance is incorporated into trust policies and processes.
- To provide operational oversight of the responsibilities of the Trust in respect of Mental Capacity Act Legislation.
- To develop, implement and monitor the integrated Safeguarding Adults, Children and Young People Annual Plan which should be reported to the Trust Board
- To oversee and monitor all activities related to safeguarding to ensure safe high-quality care is delivered, whilst managing risks to an acceptable level.
- To co-ordinate and promote partnership working for the purpose of safeguarding and promoting the welfare of adults, children and young people at risk.

The Safeguarding and MCA Group provides assurance about the safeguarding arrangements within our Trust. We work with many partner agencies and contribute to local multi-agency Safeguarding Children Partnerships, Safeguarding Adults Boards and subgroups across our footprint. The Trust provides external assurance through a variety of methods including Section 11 audits, Self-Assessments and Contractual Standards required by the Integrated Care Boards.

Progress against priorities 2023-2024

Priority	Progress
Implementation of Working Together 2023	Continue to work together with the safeguarding partnerships to embed the guidance
Development of Multi-Agency Public Protection Arrangements Standard Operating Procedure	Not achieved due to capacity issues, added to next years priorities
Improve colleagues understanding of high-risk domestic abuse and how to risk assess	Domestic abuse training reviewed and delivered
Pregnant inpatients workstream	Not achieved due to capacity issues, added to next year's priorities
Evaluation of safeguarding training	Audit completed
Sexual Safety Charter	The Trust has an updated Sexual Safety Policy and Sexual Safety Charter available on the internet

Safeguarding Training

The delivery of safeguarding training remains a key priority for the safeguarding team, with the requirement that all staff are provided with the appropriate level of training commensurate to their role as defined in the Intercollegiate documents: Safeguarding Children and Young People: Roles and Competences for Healthcare Staff (2018), Looked After Children: Roles and Competences for Healthcare Staff (2020) and Adult Safeguarding: Roles and Competencies for

Healthcare staff (2019).

The aim of the safeguarding training is to ensure that every member of staff is aware of their safeguarding responsibilities, recognises abuse and knows what to do about it, as the minimum requirement. All training delivered by the team meets national standards as described in the Intercollegiate documents. The Trust contributes to the delivery of multi-agency training programme developed by the Local Safeguarding Children's partnerships and Safeguarding Adults Boards. This includes the Graded Care Profile 2 and Professional Curiosity training in Rotherham and Doncaster. As a provider of NHS care we are required to have mechanisms in place to train staff to understand the risk of radicalisation. Mandatory Prevent training in line with NHSE Prevent Training and Competencies Framework is accessed by our staff via e-learning.

The table below shows Trust compliance with safeguarding training as of March 2025 and compares data to the previous year. All subject areas are now RAG rated green except for Domestic Abuse Level 2 which has seen an improvement in compliance since the last year.

Subject	Target	March 2024	March 2025
Safeguarding Adults Level 1	90%	97.24%	95.89%
Safeguarding Adults Level 2	90%	96.27%	96.56%
Safeguarding Adults Level 3	90%	81.11%	92.93%
Safeguarding Children Level 1	90%	97.27%	96.06%
Safeguarding Children Level 2	90%	96.81%	95.56%
Safeguarding Children Level 3	90%	80.86%	92.64%
Prevent Level 1/2	95%	92.98%	97.19%
Prevent Level 3	95%	95.33%	96.09%
Domestic Abuse Level 1	90%	97.04%	96.64%
Domestic Abuse Level 2	90%	86.83%	89.41%

The safeguarding team offer a wide and varied suite of training courses which will support staff to maintain their compliance with both level 3 safeguarding children and adults. The table below identifies the number of specific training courses delivered in 2024/2025 and the number of participants that attended. The safeguarding team have delivered training to 3088 colleagues across the Trust.

Course Name	Number of courses delivered	Number of participants
Level 3 Core Safeguarding Children	12	747
Think Family	1	19
SC Road Map	2	19
Honour Based Abuse	5	114
Adverse Childhood Experiences [Attachment & Trauma aware]	7	208
Child Neglect	5	117
Safeguarding Supervisor	6	90
Level 3 Core Safeguarding Adults	12	765
Self-neglect and hoarding	5	131
Modern Slavery	4	53
PIPOT	3	29
Domestic Abuse Level 2	13	651

Honour Based Abuse	5	114
DASH/Protection Plans	1	31
Total	**81**	**3088**

Safeguarding training audit

The safeguarding team completed a training evaluation audit in July 2024 to evaluate the blended learning approach used to achieve compliance with level 3 safeguarding training. Blended learning gives the opportunity for staff to consider their past learning and use their autonomy to choose any training that is best suited to their job role and knowledge base. It is recommended that colleagues complete at least 50% of training via a facilitator led course.

The evaluation feedback is a Microsoft form, and responses are collated anonymously towards the end of any facilitator led training session. The form gives the opportunity to anonymously give constructive feedback on:

- The objectives and content of the training
- The facilitator and interaction within the training
- A scoring of colleagues understanding of the subject before and after training
- A qualitative response in relation how we can improve the training and any other topics that would be beneficial for the future.

Evaluation of the safeguarding training feedback gave an opportunity to review and reflect on facilitator led safeguarding training and to monitor the effectiveness of facilitator led training and that the content and delivery improved the attendee's knowledge in relation to safeguarding. The audit result was outstanding and provides assurance that the safeguarding team are delivering effective and appropriate training sessions for colleagues working across the Trust and that standards are maintained.

Safeguarding Supervision

Safeguarding supervision is fundamental in supporting practitioners in delivering high quality care, providing risk analysis and individual action plans. Supervision ensures that practice is soundly based and consistent with Local Safeguarding Children Partnerships, Safeguarding Adult Boards, and organisational procedures.

Safeguarding supervision is mandatory for all staff working with children & families. RDaSH uses a cascade model for facilitating safeguarding supervision and supervisors act as a visible champion of safeguarding within their own service areas to provide a link between their colleagues and the safeguarding team. Ad-Hoc supervision is available for any staff member who has dealt with either an adult or a child safeguarding issue and requires advice and support or wishes to discuss and reflect on their practice.

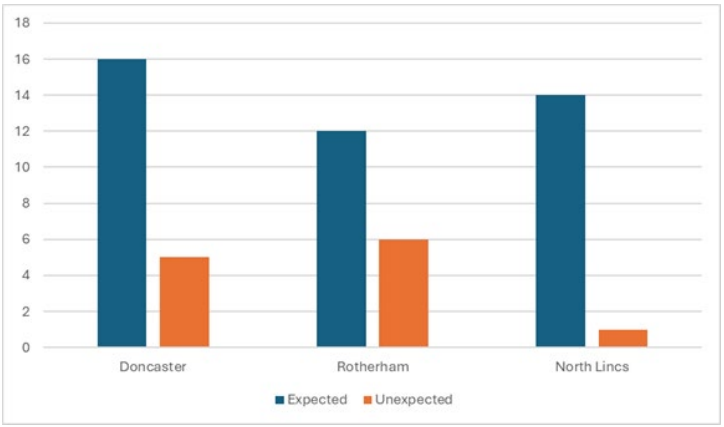
Safeguarding Children

Child Death Reviews

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand

what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

The graph below shows the number of unexpected and expected child deaths for each area. Themes for unexpected deaths are prematurity, accidents in the home, misadventure and road traffic collisions.



The safeguarding team are alerted to all child deaths in Doncaster, Rotherham and North Lincolnshire, whether the death is expected or unexpected. The role of the Named Nurse/professional is to review the records of the child, named adults and other children to ascertain any relevant, recent/current involvement from RDaSH services.

There is a robust process in place to ensure that relevant colleagues within the Trust are alerted to the child's death and support can then be offered to colleagues and where appropriate, the family. The team attend meetings where required and offer support to affected colleagues. Where there are Joint agency responses (JAR's) and Rapid Reviews-the team supports in the coordination of any information that may be required as well as any subsequent meetings. The team share any learning from reviews and support in the implementation of any recommendations.

Child Safeguarding Practice Reviews (CSPRs) and Learning Lesson Reviews (LLRs)
A CSPR is commissioned when a child or young person dies or experiences serious harm or injuries and there is interagency learning. During 2024/2025, the table below shows the reviews the Trust was engaged in:

Area	Type	Theme	Learning
Doncaster	LCSPR	Neglect and Physical Abuse/Missing from education/elected home educated (EHE)	Report not yet published
Doncaster	LCSPR	Physical Abuse	Full report not yet published. Emerging learning points are: The impact of the family's culture on how agencies worked together to support them and ensured their understanding. The relevance of the family's community on how they supported family and how they responded to agencies involvement.

			The impact on families who are transient across a number of local authority areas, The role and use of effective translation with families where English is not their first language and where domestic abuse maybe a concern. The theme of domestic abuse requires a clear focus in respect of parental domestic abuse, the nature of that abuse as well as their previous experiences of domestic abuse. For example: it is known that mother was in a domestic abusive relationship with the father of her children whilst they were living in Cheshire East. Information sharing across agencies and areas.
Doncaster	LCSPR	Neglect/Missing from Education/EHE	This is a joint report with shared learning with the case below. The importance of partnership working across Early Help (EH), Child in Need (CIN) and Child Protection (CP). Strengthening of the practice across those forums is required to consistently address and reduce the risks to children These cases have highlighted the importance of using history to inform assessments and practice There is a need for increased scrutiny when requests are made to home educate children where there are or have been concerns in relation to neglect or parenting The importance of using tools to identify and assess the level of risk from all forms of neglect, and for it to inform practice The importance of understanding the lived experience of children The need for effective managerial oversight and challenge in relation to assessments
Doncaster	LCSPR	Neglect	Not yet published. This is a joint report to include the above learning
Doncaster	Thematic Review	Suicide	To understand risks associated with self-harm and suicide ideation Multi-agency working and information sharing is paramount
Doncaster	Thematic Review	Misadventure	Stronger partnership working To always be professionally curious To explore innovative ways of engagement To limit any changes in key personnel to keep the engagement going
Doncaster	LCSPR	Child Sexual Abuse	This case has not been published due to family being identifiable. Key learning points: Cross border information sharing between police forces. System issues in police forces-lack of referrals by police to children's social care Social care decision making to close CIN case prior to checks with other services Lack of professional curiosity by professionals in all sectors to fully understand the family dynamics, domestic abuse in the home 'invisible' partners where questions are not asked about relationships and family history
Rotherham	LLR	Neglect/Missing from education/EHE	A local internal review will take place. An Elected Home Educated (EHE) /CME group has been developed to consider these children.

Female Genital Mutilation (FGM) Mandatory reporting

FGM is a procedure involving partial or total removal of the external female genitalia or other injury to the female genitalia for non-medical reasons. FGM is a deeply embedded social norm,

practised by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman, and to be marriageable. The practice is not required by any religion.

FGM is an unacceptable practice for which there is no justification. It is a form of violence and child abuse and as such colleagues have a statutory obligation to report any known cases of FGM in individuals under 18 that they identify in the course of their professional work to the police.

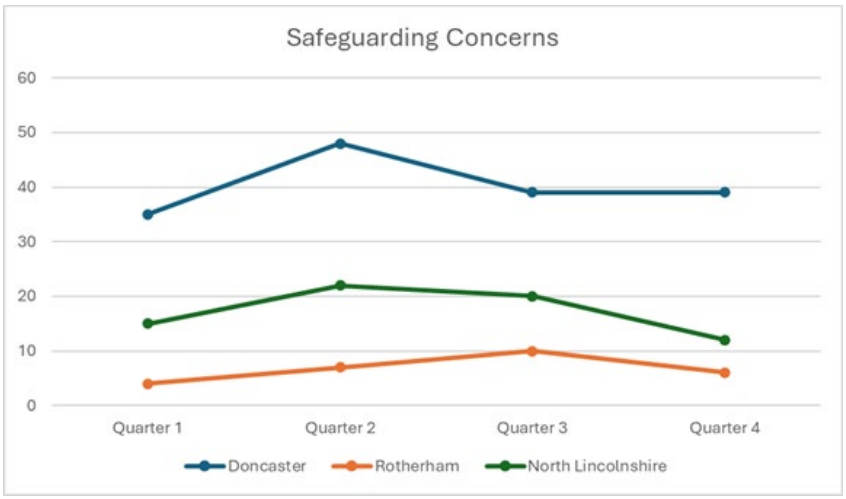
RDaSH have an FGM policy which provides guidance to assist all colleagues in the prevention and detection of FGM. During 2024-2025, there were 14 reported cases of FGM in Doncaster, 0 in Rotherham and 0 in North Lincolnshire, with no mandatory referrals for individuals under the age of 18.

Safeguarding Adults

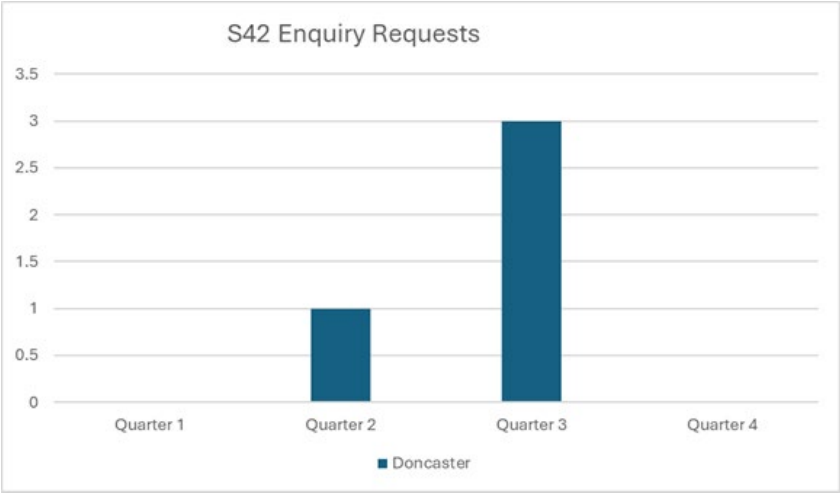
Safeguarding Concerns and Section 42 Enquiries

Safeguarding concerns are raised in line with legislation and policy to the local authority, concerns can be raised by a professional or member of the public. Local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria set out in the Care Act 2014, is at risk of or being abused or neglected. The purpose of the enquiry is to decide whether the local authority or another organisation or person should do something to help and protect the adult.

The table below summarises the number of safeguarding concerns relating to RDaSH patients that the Trust has been asked to further fact find. This is to enable the local authority to decide whether to progress to a Section 42 Enquiry:



Both Rotherham and North Lincolnshire Council manage their own section 42 enquiries and provide an update following conclusion of the investigation. As is evident from the table below, there are very few section 42 enquiries that Trust staff are asked to lead on.



Safeguarding Adult Reviews

A Safeguarding Adults Review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

Section 44 of the Care Act (2014) states that the Safeguarding Adult Board (SAB) must arrange a SAR when an adult with needs for care and support (even if the local authority has not been meeting any of those needs) if:

There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

a. the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether it knew about or suspected the abuse or neglect before the adult died) **OR**

b. the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect

The table below shows the number of reviews that RDaSH have been involved in during 2024/2025. There are no current action plans for RDaSH.

Area	Theme	Learning
Doncaster	Neglect	Listening to the voice of the adult at risk Professional curiosity Multi-agency working and information sharing
Doncaster	Self-neglect	To review the interface between self-neglect and suicidal ideation Professional curiosity in regard to LGBTQ+ and other protected characteristics
Doncaster	Self-neglect	Awaiting the final report to confirm learning outcomes
Doncaster	Self-neglect	Ongoing
North Lincolnshire	Infection control	Multi-agency working and information sharing Poor communication Lack of guidance to respond to blood-borne viruses

Sheffield	Neglect and acts of omission	Commissioning processes The need to undertake holistic assessments Issues related to the lack of effective multiagency communication

Domestic Abuse

Domestic abuse can affect anyone irrespective of sex, ethnicity, class, religion, sexuality and disability. RDaSH recognise that patients, staff, volunteers and contractors could be affected by domestic abuse for example, victim and survivor, living in a domestic abusive relationship, or a perpetrator of domestic abuse. RDaSH have a well embedded domestic abuse policy which promotes the health, safety and wellbeing of any individual in contact with the organisation.

Working in a multiagency partnership is the most effective way to approach the issue at both an operational and strategic level. RDaSH forms part of the strategic partnerships across localities, committed to responding effectively to domestic violence and abuse.

The Domestic Abuse Act 2021 Statutory Guidance conveys what best practice in supporting victims looks like, including for multi-agency working and MARACs more specifically. The MARAC is a multi-agency meeting which takes place to discuss high risk cases of domestic abuse, including Honour Based Abuse cases. It is designed to enhance existing arrangements for public protection, including safeguarding children and adults, and has a specific focus on the safety of the victim and any children.

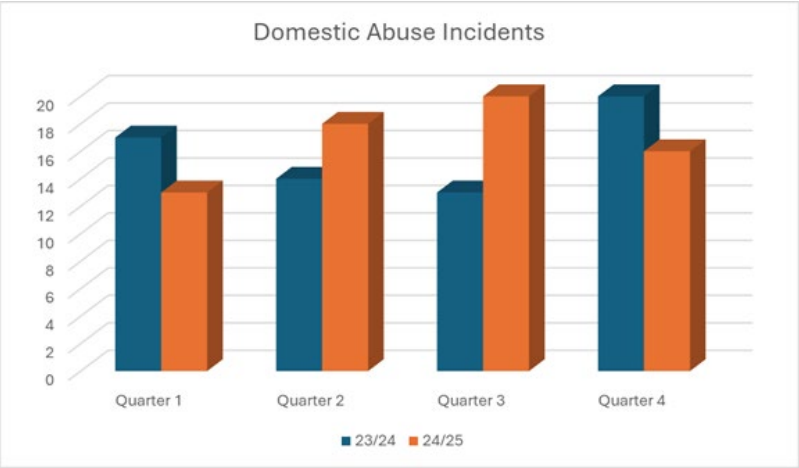
The MARAC is attended by representatives from a range of agencies including police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, mental health and substance misuse and other specialists from the statutory and voluntary sectors. The MARAC functions on the collective understanding that no single agency or individual can see the complete picture of the life of a victim or is able to identify and manage the risks, but all agencies may have insights that are crucial to the persons safety and risk management plan.

The safeguarding team have oversight of the MARAC process across the Trust and this year has seen the implementation of the MARAC SOP to ensure consistency of MARAC provision across the geographical footprint. The administration of the MARAC meetings is performed by the safeguarding administrators and support to MARAC representatives is provided by the Named Nurses/Professionals.

The Trust has recognised that there has been an increase in prevalence of domestic abuse and that it is a high priority area of work for all three Community Safety Partnerships. The Trust has invested into a dedicated Domestic Abuse/MARAC Lead role and the successful candidate commences in post this summer.

Domestic Abuse Incidents

The safeguarding team have oversight of all domestic abuse incidents and this provides assurance that patients are assessed using a Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) and subsequently offered the correct level of support. The table below shows the comparison data for the number of domestic abuse incidents reported per quarter in 23/24 and 24/25:



Domestic Abuse Related Death Reviews (previously known as Domestic Homicide Reviews)

A Domestic Abuse Related Death Review (DARDR), formerly known as Domestic Homicide Reviews (DHR), is carried out where a person has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household
DARDRs are carried out by Community Safety Partnerships to ensure that lessons are learnt when a person has died because of domestic abuse, either by homicide or suicide. The purpose of a DARDR is to:

- Establish what lessons can be learned from the homicide/suicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse and domestic homicides and suicides and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The table below outlines the DARDR's the Trust is currently involved in:

Area	Theme	Learning
Doncaster	Suicide	To produce a 7 min briefing on the theme of Domestic abuse and its interface with death by suicide. To educate staff regarding the range of risk assessment tools relating to domestic abuse
Doncaster	Suicide	To ensure that staff correspond with patients in their preferred language or format.
Doncaster	Suicide	To ensure all staff are aware of their need to demonstrate professional curiosity when receiving info relating to potential DA in a relationship.
Doncaster	Suicide	To ensure staff are professionally curious To increase staff understanding of ACES
Doncaster	Suicide	To ensure all staff are aware of their need to demonstrate professional curiosity when receiving info relating to potential DA in a relationship.

		To ensure that staff are aware of the misuse of substances as a potential coping mechanism within some domestic abusive relationship
Doncaster	Homicide	Ongoing at this time
Rotherham	Homicide	No RDaSH specific or wider multi agency recommendations required
Rotherham	Suicide	To raise awareness with staff that self-harm and suicidal ideation may be potential indicators of Domestic abuse within a relationship To ensure that a trauma informed approach is adopted within case work
Rotherham	Suicide	All agencies to ensure that education regarding ACE`s is embedded into staff training
North Lincs	Homicide	To ensure that learning from the DHR is embedded into the Trust Domestic abuse training.

Prevent

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

The Prevent duty requires specified authorities such as education, health, local authorities, police and criminal justice agencies (prisons and probation) to help prevent the risk of people becoming terrorists or supporting terrorism. It sits alongside long-established safeguarding duties on professionals to protect people from a range of other harms, such as substance abuse, involvement in gangs, and physical and sexual exploitation. The duty helps to ensure that people who are susceptible to radicalisation are supported as they would be under safeguarding processes.

Healthcare professionals have a key role in Prevent because they will meet and treat people who may be susceptible to radicalisation. This includes not just violent extremism but also non-violent extremism which can reasonably be linked to terrorism, such as narratives used to encourage people into participating in or supporting terrorism.

The Executive Lead for Prevent is the Chief Nursing Officer. The Head of Safeguarding is the Prevent lead for the Trust and provides a point of contact for the regional prevent coordinators. All NHS Trusts are required to submit Prevent data to NHS England and NHS Improvement. This is submitted on a quarterly basis. The table below shows the number of Prevent referrals made and Channel information requests provided across the Trust in 24/25:

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Prevent Referral	0	1	0	1
Channel information request	1	4	6	14

It can be seen from the data that as a Trust we make very few Prevent referrals, however, the request for information to make decisions at Channel Panel has increased throughout the year. The information requests relate to both children and adults, and it could be hypothesised that where the request relates to children on universal services, the Trust may have very little

contact with them. To provide evidence that Trust colleagues are identifying Prevent concerns and making referral where appropriate, an audit will be undertaken in 25/26.

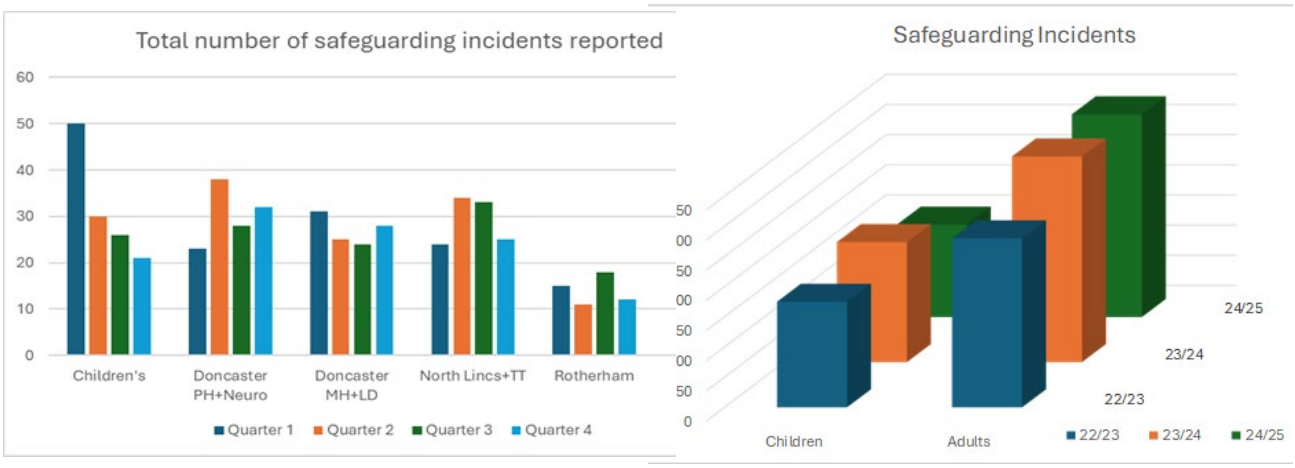
All staff are required to complete Prevent Basic Awareness Training, this is delivered during induction and updated every 3 years with an annual update from the Prevent lead which includes any changes in legislation, changes to local policy and procedure or lessons learnt.

All clinical staff are required to complete Prevent level 3 training, delivered through a combination of face-to-face and e-learning and updated every 3 years with an annual update as shown in the training table above.

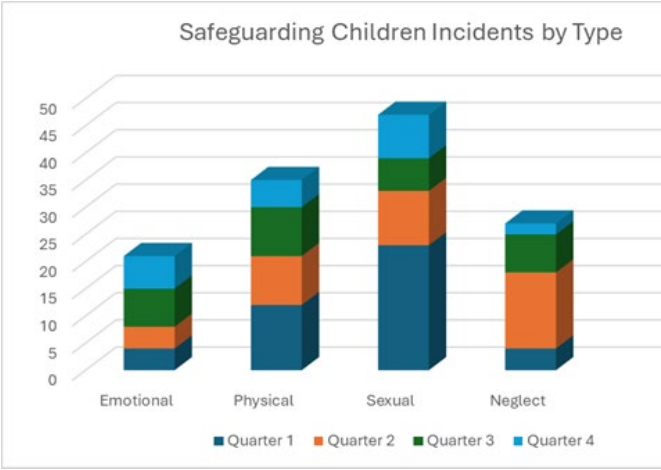
Incidents

Any incidents specific to safeguarding are reviewed and responded to by the team. This may include reviewing the patient records and/or contacting the incident reporter for further information and to offer support and guidance. The table below is a summary of the number of safeguarding incident reports received in comparison to previous years:

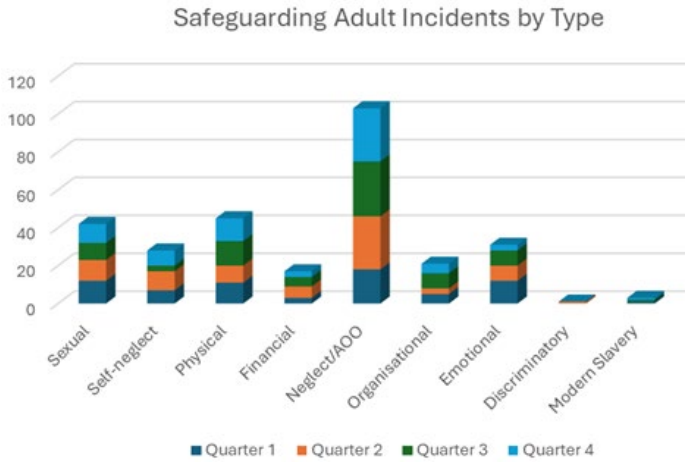
This data shows that the number of safeguarding adults incidents reported remain consistent with the previous year 341 in 23/24 and 336 in 24/25. This provides assurance that practitioners are identifying where there are safeguarding concerns. In 24/25 the number of incidents relating to safeguarding children has reduced from 199 to 153



The chart above shows that the number of safeguarding incidents reported by the children's care group has reduced every quarter, Q1 50 to Q4 21. Further work is to be undertaken to understand this. The number of incidents reported by all the other care groups remains consistent throughout the year. The team also monitor safeguarding themes and trends to identify where additional training or supervision may be required. The table below shows the types of abuse reported:



For children, the greatest number of incidents were reported under the categories of sexual abuse which is different to 23/24 as this was neglect and emotional abuse. The reason for this is that during quarter 1, there were concerns for a large number of young people in relation to a particular area. Multi-agency working commenced with a positive outcome that reduced the risk to the young people involved.



Incidents concerned with the theme of neglect and acts of omission far outweighs other incident themes for safeguarding adults, again paralleling the themes identified in 23/24.

Local Authority Designated Officer (LADO)

The role of the LADO (or Designated Officer) is set out in Working Together to Safeguard Children (2023) and is governed by the Local Authorities duties under section 11 of the Children Act 2004. The LADO is responsible for managing allegations against adults who work with children. This involves working with police, children's social care. employers and other involved professionals. The LADO does not conduct investigations directly, but rather oversees and directs them to ensure thoroughness, timeliness and fairness. The LADO must be contacted in respect of all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed a child; (Criminal Threshold)
- Possibly committed a criminal offence against or related to a child; (Harm Threshold)
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children. (Risk Threshold)
- Behaved in a way which raises concerns as to their suitability to work with children and that they are safeguarded.

There have been 5 referrals to the LADO in 24/25 which involved working with Local Authority practitioners, Human Recourses internally, managers and in some cases police and professional bodies such as NMC/GMC. Staff who are involved in the process are supported throughout the investigation.

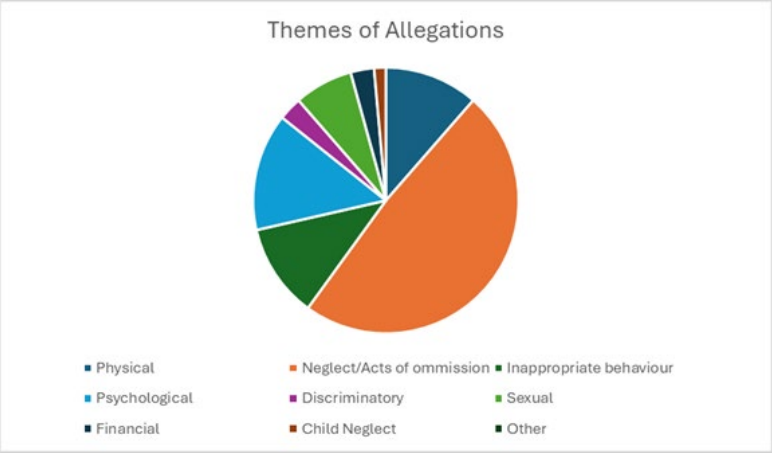
Persons in Position of Trust

As a relevant partner to a number of local authorities and an organisation providing care and support services to adults; the Trust is required to have a clear process in place for dealing with allegations against 'Persons in Positions of Trust' (PiPoT). RDaSH is required to provide assurance to the Safeguarding Adults Boards that arrangements to deal with such allegations within RDaSH, are functioning effectively. The Trust has a robust and mature PiPoT policy in place.

The table below details the PiPoT referrals made to the safeguarding team. Where the allegation was substantiated, on two occasions there was a parallel police investigation, and two occasions LADO procedures were followed due to the possible transferrable risk to children. On one occasion the PiPoT left the organisation, however, despite assurance can be given that the process continued to its conclusion.

Care Group	No	PiPoT criteria not met	Substantiated	Unsubstantiated	Unfounded	Open
PH + Neurodiversity	7	0	5	0	0	2
Doncaster MH +LD	28	0	17	7	0	4
North Lincs + Talking Therapies	21	1	8	6	0	6
Rotherham MH	16	1	8	6	0	1

It is evidenced from the chart below that the greatest number of allegations was in relation to neglect and/or acts of omission followed by psychological abuse.



Mental Capacity Act 2005

The MCA provides a legal framework for acting and making decisions on behalf of individuals aged 16 and over who lack the mental capacity to make decisions for themselves. The MCA

makes it clear who can make decisions, in which situations, and how they should do this. The same rules apply whether the decisions are life-changing events or everyday matters.

The underlying philosophy of the MCA is that any decisions made, or actions taken on behalf of a person who lacks capacity, should be in their best interests. The MCA requires an individual approach that prioritises the interests of the person who lacks capacity, not the views or convenience of those caring and supporting that person. However, there are certain decisions that can never be made on behalf of a person lacking capacity because they have been specifically excluded from the provisions of the MCA.

The MCA's starting point is that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves, unless it can be shown that they lack capacity to make a decision at the time the decision needs to be made. The MCA also states that people must be given all appropriate help and support to enable them to make their own decisions or be included in any decision-making processes. The MCA places a duty on key people and bodies (including RDaSH), to ensure that their functions are discharged in line with the law and therefore safeguard and promote the rights of people who may lack capacity, and this is supported by Statutory Codes of Practice.

MCA Training

The Trust has an MCA Training Framework in line with the National Mental Capacity Act Competency Framework and Adult Safeguarding: Roles and Competencies for Healthcare Staff (2024). Most of the training is delivered by e-learning Health Education England which is updated regularly to incorporate changes in case law. The MCA lead delivers two of the MCA Level 4 courses, DoLS and MCA for Managers. Compliance with MCA training is monitored monthly.

The table below shows Trust compliance with MCA training as of 31st March 2024 and comparison data is provided for the previous year. There has been an increase in compliance in every level of training. Only a small number of colleagues require level 4 training, with this level of training being once only.

Competency	Target	March 2024	March 2025
MCA Level 1	90%	96.87%	98.77%
MCA Level 2	90%	93.21%	94.65%
MCA Level 3	90%	87.62%	91.02%
MCA Level 4 Complex	90%	88.62%	89.22%
MCA Level 4 DoLs	90%	83.78%	86.46%
MCA Level 4 Manager	90%	75.21%	77.37%

In addition to the training outlined in the framework the MCA lead delivers Ad Hoc training to teams and wards as and when required. The table below outlines the additional training delivered in 24/25:

Training Type	Area
MCA Briefing	District Nurses
MCA Briefing	Aspire
MCA Briefing	Care Homes champions meeting
MCA Briefing	District Nursing East Team

DoLs for wards	Doncaster PH and Neurodiversity Care Group
Capacity and Consent	District Nursing Team South
MCA Briefing	District Nursing Team Central
Consent	Doncaster PH and Neurodiversity Care Group
MCA training	Learning Disabilities Team
Assessing Capacity	Doncaster PH and Neurodiversity Care Group
MCA Briefing	FOILS team
MCA Briefing	Children's Long-Term Conditions

Advocacy

The Independent Mental Capacity Advocate (IMCA) service provides independent safeguards and helps people who lack capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends (excluding paid carers) who it would be appropriate to consult. There is a statutory duty to request an IMCA in these circumstances. Information and guidance about IMCAs are included in the MCA, DoL and Safeguarding Policies and are also available on the intranet. It is worth noting that each locality has a different IMCA service, commissioned by the local authority.

The number of requests for an IMCA is low; however, most people have capacity to consent to the decisions which need to be made, or they are represented by family or friends so usually the criteria for use of an IMCA is not met. It is not possible to know if an IMCA should have been appointed and was not without doing a full audit of the patient's journey looking at the decision which needed to be made. Consideration regarding the duty to appoint an IMCA will be included in next year's MCA Audit.

Advance Decisions, Power of Attorney and Court Appointed Deputies

Guidance on Lasting Powers of Attorneys (LPAs) and Court Appointed Deputies (CADs) is included within the MCA policy. Guidance on assessing the validity of advance decisions and powers of attorney (and how to access further assistance in the case of doubt) is available within the MCA policy and on the MCA pages on the staff intranet.

Deprivation of Liberty Safeguards 2007 (DoLS)

DoLS are part of the MCA introduced in April 2009. The safeguards apply to people in hospitals and care homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. Where a person is deprived of their liberty the safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed.

People can be deprived of their liberty in settings other than hospitals and care homes but in such cases, this can only be approved by the Court of Protection. Whilst the MCA allows for the use restriction and restraint where it is in the best interests of the person and is necessary to prevent harm, if that restriction and restraint becomes a deprivation of the person liberty it must be authorised in accordance with Article 5 of the European Convention on Human Rights, this includes the use of DoLS where the criteria is met.

DoLS Activity

Data and information on compliance with DoLS is collected in relation to the number of requests for authorisation made to the Supervisory Bodies and reviewed in the Safeguarding and MCA Group. Any issues around compliance with use of the safeguards are dealt with on a case-by-case basis and areas for improvement identified and addressed.

The table below shows the number of new requests for DoLS between 1st April 2024 and 31st March 2025, numbers were similar to the previous year.

Area	2023/2024	2024/2025
Mental Health Wards	44	33
Danes Court	1	5
Physical Health Wards	27	24
St Johns Hospice	1	3
Total	71	65

Local Authority delays in carrying out DoLS assessment and granting authorisations continues to have an impact on requests being processed and in most case the patient is discharged before DoLS assessment are carried out, resulting in the patient being unlawfully deprived of their liberty for long periods of time. The longest period being 84 days for an adult mental health patient, and 169 days for a patient on a physical health ward. This has reduced since 23/24 when the numbers were 98 and 224 respectively.

This could mean that people are being deprived of their liberty for longer than they should have been, or where less restrictive options could have been identified if they had been assessed. When assessments are delayed, staff face the challenge of keeping people safe while protecting their rights. This is particularly difficult if an urgent DoLS authorisation expires before the person has been assessed for a standard authorisation. This situation also affects people's ability to challenge the deprivation of liberty, as public funding for legal support depends on an authorisation being in place.

Completion of DoLS rests outside of the Trusts control and sits with the local authority, therefore the Trust is not able to act on this other than highlighting the deficits. A desire to improve the situation nationally has resulted in legal reform and the Liberty Protection Safeguards (LPS) were brought into law through the MCA Amendment Act 2019. LPS was originally due to be implemented in October 2020 but was postponed because of the COVID-19 pandemic. In April 2023 the government announced that the implementation would be further delayed until a new government was in place, however, no additional information has been published since that date.

Court of Protection

The Court of Protection (CoP) was established under the terms of the MCA and came into force on 1 October 2007. It is a specialist court which makes specific decisions or appoints other people known as deputies to make decisions on behalf of people who lack the capacity to do so for themselves. The Court of Protection can:

- decide whether a person 'has capacity' (is able) to make a particular decision for themselves
- make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make these decisions
- appoint a deputy to make ongoing decisions for people lacking capacity to make those

decisions
- decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid
- remove deputies or attorneys who fail to carry out their duties
- hear cases concerning objections to register an LPA or EPA.
- Cases are heard by Circuit, District and High Court Judges, at the central registry in Holborn, and at courts throughout England and Wales.

The Trust has made 0 applications to the Court of Protection in 2024/2025 and were party to 0 cases.

Section 49 requests

Under section 49 MCA, the CoP can order NHS health bodies and local authorities to arrange for a report to be made for the purpose of considering any question relating to someone who may lack capacity. The report must deal with such matters relating to the individual in question 'as the court may direct.'

An order under section 49 places an obligation on the NHS body (typically a mental health trust) to comply with such requests. This obligation does not extend to any individual member of staff and the Trust must make appropriate arrangements to complete the report. Section 49 reports are frequently requested from Trusts where there is no prior knowledge of, or relationship with, the individual in question. Compliance with s49 reports is currently problematic to the Trust for several reasons:

- There are insufficient consultants in the pool who are willing to undertake this work.
- Not all specialities are represented in the pool of consultants willing to undertake the work e.g. there is no one from physical health
- Consultants are reluctant to undertake the s49 report because of the impact on clinical time or may not know the patient i.e. the person may have been seen by the team or a junior doctor or may not be known to the team at all.

The table below evidences the number of S49 requests the Trust has received since 2020:

	20-21	21-22	22-23	23-24	24-25	Total
Number of Requests	15	9	6	3	5	38

Patient Experience

At this point in time there is no engagement with people who may have had decisions made by professionals within the Trust under the MCA. IT is recognised that it is difficult to engage with people who lack capacity in relation to their experience of the MCA as most patients will be unaware of decision made on their behalf. However, to meet with Integrated Care Board and Care Quality Commission requirements this is an area which needs to be explored to improve patient experience and the quality of their care.

Audits

The Trust has a Safeguarding audit plan that audits several areas of safeguarding practice. See table below:

Activity	Aim	Summary	Outcome	Actions
Persons in Position of Trust	Adherence to policy	An increased compliance is required in relation to ensuring that an incident report is completed on the instigation of the PiPoT process and in respect of the timeliness of the initial PIPoT meeting being convened.	Good	To ensure PiPoT meetings are scheduled within 5 working days Incident report to be completed when submitting a PiPoT referral
Prevent	Adherence to policy	An increased compliance is required in relation to ensuring that an IR1 is completed on the instigation of a PREVENT referral and an increased awareness through training of what constitutes an appropriate referral.	Good	Process to be reiterated during training, supervision and senior leadership governance. Training compliance to be monitored.
Blended Learning	To evaluate the effectiveness of the blended learning approach to level 3 safeguarding training	Colleagues are utilising the blended learning approach to Level 3 safeguarding training with a mixture of facilitator led, E Learning and reflective learning. A higher proportion (over 50%) of facilitator led training was recorded, as recommended in the intercollegiate document and blended learning guidance.	Outstanding	To ensure that colleagues continue utilising a variety of training methods as suggested in the blended learning approach (Over 50% facilitator led) and identify the most popular methods ie, facilitator led, eLearning or reflective practice.
Safeguarding training evaluation	To evaluate the effectiveness of safeguarding training	The Safeguarding facilitator had a sound knowledge of the training subject and delivers the training in a helpful and supportive manner. The facilitator encouraged interaction within the training session. All attendees self-reported an increase of knowledge around the subject matter after completing the training.	Outstanding	The safeguarding team to review the training portfolio and introduce new topics based on qualitative feedback The safeguarding team to continue to request evaluation feedback forms after each safeguarding training session to ensure standards are maintained.

Internal Audit

During October 2024, a 360 internal audit was undertaken in respect of safeguarding across the Trust. The overall objective was to provide an independent assurance opinion on the overarching governance function and policies for safeguarding within the Trust. The audit outcome identified **limited assurance** and highlighted that there are weaknesses in the design and/or inconsistent application of the framework of **governance, risk management and control** that could result in failure to achieve the objectives of the system under review.

The authors identified that their opinion was limited to the controls examined and samples tested as part of this review. They identified good practice including that there is a clear staffing and leadership structure within the safeguarding team, there is a suite of safeguarding policies available to staff and there were examples of excellent practice regarding the Trust's safeguarding training offer. It was noted that there were risk issues in respect of safeguarding governance within the organisation, with regards to themes, trends, action plans and learning from safeguarding incidents were not presented through the governance structure.

The medium risk findings are detailed below:

1. The Trust produces quarterly and annual safeguarding reports which are extensive and cover a broad range of topics. However, they do not include any themes, trends, action plans or learning that relate to safeguarding incidents. Sections on care groups are text heavy, and it is difficult to pull out key issues from these sections.
2. The Safeguarding Assurance Group is the key operational group in which matters are progressed through the governance structure. However, the Terms of Reference for this group are out of date and on no occasions during the 6-month period examined was it quorate; divisional representation was particularly inconsistent and attendance from the Named Doctor for safeguarding was low. The Terms of Reference state that the group should receive oversight of themes and trends from Person in Position of Trust (PiPoT) and Local Authority Designated Officer (LADO) referrals; however, this was not seen within the minutes we reviewed. Actions were not always translated on to the action log and those logged were not always completed in a timely manner.
3. The upward flow of assurance from Safeguarding Assurance Group to Board to the Clinical Leadership Executive Quality and Safety Group is unclear in regard to the format and frequency of reporting into the group.

The audit identified a number of recommendations to ensure that governance and process were strengthened. In response to the audit and its recommendations, the Head of Safeguarding took steps to strengthen and develop the governance and safeguarding learning and this has been embedded within a robust action plan. The action plan was disseminated to the Integrated Care Board and internally to the Quality and Safety group where closure was agreed as all actions were complete.

External Audit
The safeguarding team participate in external multi-agency audits when requested.

Policies and Procedures
The following policies and procedures have been reviewed or developed:

Sexual Safety Policy	Management of Allegations against a Person in Position of Trust Policy (PiPoT)

Prevent Policy	Mental Capacity Act Policy
Perplexing Presentations/Fabricated or Induced Illness Policy	Advanced Decisions to Refuse Treatment Policy

All are available on the Safeguarding page of the Trust internet/intranet.

Newsletters

The safeguarding team aims to produce quarterly newsletters to inform staff of changes to legislation, new guidance and training opportunities. They also contain links to partnership information to support staff to safeguard patients. Unfortunately, due to capacity issues the newsletter was only produced in Autum and Winter and can be found below:

Autumn Newsletter

Winter Newsletter

Partnership Working

The Trust is fully committed to multi-agency working and ensuring that effective safeguarding arrangements are in place across each of the three locality areas the Trust operates in. This is achieved by:

- Membership of Doncaster Safeguarding Children Partnership (DSCP), Doncaster Safeguarding Adult Board (DSAB) and sub-groups of both.
- Membership of Rotherham Safeguarding Children Partnership (RSCP) and Rotherham Safeguarding Adult Board (RSAB) and sub-groups of both.
- Membership of North Lincolnshire Safeguarding Children Partnership (MARS) and North Lincolnshire Safeguarding Adult Board (NLSAB) and subgroups of both.
- The MCA Lead attends several multi-agency MCA forums including Rotherham ICB MCA/DOLS Forum, Doncaster MCA Forum and North Lincs MCA Forum.

Achievements

Conclusion

The safeguarding team has made progress in 2024/2025, actively engaging with both local and national developments. The ‘Think Family’ approach ensures safeguarding is seen as a shared responsibility, with all staff understanding its impact on adults, children, and families, and responding appropriately to concerns and disclosures.

The safeguarding and MCA team is committed to providing leadership, support, advice, and guidance to staff, ensuring the Trust delivers the highest level of care to patients and families. RDaSH prioritizes the protection of vulnerable patients from abuse or neglect, with a workforce dedicated to safeguarding as a core responsibility.

To further strengthen safeguarding, the team structure will be enhanced, including the addition of roles such as the MCA, MARAC, and the Multi-agency Safeguarding Hub Health Representative, ensuring consistent and streamlined safeguarding practices within the Trust.