NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 26 September 2024 at 10.00am
The Pavilion, Askern Rd, Bentley, Doncaster DN5 0HU

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Dr Richard Falk, Richard Banks	Note		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest	Information		A
Patient Story				
5	*Experiences of care within a ward*	Information		Verb
Standing items				
6	Minutes of the meeting held in public on the 25 July 2024	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Trust People Council	Assurance	DV	D
9	Quality Committee	Assurance	DL	E
10	Audit Committee	Assurance	KG	F
11	Mental Health Act Committee	Assurance	SFT	G
12	People & Organisational Development Committee	Assurance	RB	H
13	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	I
14	Finance, Digital & Estates Committee	Assurance	PV	J
15	Chief Executive's Report	Information	TL	K
15a	Independent investigation of the NHS in England by Lord Darzi (Annex 5 to Paper K)	Information	JMcD	
15b	EPRR provisional standards submission (Annex 6 to Paper K)	Decision	RC	
BREAK (11.30)				

RDaSH nurturing the power in our communities

Key matters for decision or assurance				
16	Anti-Racism (*inc ref to WRES*)	Information	CH	L
17	Clinical and Operational Strategy: Strategic Objective 4	Assurance	TL	M
18	Trust Bed Base including closure of Emerald	Information	RC	N
19	Biannual Report of the Board's Security Champion	Assurance	SF	O
20	Induction of new RDaSHians into our communities / Trust	Information	CH	P
21	Out of Area Placement Risk Share	Decision	IM	Q
22	Adult Eating Disorder Contract	Decision	IM	R
Routine reports				
23	Promises / Priorities Scorecard	Assurance	TL	S
24	Strategy Delivery Risks 2024/25	Assurance	PG	T
25	Integrated Quality Performance Report (IQPR)	Assurance	TL	U
26	Operational Risk Report - Extreme Risks	Assurance	PG	V
Supporting Papers (previously presented at Committee)				
27a	Business Continuity Policy	Decision	RC	W
27b	Health, Safety and Security Annual Report 2023/24	Information	KL	
	Bi- Annual Safe Staffing Review			
	Medical Revalidation Annual Report 2023/24			
	Guardian of Safe Working Hours			
28	Any Other Urgent Business (to be notified in advance)		KL	Verb
29	Any risks that the Board wishes the Risk Management Group to consider			
30	Public Questions *			
31	Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.'*		KL	
32	*Minutes of the meeting held on 25 July and 29 August 2024 (private sessions)*	*Decision*	KL	AA
33	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
34	*Reflections on the patient story*	*Discussion*		Verb
35	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC
36	*Estate Plan Update*	*Information*		DD
37	*Electronic Patient Record Update*	*Decision*		EE

*** 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 28 November 2024 10am at Brinsworth Community Centre, Rotherham S60 5DT

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Chloe Pearson, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	26 September 2024

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

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.

- The report outlines the changes to the register since the last meeting which relates to the removal of Dr Graeme Tosh and the inclusion of Dr Diarmid Sinclair as the Interim Medical Director.

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?)
Not applicable

Recommendation (indicate with an 'x' all that apply and where shown elaborate)	
The Board is asked to:	
x	**RECEIVE** and note the Register of Interests.

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

Trust Risk Register							
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.
Richard Chillery, Chief Operating Officer	• 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

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

Name / Position	Interests Declared
Izaaz Mohammed, *Director of Finance and Estates*	• Chair of Governing Body – Westmoor Primary School, Church Lane, Dewsbury, West Yorkshire. • Trustee of Howlands Community Hub – charity based in Dewsbury which runs arts and crafts sessions for people with learning difficulties and physical disabilities.
Dr Diarmid Sinclair, *Interim Medical Director*	• **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.
Dr Richard Falk, *Associate Non-Executive Director*	• Medical Consultancy advice to H I Weldricks Pharmacies (who have a footprint across the RDaSH geographical area).
Rachael Blake, *Associate Non-Executive Director*	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • Elected Member - City of Doncaster Council • Trustee - South Yorkshire Community Foundation • Director - Bawtry Community Library

Item 5: Patient Story

Brief to follow

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 25 JULY 2024 AT 10.00AM SCUNTHORPE UNITED FOOTBALL CLUB, GLANFORD PARK, SCUNTHORPE, DN15 8TD

PRESENT

Kathryn Lavery	Chair
Clare Almond	Interim Deputy Director of People and Organisational Development
Richard Chillery	Chief Operating Officer
Dr Richard Falk	Non-Executive Director
Sarah Fulton-Tindall	Non-Executive Director
Steve Forsyth	Chief Nurse
Kathryn Gillatt	Non-Executive Director
Dr Janusz Jankowski (v)	Non-Executive Director
Dawn Leese	Non-Executive Director
Toby Lewis	Chief Executive
Izaaz Mohammed	Director of Finance and Estates
Dr Graeme Tosh	Medical Director
Dave Vallance (v)	Non-Executive Director
Pauline Vickers	Non-Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Jude Graham	Director for Psychological Professions and Therapies
Jyoti Mehan	NeXT Director
Jo McDonough	Director of Strategic Development
Lea Fountain	NeXT Director
Laura Brookshaw	360 Assurance
Lisa Connor (v)	Corporate Nurse Director
Sarah Dean	Corporate Assurance Officer (Minutes)
Dr Andrew Heighton	Medical Director, North Lincs Adult Mental Health & Talking Therapies Care Group
Iona Johnson	Care Group Director, North Lincs Adult Mental Health & Talking Therapies Care Group
Ian Spowart (v)	Governor
Philip	Staff Story

Ref		Action
Bpu 24/07/01 & Bpu 24/07/02	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Carlene Holden, Director of People and OD and Rachael Blake, Non-Executive Director.	
Bpu 24/07/03	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 24/07/04	**Declarations of Interest**	

	Mrs Lavery presented the Declarations of Interest report which outlined the changes to the register since the last meeting. Whilst there is already a record of Ms Gillatt's work with NHSBSA, for complete openness and transparency Ms Gillatt has declared that NHSBSA makes payments related to NHS Training Grants and bursaries to individuals, and has been commissioned to develop a system for medical examiners to use when reporting deaths and the Medical Examiner's Office. **The Board received and noted the changes to the Declarations of Interest Report.**	
PATIENT / STAFF STORY		
Bpu 24/07/05	**Staff Story: Apprenticeships** Mrs Lavery welcomed Philip to the meeting who was invited to share his story and apprenticeship experience. Philip gave thanks to the Board for inviting him to hear his story. He provided details of his early career and the circumstances that led him to consider and secure a Bank Role in Doncaster Adult Mental Health. He noted as he progressed, he took an opportunity in 2018 to start an apprentice journey through the Trainee Nurse Associate (TNA) Foundation Degree Apprenticeship Programme. Within a variety of placements, he developed a passion for rehabilitation and in particular he reflected on how much he enjoyed his work on Magnolia Lodge. to acute mental health or general nursing. Progress and development continued through a Qualified Nurse Associate (QNA) role on Magnolia, securing a Trust GEM Award on the way and he has since gone on to undertake the Registered Nurse Degree Apprenticeship Programme and qualify as a Registered General Nurse (RGN) (March 2024). Most recently Philip noted he was awarded the South Yorkshire (SY) apprenticeship of the year award in health and social care and was applying for a Band 5 Development Post on the ward. Philip responded to a number of questions from the Board, noting within his responses the importance of support both at home and at work to apprentices, to better place them to succeed. This support maybe emotional support but also dedicated time and opportunity to complete studies alongside working in his role. Financial support to make courses and opportunities possible was also very much appreciated and Philip was pleased to hear about the Trust's commitment to the full use of the apprenticeship levy. He noted that since joining 10 years ago, he had always felt supported by management and leadership teams, any issues he came across were dealt with quickly and was encouraged to further develop his roles within the Trust. Dr Tosh referred to Philip's skillset, being a qualified nurse as well as a chef, and the importance of nutrition and invited Philip to consider being involved with the Grounded Research Team and the nutrition research on the ward. Philip confirmed he would be interested to be involved, and was aware of some of the research studies being undertaken in Doncaster. Dr Tosh agreed to share details outside of today's meeting.	

	Dr Graham referred to the Trust's expansion of its education offer and was interested to hear from people with lived experience of carers, and how the education offer could encourage more people to bring that lived experience to experts in education as well. Philip suggested any experience can be pulled from anywhere and by anyone, whether volunteering or lived experience of caring for people at home and the community and encouraged employers to support and empower people to progress through an apprenticeship course. Mrs Lavery and the Board thanked Philip for taking the time to speak about his experience and noted the intended reflection time later on the agenda.	
	STANDING ITEMS	
Bpu 24/07/06	**Minutes of the previous Board of Directors meeting held on 30 May 2024** **The Board approved the minutes of the meeting held on 30 May 2024 as an accurate record, subject to a minor wording amendment (page 13 Minute Item 24/05/20 reference to Mr Falk to change to Dr Falk).**	
Bpu 24/07/07	**Matters Arising and Follow up Action Log** There were no matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed. Mr Lewis referred to RIDDOR information (closed action Bpu 24/03/13) and requested RIDDOR was included on the Board's workplan (bi-annual reporting).	**PG**
	BOARD ASSURANCE COMMITTEES	
Bpu 24/07/08	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper highlighting 3 main areas under the remit of the Committee. There had been focus on the performance of the finance and savings plans previously approved by Board, as well as scrutiny of mitigating risks against the savings plan. The finance plan showed a planned deficit of £3.6m. There are five areas of risk including a cost pressure of £1.1m in respect of energy inflation. Plans to mitigate energy inflation are being developed and form part of the Trust's savings plan. Mr Lewis clarified there had been an estimated £1.1m increase in energy costs and that additional funds, totalling £800k, had been budgeted for to offset this. The mitigating actions continue to help manage the £300k financial risk. The Committee were content that audit recommendations were being responded to appropriately and noted that the work on the IQPR received significant assurance in relation to its functionality and being fit for purpose.	

	Business cases received and approved were in respect of Great Oaks and Waterdale (Doncaster) and the Committee would be kept informed of progress via future capital reports. Great Oaks: Capital phases 1 and 2 were noted in respect of improving staff and patient areas and it was agreed by the committee to proceed with Phase 3 & 4 in respect of the creation of two additional bedrooms, a crisis assessment centre and other associated work including office space. Waterdale: The relocation of Children's Services into a central space in Doncaster City Centre was to proceed subject to completion of the impact assessment. Mr Banks reflected on the DSPT audit recommendation and confirmed the completion of the 2023/24 DSPT submission against all assertions was completed by the 28 June 2024 deadline. Ms Gillatt was content that audit recommendations and actions identified within the Committee's remit were being reviewed and scrutinised. With regards to business cases, Ms Gillatt questioned whether any could be considered being funded elsewhere such as charitable funds. Mr Lewis confirmed that option was available normally, but in respect of the business cases received for Great Oaks and Waterdale neither was appropriate. Mrs Vickers explained a process was being developed similar, to capital bidding, where larger applications that meet charity criteria with a clear link to the strategy are identified to be funded through charitable funds. Mr Gowland referred to the energy inflation and mitigating action underway, noting this was currently an extreme risk to be presented in further detail to the Board later on the agenda (see Bpu 24/07/25). **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 24/07/09	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Mrs Leese presented the paper, highlighting the progress with the development of both the Research & Innovation Plan and Equity & Inclusion Plan. She also noted that work was underway in respect of Promise 5 and the aim to involve our communities'. Support had been provided by the Committee at the meeting to the appointment of three new Directors for Flourish. Subsequent to this, Mrs Lavery confirmed the Board's approval of the appointments. Work continued to mobilise and start shaping delivery against Promise 8 (the RDaSH 5) in identifying 5 key areas to have an impactful change in terms of inequalities – 3 areas are already in progress (physical health checks, dementia, older peoples Talking Therapies). The Committee focused on health inequalities for Gypsy Roma Traveller (GRT) communities and working with our partners. An update would be	

	received at its next meeting following discussions and dialogue between the Trust with SY ICB on funding, investment, research and GP registration criteria. Mr Lewis recognised the partnership and research opportunities with community leaders particularly in Doncaster, as well as raising cultural awareness amongst staff. In raising this awareness Mr Gowland referenced the link to the Strategic Delivery Risks and how, the current shortfall in cultural capability was referenced. He noted the need to support staff to complete their individual roles and through such as the new leadership development offer and revised induction, those staff would have greater cultural awareness of the Trust and the communities it serves. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 24/07/10	**Report from the People & Organisational Development (POD) Committee** On behalf of Mr Vallance, Ms Fulton-Tindall presented the paper and highlighted the focus on the retention rate. Consultant vacancy rates remained static but she noted two new recruits would be joining the Trust in the coming months. Recruitment to post was beyond expected timescales primarily due to slow returns on DBS checks and candidates taking time to decide between multiple offers. Work remained ongoing with Care Groups to address this and drive up performance against recruitment targets. The recommendations and actions identified following the Appraisals audit resulted in the audit opinion being given as moderate assurance. Work was underway to implement the agreed actions in response, specifically in relation to performance management development and the overarching training needs analysis for the Trust's workforce. There had been an improvement in the Gender Pay Gap, with local benchmarking undertaken as a comparator. Dr Graham added there remained a large amount of work to do in order to fully address the gender pay gap, and that she would be inviting male managers to explore this matter further. RIDDOR information would be captured in future through the IQPR. Ms Fulton-Tindall advised the administrative support for the Guardian of Safe Working Hours (GoSWH) had previously been raised as an issue and there had been an agreement that this would now be put in place. Dr Tosh advised that there had been an increase in Doncaster of breaches and inappropriate on-calls. Following review, it was noted less than 5% of call outs were inappropriate, and Dr Tosh felt this was an acceptable level. Mr Lewis highlighted the change and implementation of the new rota design and related numerations. The Board noted Ms Blake would take the role of Chair of the Committee from Mr Vallance at the next meeting.	

	The Board received and noted the report from the People & Organisational Development Committee.	
Bpu 24/07/11	**Report from the Mental Health Act (MHA) Committee** Ms Fulton Tindall presented the paper, highlighting an area of concern in relation to MHA compliance and performance. During Q1 there were 130 detentions representing 110 people and the concerns related to detention admissions paperwork, recording of consent to treatment, Section 132 Rights and Section 17 Leave. Level 3 and Reducing Restrictive Interventions training remains challenging. The Committee identified a theme throughout the reports received which continued to identify issues with incorrect Receipt, Scrutiny and Recording. Work was underway to address the concerns and issues identified, and this would be challenged at forthcoming Delivery Reviews. MHA Compliance would have a future emphasis and focus on key areas, to resolve the over 24-hour length of stay in the Trust's Section 136 suites, and to ensure the Trust was working multi professionally on its seclusion arrangements. Patient feedback would be reported bi-annually. Mrs Leese was pleased to note the Committee's future areas of focus on compliance and greater understanding of MHA data, as well as being challenged in Delivery Reviews. Mr Chillery referred to the MHA breaches and the potential impact of Out of Area Placements (OOAP), and acknowledged work was underway to 'smarten' these measures. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 24/07/12	**Report from the Quality Committee (QC)** Mrs Leese presented the paper and highlighted the safe staffing reporting arrangements were enhanced with daily oversight having been implemented. The safeguarding annual report provided assurance that the Trust was meeting its statutory requirements. Resuscitation compliance remained a concern, in particular resuscitation equipment audits and level 3 training. Mr Lewis recognised the slight improvements made in terms of audit compliance but there remained further work to address and sustain overall compliance. The MCA annual report did not provide assurance and identified gaps in respect of data compliance, performance and risks. Mr Lewis noted the QC action (September 2024 QC) requesting for an assessment of current performance, compliance data, the associated gaps, level of risk and recovery plan. Mr Lewis recommended that this was presented to QC in Q3/Q4. There remained concern in relation to complaints management with a new process under review and a recovery plan to be developed. Mr Lewis stated that at present there were 51 open complaints and a recovery plan was in place to resolve and respond to these complaints.	**SF**

	The Committee received the draft Quality & Safety Plan, with further comments to be provided for consideration. Dr Graham referred to the development of future patient experience reports to include the feedback received via the new platform, Care Opinion. In response to Mrs McDonough, Dr Graham advised of the advantages of moving to Care Opinion that included its enhanced functionality, with it having Easy Read and different languages meaning it would be more accessible to the public and would still be used for people who are digitally excluded through our service champions. Mr Lewis reflected that this was an important development in how the Trust received and shared real time patient feedback to identify themes, and by December 2024 the sharing of patient feedback would be in place for inclusion at the Delivery Reviews. **The Board received and noted the report from the Quality Committee.**	
Bpu 24/07/13	**Report from the Audit Committee** Mrs Gillatt presented the paper and confirmed that the Trust's Annual Report and Accounts 2023/24 were signed as complete on 11 July 2024. The reports were not available to the public at the Trust's Annual Members Meeting on 20 July 2024 as they were waiting to be laid before Parliament prior to publication. There had been improved progress regarding Audit recommendations with increased oversight on outstanding actions and delivery through the Trust's governance structure, including the Committees. The Committee was not assured in relation to the report it received relating to the Standing Financial Instructions, in particular about the waivers applied to the quotation or tender process. Mr Mohammed advised there had been improvements made in proactive planning for procurement processes but that this remained a focus area of work for his team. **The Board received and noted the report from the Audit Committee.**	
Bpu 24/07/14	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report. Mr Lewis apologised for the incorrect statement within his cover sheet, and confirmed there, "would be **no** new further new initiatives or areas of focus during Q2…" There has been strong conversations held within the Clinical Leadership Executive (CLE) regarding the wider issues in older people's services and how to address the inequalities and support an aging population. The CLE recognised the journey to develop staff knowledge on the balance between an aging population, the general skills required to care for those people and the small number of people who will require refined expert specialist skills. This ambition had been subject to national publications	

	but had not yet found practical application, Mr Lewis advised this needed to be considered as part of the workforce and training needs plans, and to confirm how it would find practical application. The Children's Care Group remained fully focused on the maximum 4 week wait to receive specialist intervention and support (CAMHS) for young people with mental health needs (excluding Looked After Children and Neurodiversity). Progress had been made on the wait list backlog since the Board last met, and Mr Lewis stated he would expect to achieve the agreed position by end of July/August 2024. Mr Lewis highlighted that other CAMHS services, locally and nationally, had far longer waits. Mr Lewis acknowledged that there remained secondary waits for those receiving medication in children and adult neurodiversity services. Mr Lewis advised an update to the Board would be provided in September confirming the removal of the backlog of medication waits in neurodiversity and a sustainable go forward position. Mr Lewis recognised the considerable work to be undertaken on the renewed autism work to ensure people in our services are supported in the appropriate manner. The Mental Health Learning Disabilities and Autism (MHLDA) Collaborative Board had approved an analysis of Medical Emergencies in Eating Disorders (MEED) guidance compliance for liaison provision for eating disorders care to ensure collective efforts are effective and well-structured across partners. Steps were being taken to change services as part of the new Eating Disorders Collaborative. Mr Lewis advised it was important that the Board remained sighted on this collaboration. The changes in the use of Agency staff has gone live and provided a real insight to better working in teams. Initial enthusiasm remained positive with teams looking at identifying resource solutions to sustain financial and savings plans. Mr Lewis would expect to see reductions on agency expenditure, as currently trajected by October 2024, being achieved. The inaugural meeting of the Trust People Council was held on 24 July 2024 with key focus to continue on institutional cultures. A report from the Council would come to the next Board meeting. Mrs Leese noted the concerns previously raised from the patient story at the Board's last meeting regarding neurodiversity secondary waits was being listened to, as well as action taken to address the issues. Mrs Leese stated this linked to Promise 4 and one way of putting patient feedback at the heart of how care was delivered. Mr Lewis highlighted the importance of improving waiting times for people accessing services, of learning from patient feedback and of how this is shared and embedded with leaders. Mr Gowland suggested that those people who present their staff and patient stories were provided with reflections and feedback, including what learning and improvements were identified, as well as what changes has the Trust made as a result. Mr Lewis referred to the financial plan to release £500k of costs in-year by reducing the bed base through the closure of Emerald Lodge community rehab facility during October 2024. The estate asset itself	**TL**

	would need to be repurposed and he was confident that this could be done either within Trust needs or working with partners. Mr Lewis was satisfied that the Trust was taking the right step and that it would bring clinical benefits. No staff redundancies would be made, with redeployment arrangements in place. A detailed paper would be provided to a future Board. Mrs Leese commented that it was extremely useful to be transparent including financial reinvestments or change to how services are delivered. Mr Chillery advised engagement with staff and unions had already commenced with early communications outlining the vision for service improvement and patient outcomes. Ms Almond stated the Staff Side Chair was fully supportive of the plans. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	**TL**
Bpu 24/07/15	**Change in Responsible Officer** Dr Tosh presented the paper which included a request for the Board's approval in the transition the role of Responsible Officer from Dr Sunil Mehta, Deputy Medical Director, to Dr Diarmid Sinclair, Deputy Medical Director, from the 1 September 2024. **The Board approved the transition of the Responsible Officer to Dr Diarmid Sinclair, Deputy Medical Director, from the 1 September 2024.**	
Bpu 24/07/16	**Trust Response to the Independent Culture Review of the Nursing and Midwifery Council (NMC)** Mr Forsyth presented the paper that represented the Trust wide response to the nursing and wider professionals workforce following the culture review of the NMC. Mr Forsyth expressed his personal disappointment and concerns following the investigations into the NMC that found key cultural findings, many of which were longstanding, consisting of a dangerous toxic culture that featured racism, discrimination and bullying. There was a failure in senior leadership to face the challenges within the NMC. Mr Forsyth has independently written to the Health Secretary asking for action. The investigation found fundamental issues including the backlog of NMC Fitness to Practice (FtP) cases (circa 6,000), that was resulting in serious impact on those people who had been referred under the FtP process. It was distressing to learn people that had been subject to the NMC FtP process had died by suicide. To support the Trust workforce, there was the need to demonstrate compassionate leadership and ensure clarity from the Trust that bullying and racism are unacceptable, and that colleagues are encouraged and are free to speak up. The Trust would review those currently under or recently concluded FtP investigation and offer compassionate support to them during this period of unease. Mrs Leese was supportive of the recommendations and commented that the findings had been part of discussions within the QC. Mrs Leese	

	acknowledged there were wider implications including trauma for those people who were in the FtP process and the length of time taken for decision making. Dr Tosh was aware of similar processes within the General Medical Council and it was acknowledged that the outcome of the findings would likely impact on wider regulatory bodies and professional groups Mr Lewis confirmed he was fully supportive of the recommendations made and understood the current Freedom to Speak Up (FTSU) position, stating he would wish to understand any barriers should they arise in raising the profile of FTSU and increasing FTSU champions. Recommendations made in the report were to be taken forward through the POD Committee (linked to Promise 26). Dr Falk referred to Mr Forsyth letter to the Health Secretary and recommended the Board support a Trust response. Mr Lewis and Mrs Lavery agreed that they would write a Trust response to express their disquiet into the independent culture review of the NMC. **The Board received the Trust Response to the Independent Culture Review of the Nursing and Midwifery Council (NMC) and agreed the recommendations included in the report, noting the action for a Trust response to be formulated and sent.**	**TL / KL**
Bpu 24/07/17	**Strategy Delivery Risks 2024/25: Q1 report** Mr Gowland presented the report noting that the Board had previously received and considered the Strategic Delivery Risks (SDR) in May and since then the risks had been further refined. He noted work remained ongoing to mange the risks and that the current SDR report now presented initial risk scores and target risk scores, specific actions, controls and respective leads for mitigating actions. Actions would impact on the risks and future reporting would present details of where and why risk scores reduced. There are areas of commonality within the five risks such as leadership, culture awareness, and capability. Mr Gowland cautioned as the SDR are major risks, they will take time and energy in mobilisation and delivery. The SDR will be reported and scheduled through the Board's assurance Committees FDE, PHPIP, POD and QC. In response to Mr Lewis, Mr Forsyth explained the leadership offer with respect to SO1 was linked to the delivery of Promise 26 and that he would expect the delivery timeframes to be aligned. In response to Mr Mohammed, Mr Forsyth explained the first point of focus would be with leaders and new starters, with other work then broadening the offer across the Trust. Ms Almond added there were supplements to support and embed existing mechanisms in recruitment and leadership development, such as talent management and supervisory programmes. In response to Mrs Fulton-Tindall, Ms Almond advised the recruitment process of new starters was part of a values based recruitment approach, capturing people for both their skills and values.	

	Mrs Leese noted the QC would be sighted on the SDR in September 2024, and acknowledged the SDR was subject to further development including impactful measures. In response to Ms Gillatt, Mr Banks referred to data availability (SO2) and explained the challenges faced as well as the work that had progressed to mitigate against the risk. Mr Lewis referred to SO3 and advised he was meeting with Primary Care partners to build on mutual understandings. Mr Chillery referred to SO4, and the need to fully understand the current position of seven-day services to create a baseline. A key example, that would have a significant impact, would be discharges, which are only currently delivered during 'working hours' 5 days per week. The ability of partners to support seven-day services such as housing and social work would also noted. **The Board received and noted the progress with the development of the mitigating plans for the five Strategic Delivery Risks and the planned next steps and the commencement of new monitoring arrangements via AC Chair meetings, Board Committees and at the Board of Directors**. **The Board supported the individual risk scores assigned to each SDR and the target score and associated time scales (for risk mitigation).**	
Bpu 24/07/18	**Learning Half Days (LHD): Introduction and pilot learning** Dr Graham presented the report and highlighted the key aims of the LHD as part of the Learning and Educational Plan and delivery of Promise 24 of the Trust's Strategy. Evaluation from the pilot held in North Lincolnshire highlighted both successes and challenges. Wider implementation work would require consideration during the next 2 years to align with strategic ambitions. Next steps include Trustwide implementation from September 2024, the prototype approach and learning from the pilot would inform mobilisation for the other 21 directorates in the Trust. There would be sessions that are beneficial for across Trust/Directorate attendance. Future considerations would include increased partnership working, greater inclusivity for staff who work shifts, and enablement of learning cycles. In response to Ms Fountain, Dr Graham advised Shwartz Rounds are reflective sessions on experiences, they are emotive and are facilitated around particular models and themes. These would be expanded on what people wish to discuss including antiracism. From a Care Group perspective, Dr Heighton explained the challenges from the pilot included supporting people and why learning applies to everyone in all roles across all services. Since introducing the protected time to learn, Dr Heighton reported that there had been a number of	

	different learning opportunities and the uptake had increased amongst staff. Dr Graham advised the protected time to learn would be introduced and the expectation was that all directorates adopt this approach starting in September 2024. Workforce policies and processes would reflect the support required for the mandating of learning. In response to Ms Mehan, Dr Graham advised learning sessions would be beneficial for across Trust/Directorate, as well as building a library of learning for people who are unable to attend on the day. All learning would be considered for next session planning, with evaluation of learning topics and the offer of repeated sessions. Mr Lewis recognised that Learning Half Days could have some content from Executive leadership but the majority of those agendas would be driven by local leaders across the workforce. **The Board supported the introduction of Learning Half Days, recognising the commitment to education and learning leadership highlighted within the paper**.	
Bpu 24/07/19	**Placements in each profession** Mr Forsyth presented the paper and highlighted the Trust's placement landscape was complex, ranging from formal placements through to work experience and volunteering. It was important to consider the service delivered and quality impact that placements brought, alongside supporting the delivery of the Trust's Strategy and its Promises. The Trust currently works with professional bodies in terms of regulation and funding, and has formal placement agreements across nursing, allied health professions, social work, psychological professionals, medical and pharmacy. Mr Forsyth stated there were considerations to be made on how the Trust attracted a wider placement landscape whilst retaining the quality of those placements, and how it would encourage young people and others from inside local communities to take up those placements. The Board requested the recommendations made in the report were considered by the POD Committee. **The Board received and noted the Placement Landscape report, noting the obligations of the Trust regarding commissioned and non-commissioned training.**	**SF / JG**
Bpu 24/07/20	**Learning and Education Plan** Dr Graham presented and explained the report was presented to enable an understanding of what education and learning meant in respect of the Trust Strategy and to provide clear and measurable actions for change. There was specific focus upon promises 9 and 24 as well as a summary of what would constitute success in the future. Despite the new Government's plan to reform the apprenticeship levy, the Trust's commitment would remain the same and there was no intention to change Promise 9 and its delivery. **The Board received and noted the Learning and Education Plan, and the work being done to develop a coherent plan for the Trust**.	

Bpu 24/07/21	**Learning from Deaths** Mrs Lavery highlighted that it would be the last Board meeting attended by Dr Tosh who would be leaving the Trust and thanked him for his contribution and work over the twelve years at the Trust. Dr Tosh presented the report and highlighted the importance of learning from deaths in the Trust and the tragic case which led to the national agenda on improving this. The report outlined the processes through which every death was reviewed and seek to learn from these where possible and if appropriate spread that learning across the Trust (and beyond). In relation to mortality, individual clinicians are supported to be inquisitive and to learn, corporately there was a need to identify lessons to be learnt and take appropriate action. Dr Tosh referred to the importance of the work of the mortality operational group (MOG) in analysing 593 deaths in our care during 2023/24, 62 of which were escalated to structured judgement reviews (SJR). The paper supplements the Board's focus on learning and education, and provided detail on the mortality governance pathway and processes in place of how we implement and evidence learning where we identify potential for improvement. A new statutory medical examiner system would be rolled out nationally to provide independent scrutiny of deaths and to give bereaved people a voice. From 9 September 2024 all deaths in any inpatient health setting that are not investigated by a coroner would be reviewed by NHS medical examiners. The Trust was already active with the local medical examiners' process and it appeared to be working well. Dr Tosh advised the Trust Learning From Deaths policy will be amended to include the application of the Medical Examiner process. Learning from deaths continued to be disseminated across Care Groups as well as Clinical Learning Briefs. Dr Tosh referred to the improving and recommissioning our incident reporting system will be made more user friendly to those reporting or reviewing a death. Mrs Leese advised the QC had regular oversight of mortality, and highlighted the importance of the Board being sighted on mortality and learning from deaths, and recognised the learning and benefits to the improvement work that has been produced across the Trust. Dr Falk noted the mortality governance arrangements and processes in place, stating Primary Care also have responsibilities in shared care cases as well as the Trust. Dr Tosh explained that whether a death was in scope or out of scope, each notification of death was subject to the same scrutiny, review and reporting. **The Board received and noted the Learning from Deaths report, recognising the mortality governance arrangements in place and importance to seek to learn from these**.	
Bpu 24/07/22	**Clinical and Operational Strategy: Strategic Objective 3 (SO3)**	

	Mrs McDonough presented the paper and highlighted the progress made to extend the community offer in physical, mental health, learning disability, autism and addiction services. There are 5 Promises which sit within SO3 and there are complexities and difficulties anticipated with the aim to shift care into communities from the current bed based services; to provide more integrated care to our community patients with partners, especially primary care; and to meet the challenging target to reduce the time that patients wait for care to 48 hours for urgent care and 4 weeks for routine care. Successful delivery of the objective would include working with local communities, education, primary care partners and other partnerships. Dr Falk referring to Promise 15, recognised the development across Scunthorpe South and engagement with Primary Care and other partners. Mrs Johnson explained the model of integrated neighbourhood working and how engagement and progression was being produced in a staged but impactful way. This work included reviewing health inequalities data and identifying which areas need to be targeted and prioritised. The Board noted the intentions to develop similar joint working opportunities in Rotherham and Doncaster. **The Board received and noted the Clinical and Operational Strategy focused on Strategic Objective 3**.	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 24/07/23	**EPRR Biannual Update** Mr Chillery presented the paper and reminded the Board of the position reported in January 2024, where a 'hard reset' had been applied nationally and benchmarking results showed the Trust's compliance of 21% (as against 17% on average for Trusts in South Yorkshire). The Trust had developed a 2-year programme of work to achieve compliance by September 2025. The focus for year 1 was 3 core pieces of work, and the aim to report 60% compliance in October 2024 for the annual Trust EPRR Core Standard submission. Key areas of focus included in improvement plans were business continuity and exercises based on those plans, temporary shelter and evacuation plans, and development of the training programme for on call colleagues, both tactical and strategic level training. Training exercises had already taken place to test readiness and responsiveness to incidents, and learning had been disseminated through the Trust's EPRR Group. In response to Mrs Lavery, Mr Chillery confirmed that the Trust was part of the regional planning committees which was a requirement to meeting the EPRR core standards. **The Board received and noted the EPRR Biannual update**.	
Bpu 24/07/24	**Integrated Quality Performance Report (IQPR)** Mr Chillery presented the IQPR reporting the position in June 2024 against operational performance, quality, workforce and finance data.	

	The Trust continued to focus delivery on 10 key metrics on the understanding that all performance was a priority. There remained a number of key performances metrices where there are areas for development and action. The CLE and individual leaders are deeply engaged with the accuracy and meaning of the core data. A review of that data and items in the IQPR had been largely completed, but there was further work to develop quality and safety data. Mr Chillery highlighted that the MHA Section 136 metric went live from 1 July and would be reportable from August 2024. In addition, the metric in relation to CMHT access continued to double run as it transitions across metrics. Talking Therapies access and OOAP metrics continued not to achieve their targets. In terms of metrics on plan to achieve target, Mr Chillery confirmed these were CMHT transformed access, perinatal services, C&YP access and the ADHD adults. With regards to dementia, although not a Trust target and reported through primary care, the national target was set at 66% which was achieved in South Yorkshire, however North Lincolnshire was under target at 55%. This was being explored further by Mr Chillery with Mrs Johnson. The trajectory for SMI health checks was on track to be achieved, and currently achieved in Doncaster and North Lincolnshire. Mr Lewis noted the financial position and overspend in relation to the AED as referenced in his CEO report. There remained a savings gap target to be identified through full year effects of prior savings schemes and additional income opportunities in year. **The Board received and noted the Integrated Quality Performance Report**.	
Bpu 24/07/25	**Operational Risk Report – Extreme Risks** Mr Gowland presented the report and highlighted the Trust's current extreme risks. There were 8 extreme risks which were all subject to regular review by the respective risk owner and monthly scrutiny via the Risk Management Group. Themes are now visible associated with eating disorders and OAP, long waits for neurodiversity diagnosis and care. Mr Gowland advised that the risk registers were being explored in respect of how they connect to system based registers, for example ICBs and partners. Mr Gowland advised risk training has been commissioned through NHS Providers to support risk leads, the first session of which was in early August. Mr Lewis referred to the current extreme risks and sought clarity in future reports of the actions being taken and the planned and actual reduction in the risk scores. In particular risks relating to OOAP, Eating Disorders and Autism related to waiting times. Mr Chillery advised in relation to neurodiversity, this had been shared with CLE and there was a trajectory on waiting times with the expectation that improvement would start to be seen from September 2024.	

	The Board received and noted the Operational Risk Report – Extreme Risks update.	
Bpu 24/07/26	**Risk Management Framework (RMF) Annual Report** Mr Gowland presented the annual report and highlighted the RMF provides an overview of the work undertaken during 2023/24 in respect of Strategic and Operational risk. The Board were reminded of the improvement work undertaken in raising the profile of risk management. This had resulted in a significant increase in number of risks on the registers, enabling the production and use of a more comprehensive risk profile. Risk had become a specific point of reference within decision making processes. At 2023/24 year end, the registers contained 237 open risks, a three-fold increase on the position at the end of the previous year. Mrs Lavery commented that it was encouraging to see the positive results from raising the profile of risk management. In response to Ms Gillatt, Mr Gowland advised the role and responsibility of the Risk Management Group was to ensure the RMF was implemented effectively and to oversee work to mitigate risks, as well as identifying cross trust risks (themes). Longstanding risks are scrutinised and challenged with risk owners. **The Board received and noted the Risk Management Framework Annual Report, and took assurance on the delivery against the framework and that the Trust has in place robust arrangements for Risk Management acknowledging that there was further scope for development**.	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 24/07/27	**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: • Accountable Officer for Controlled Drugs Annual Report 2023/24 • Safeguarding Annual Report 2023/24 **The Board received and noted the additional reports for information.**	
Bpu 24/07/28	**Any Other Urgent Business** There was no further business raised.	
Bpu 24/07/29	**Any risks that the Board wishes the Risk Management Group to consider** No risks were identified.	
Bpu 24/07/30	**Public Questions** There were no questions raised by members of the public.	
Bpu 24/07/31	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 : SEPTEMBER 2024 **PAPER C – ACTION LOG**

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/01/13a Bpu 24/01/3b Bpu 24/03/13	**Resuscitation Equipment** Mr Lewis was keen to revisit this topic at the next Board for further discussion to understand the challenge and issues on resuscitation equipment.	TL	**September 2024:** Updated (improved) position reported to QC in September (see Quality Committee Report to Board of Directors)	Propose to Close
Bpu 24/03/11	**Mental Health Act Committee Report** TAMS Training and impact on compliance with MHA. Dr Tosh noted the planned discussion to address this feedback and also the work with Ms McIntosh to ensure a recent change in the law was actioned, which may result in the TAMs inheriting employee status.	DS / CH	**September 2024:** Updated position (TAM recruitment inc NEDs and TAM employment status) within Chief Executive's Report to the Board.	Propose to Close
Bpu 24/03/13	**Racist Incidents** Mr Lewis stated the intention for CLE to discuss this matter in April, with a view to agreeing the policy that he had outlined in January at May's CLE.	TL	**September 2024:** Paper L and the Chief Executive's Report refer to related work in respect of Anti-Racism (Promise 26) that links to previously reported incidents and to a new Acceptable Behaviour Policy.	Propose to Close
Bpu 23/11/15a	**Chief Executive's Report** RCRP data management Consequences from RCRP implementation with annex 3 setting out the planned data focus - yet noting a lack of baseline.	TL	**September 2024:** Chief Executive's Report includes an update on this topic.	Propose to Close
Bpu 24/03/17	**Chief Executive's Report** WRES data The People and OD Committee were requested to receive a report at its June Committee on WRES that also included additional information drawn from sources such as FTSU, PSIRF and Trade Unions.	CH	**September 2024:** WRES data will be presented to POD Committee in October and then published by the Trust ahead of the 31 October 2024 deadline. Reference is made within Paper L on today's agenda.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/05/10	**Report from the Public Health, Patient Involvement & Partnerships Committee** The review to be undertaken (at pace) of inequalities data required as part of routine reporting at Board level.	RB/JM	**September 2024:** Updated position reported to PHPIP in September (see Committee Report to Board of Directors)	Propose to Close
Bpu 25/05/16c	**Chief Executive's Report** Review of the effectiveness / appropriateness of the quality and safety metrics to be used within the Trust's revised IQPR.	SF	**September 2024**: The metrics have been reviewed and within the draft Q&S plan (presented to the Quality Committee) it brings in always events to enhance IQPR. Further refinements have been made to the MFRA and reduced the assessment to 12hrs.	Propose to Close
Bpu 24/07/07	**Matters Arising** RIDDOR reporting to be included on the Board's workplan.	PG	**September 2024:** Scheduled to be reported to the Board on a bi-annual basis: November (Q1/Q2 data) and May (Q3/Q4 data) – in both cases, this is after reporting has taken place to the POD meeting earlier in the month.	Propose to Close
Bpu 24/07/14a	**Chief Executive's Report – neurodiversity secondary waits** An update to be provided to the Board in September regarding the backlog of medication waits in neurodiversity.	TL	**September 2024:** Chief Executive's Report includes an update on this topic.	Propose to Close
Bpu 24/07/14e	**Chief Executive's Report – staff / people networks** A detailed paper on reducing our bed base and the closure of Emerald Lodge to be provided to a future Board.	TL	**September 2024:** Paper N on today's agenda	Propose to Close
Bpu 24/07/16a	**Trust Response to the Independent Culture Review of the Nursing and Midwifery Council (NMC)** Recommendations made in the NMC report were taken forward through the POD Committee.	JG	**September 2024:** A further discussion on this topic is scheduled for the People and Organisational Development Committee meeting in October 2024.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/07/16b	**Trust Response to the Independent Culture Review of the Nursing and Midwifery Council (NMC)** Trust response to be written to express their disquiet into the independent culture review of the NMC.	TL / KL	**September 2024:** A letter was sent on behalf of the Trust by the Chair and Chief Executive on 1 August 2024 to the Professional Standards Authority setting out the concerns that, at that time, the response of Council did not appear to match the gravity of the situation, the seriousness of the failings, nor to allow our nurses to have confidence in the future. A response was received on 12 August. The Trust also offered to be part of an oversight and support group that was being established.	Propose to Close
Bpu 24/07/19	**Placements in each profession** Recommendations made in the placements report to be considered by the POD Committee.	SF / JG	**September 2024:** Reference was made within POD in August, with a more substantive paper to be considered in October's POD meeting.	Propose to Close
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).	GT	**September 2024:** Updates on the progress with the review of the disengagement policy and with the approach to the MEED guidance will be provided to the Board of Directors in **November 2024**.	Open
Bpu 24/05/17a	**CQC Preparedness – Well Led** Mr Lewis clarified that the evidence in respect of the Well Led Framework would be collected, a self-assessment would be undertaken,	PG	**September 2024:** As noted at the previous meeting, Well-Led self-assessment will be presented to the Board of Directors in **November 2024.**	Open
Bpu 24/05/23a	**Capital Plan 2024/25** Ligature risk and door safety - there will be a full review of ligature risk by ward, by Q4.	SF	**September 2024**: As noted at the previous meeting, a full review of ligature risks by ward has commenced, to be completed **by Q4**.	Open
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	**September 2024:** This action will be addressed through a paper to the Quality Committee in **January 2025**.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper D
Date of meeting:	24 July 2024		
Attendees:	Dave Vallance, Kath Lavery, Toby Lewis (Board) Simon Mullins (LNC), Babur Yusufi (GOSWH), Rosie Elliott (DAWN), Jaqui Hallam (Womens'), Glyn Butcher (Patient rep), Tinashe Mahaso (REACH), Dr Mike Seneviratne (staff gov) Sue Statter (JLNC)		
Apologies:	Kathleen Green (volunteer), Naomi Handley-Ward (LGBTQ+), James Hatfield (FTSU), Dr Amanda Hendry (Sen Doctors Ctte), Carlene Holden (Board), five staff governors (vacant)		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	Explored what the **Trust People Council (TPC)** members wanted from, and could bring, to the meeting. There was a wish to ensure it supported the welfare of those doing difficult jobs inside the organisation. Confirmed that the Board Chair had set up the TPC to provide direct advice and that advice would be considered in public, alongside the Board's assurance committees. The discussion focused on current and future culture – as a distinct collective purpose, not replicated by other senior forums. Some members suggested this was the first such engagement for many years. The working draft of the **People & Teams plan** was presented and colleagues were asked to make any comments to Carlene Holden by 31/08/2024. **Promise 26:** the working approach to, in particular, anti-racism was explored, and colleagues reflected on their experiences. Work was outlined on bystander/allyship training, on adapting leadership membership to reflect the population, on consequential policies like the Red Card, on explicit respect and tolerance guidance and on widening the reverse mentor work. Colleagues made various comments on **policies** to support and protect students; racism and the need for promise 26/promise 8 to address structural inequalities; experience of employees outside the workplace and the wearying effect of abuse; low level of confidence that consequences will follow, leading to under reporting; concern that the Trust was only focused on racism and not other forms of harm and hate; need to acknowledge past efforts and limited impact from them.		
Positive highlights of note:	Good engagement from those involved and a desire to work together		
Matters presented for information or noting:	As above		
Decisions made:	Confirmed cultural focus – formal TOR to be drafted.		
Actions agreed:	Comments on the draft People & Teams plan to be sent to Carlene Holden. Suggestions for useful qualitative and quantitative data to assist the TPC to be suggested to Toby Lewis to inform October's meeting.		

Dave Vallance, Non-Executive Director and Chair of the Trust People Council
Report to the Board of Directors meeting scheduled for 26 September 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper E
Date of meeting:	18 September 2024		
Attendees:	Dawn Leese (Chair), Dave Vallance, Dr Janusz Jankowski, Dr Diarmid Sinclair, Steve Forsyth, Richard Chillery, Richard Banks, Dr Richard Falk, Maureen Young and David Vickers.		
Apologies:	Dr Jude Graham		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Quality Safety Impact Assessment (QSIA):** Work is underway to undertake QSIA for all 24/25 savings schemes. However, there was still work to be done on the system and processes for assessing the cumulative impact of agreed service changes and therefore mitigating any risks of unintended consequences. Action agreed for the consideration of what a mature QSIA would look and how assurance could be provided. **Findings from the CQC rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT):** The committee received and noted the findings from this report and the initial assessment undertaken. It was agreed a more detailed discussion would take place at November QC meeting to review final actions and process for ongoing monitoring. **Strategic Delivery Risks Report (SDR4):** The committee reviewed SDR4 – the risk, controls and plans to mitigate any risks to the delivery of high quality therapeutic bed based care with a focus of 7 day bed based care. This risk will be reviewed again at November QC with a focus on a baseline assessment and ongoing monitoring progress. **Patient Safety Assurance Reports, June and July 2024:** This report was presented and noted. An external evaluation / report on the implementation of PSIRF has now been concluded resulting in 7 actions, 4 of which related to improving the monitoring of investigations. The final report is expected in November 2024 QC and the committee would discuss the recommendations and action plan at this meeting. **Mortality Report – May and June 2024:** The committee received this report and noted a backlog of Structured Judgement Reviews (SJR). It was noted that this was due to capacity issues within the team. The committee requested a full assessment of the impact on compliance with the learning from deaths policy at the next meeting. This would include the Coroner's processes and responses to Regulation 28 letters. **Clinical Effectiveness Report – April to August 2024:** The committee noted the progress made on the clinical effectiveness programme and the evidence of learning following the clinical audits and NICE reviews. **Health Safety and Security Annual Report 2023/24:** The committee received this report and noted the content. Further action was required in relation to: 1. Violence prevention and reduction standards (action plan provided). 2. Fire safety / compliance information was missing from the report however verbal update provided and revised report including fire information was circulated post meeting. See Paper W of the Board agenda pack. **3.** Concluding recommendations identified gaps in compliance and needed further consideration to ensure timely completion. These changes would be made prior to the Report being presented to the Board of Directors (on today's agenda)		
Positive highlights of note:	**Safe Staffing Declaration – Six monthly review:** The committee commended the positive work by Mr Forsyth and his team to deliver a comprehensive		

	assessment of the ward-based nurse staffing. This work was robust and compliant with required standards. No immediate risks identified, and further work is ongoing to continue progressing the workforce assessment (next assessment – annual safe staffing declaration due to QC March 25). **Inpatient Safe Staffing Report June and July 2024:** The Committee received and noted the report. Evidence was provided of the operational management of day to day safe staffing and forward look to manage effectively nurse staffing resources. **Quality and Safety Plan (draft):** It was evident that significant progress was made in developing this plan, this was supported / approved to progress to the Board development session in October 2024. **Resuscitation update:** The committee received a very positive report on current position and noted significant improvement with compliance. It was agreed for this report to move back to routine monitoring. The next update would be presented to the committee in January 2025. **Medical Devices Position Statement:** Significant progress was noted regarding full compliance in this area. The Committee received and noted the **Medicines Management Annual Report 2023/24**. **Complaints Management Annual Report 2023/24** received and noted – actions required to ensure compliance with required standards including timeliness and quality of responses, evaluation of feedback and ongoing improvements. External review of current position and action plan will be shared at November QC.
Matters for information:	**Internal Audit Reports / Recommendations:** There were 3 overdue internal audit actions relating to complaints and safe staffing. Two of these following the information provided at the meeting would be signed off as completed. The committee was assured by the action owner the one remaining action would be completed to revised timelines.
Decisions made:	**Support** for the following: **Six monthly safe staffing** report and recommendations Routine monitoring of **Resuscitations compliance** - Jan 25 Support for the draft **Quality and safety plan**
Actions agreed:	• **QSIA** – further work to develop assurance processes related to quality and safety • **PSIRF** – external review complete and action plan outstanding • **Complaints** – external review complete and action plan outstanding • **Findings from the CQC rapid review of NHFT** – evaluation underway and completed review / actions to be shared when available.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper F
Date of meeting:	7 August 2024		
Attendees:	Kathryn Gillatt (Chair), Dawn Leese, Pauline Vickers. In addition: Phil Gowland, Steve Forsyth, Rob Kirkby, Kay Meats (360 Assurance), Matthew Curtis (360 Assurance), Paul Hewitson (Deloitte), Caroline Jamieson (Deloitte).		
Apologies:	Izaaz Mohammed.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Management Response to 2023/24 External Audit -** • The 2023/24 external audit work had been completed and the 2023/24 Annual Report and Accounts had been laid before parliament and published on the Trust's website. • The ISA260 Report and Annual Auditors Report was received, including the proposed response to the eleven Value for Money related recommendations. • Proactive work had commenced in relation to the management of strategic delivery risks and the enhanced oversight and focus on internal audit recommendations follow up through executive leads and as part of the delivery reviews. **Counter Fraud, Bribery and Corruption Progress -** • Summary provided of the counter fraud work completed during 2024/25 to date, additional detail of the counter fraud standards and the work involved would be provided at the next meeting. **Audit Recommendations Progress –** • Currently 4 overdue internal audit actions from the 23/24 plan. • The focus during quarter 1 had been the liaison with executive leads to agree a clear objective, scope and timescales for reviews included within the 2024/25 internal audit plan. • The Committee noted the change in internal audits approach for 2024/25 with the intention to support improvement and to enable additional insight into the elements of the head of internal audit opinion throughout the year.		
Positive highlights of note:	• The Committee received the Trust wide arrangements for raising concerns update which accurately reflected the governance process in place. **Risk Management Framework Update** • Improvement work - externally commissioned risk management training recently took place with several members of the Risk Management Group and other colleagues - further sessions scheduled for the coming months. • The Committee noted the revised oversight arrangements with regards to Strategic Delivery Risks and the comprehensive plans in place. **Standing Financial Instructions** - Reducing (positive) trend in respect of the value of single quote / tender waivers and losses and compensation payments.		
Matters presented for information or noting:	None.		
Decisions made:	The Committee supported and agreed the Audit Committee Effectiveness Proposal.		
Actions agreed:	**Declarations of Interest (DoI)** – Progress being made with the		

	annual refresh of the DoI register, agreed to provide confirmation at the next meeting that 100% of decision makers had submitted their annual declaration. **Petty Cash Review** – The Committee requested for the controls in place to manage access to petty cash floats and consistent access to corporate debit / credit card to be considered further.

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

Report to the Board of Directors meeting scheduled for 26 September 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper G
Date of meeting:	21 August 2024		
Attendees:	Sarah Fulton Tindall (Chair), Dr Janusz Jankowski, Dr Jude Graham, Toby Lewis, Dr Diarmid Sinclair		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**MHA Compliance Report** There were 439 detentions in Quarter 1. Challenges still remain in respect of Documentation Compliance (81 sets required amendment), Consent to Treatment on Admission (23 out of 126 cases in Rotherham, 15 out of 72 in Doncaster and 23 out of 53 in North Lincolnshire where consent was not recorded), Section 132 Rights (in 10 out of 349 cases rights had not been read within the initial time period, plus an additional 34 cases in which there was no evidence that rights had been read), Section 23 Discharges (6 out of 136 cases where paperwork was not completed). The Committee identified two underlying contributory themes which are being addressed: • Incorrect Receipt, Scrutiny and Recording (already known to the Board) • Appropriate induction and preparedness of temporary medical staff in respect of RDaSH processes and practices. MHA Level 3 Training compliance is still a challenge (85%), as is Reducing Restrictive Interventions (RRI) (69% for Disengagement and 83% for Comprehensive training). The Committee was pleased to see that work is being undertaken on a number of fronts to address the above, with a range of positive and targeted actions underway, including those detailed later in this report. It also wishes to recognise that for the large part we are compliant and acknowledge this good practice. **MHA Performance Report** Work is continuing to improve seclusion experiences.		
Key points of discussion relevant to the Board:	The Committee largely focused on the MHA Compliance and Performance reports. The progress made to date on key areas of activity, including refining the data that is being considered, has allowed a more focused set of discussions, thereby aiding a more sophisticated understanding of where we sit in respect of both our Trust expectations and legal obligations. It has also helped the Committee to learn more about why things may or may not be working, so as to support improvements in a positive way for both our staff and patients.		
Positive highlights of note:	**MHA Compliance Report Q1** • Of the 439 detentions received into the Trust, 100% were lawful and 100% were compliant at the point of scrutiny by Matrons and Medics. Doncaster was showing a month-on-month improvement in its Consent to Treatment in Admissions (92%). • A new weekly urgent metrics review report to be used on the ward has been introduced, which includes compliance with Consent to Treatment (psychiatric medication) and Section 132 Rights, which should start to show an improvement in these key areas for the next report. The Committee recognised this as good		

	practice that could be shared across the Trust. • MHA Training Levels 1 and 2 Core are seeing improvement at 90% and above, with Level 1 at 97%. • Future mandatory staff training reporting will be aligned with Personal Development Reviews and correspond to a 12 month training cycle. • It is intended to explore how RRI training is delivered to see whether a different format or modular approach could be adopted to aid take up. **MHA Performance Report Q1** • All of the 136 Suite Assessments (122) were carried out within the 24 hour period.
Matters for information:	New mental health law reform was announced as part of the King's Speech in July this year. The next step will be for Parliament to consider the Mental Health Bill in due course. It is acknowledged that the timing of actual changes will be dependent on the recruitment and training of more medical and judicial staff and could take a number of years.
Decisions made:	None
Actions agreed:	• Explore whether the 3 day RRI training can be split into 6 half day learning sessions. • Explore whether the 15% MHA Level 3 training gap represents individuals with long standing non-compliance.

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Act Committee
Report to the Board of Directors meeting scheduled for 26 September 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper H
Date of meeting:	21 August 2024		
Attendees:	Rachael Blake (Chair), Dave Vallance, Carlene Holden, Ian Spowart, Pauline Vickers, Dr Judith Graham, Richard Chillery, Steve Forsyth, Lea Fountain, Richard Rimmington and Dr Graeme Tosh		
Apologies:	Dr Babur Yusufi		
Matters for escalation:	The Guardian of Safe Working Hours (GoSWH) report. Annual Medical Revalidation report. RIDDOR Report (Q1 2024/25).		
Key points of discussion relevant to the Board:	**IQPR**: **Retention** rate was below 10% due to positive impact of People Promise Exemplar (PPE). **Sickness absence** had increased slightly due to short term sickness absence, recent spikes were due to COVID absence and seasonal variation. **Support worker vacancies** at 11% will be picked by the recruitment drive and actions to reduce bank / agency expenditure. **Vacancy rate** had reduced from 7.5% to 7.37%, achieving 97.5% fully staffed by the end of January 2025 will not be satisfied at the current trajectory rate. Care Group managers to implement robust recruitment campaigns. **Flu vaccine roll out** would begin at the end of summer/early autumn and incentives to improve on last year's result will be considered. **GoSWH** a monitoring exercise review had led to a change in shift patterns; change of terminology from '*doctors in training'* to *'resident doctors'*; changes to the shift pattern for the August rotation in Rotherham and N Lincs with 62 resident doctors joining the organisation. Further work is to take place in the Doncaster locality in relation to exception reporting and breaches and picked up at the next exception review. **RIDDOR**: Report showed an increase of 71 incidents in Q1 (Doncaster Care Group Skelbrooke and Windermere wards), committee members expressed concern on the language used during incidents and advised Windermere had challenge due to individuals with history of violence, however, a reduction was expected in the number of incidents in Q2 based on management of the acuity through Q1. There was challenge around implementation of the 'zero-tolerance policy', potential clash with the Hippocratic oath, practice guidance and individuals' religious beliefs. In such cases a clinical and ethical decision-making group would be convened to support staff. Staff support during race events had been through extraordinary Race Equality and Cultural Heritage (REaCH) staff network meetings. A training requirement on racism within the Trust and galvanising allyship was noted. The report had been expanded to give context in terms of severity of people's daily experience covered by changes to the inappropriate behaviour / red carding policy including racism and sexual violence. The policy was now with the legal team and CEO for final iterations.		
Positive highlights of note:	**Apprenticeships** An organisational approach to advertise all Band 2 and 3 as Apprenticeship First posts from 1 September 2024 with level of confidence that the Trust would achieve close to100% of levy spend (Promise 24) in 2024/25. The benefits of a communications campaign to push the success of Apprenticeship First approach more widely was noted. **Trust People Council (TPC):** The first meeting had taken place – see Agenda item 8 Paper D for update. **MAST** remained above 90%, with confidence this would continue. Further targeted work was taking place on the Oliver McGowan training.		
Matters for information / noting:	**Placements in each Profession**: The complexity of the current placement landscape was stressed all requiring different types of support. Discussion points will be picked up by PODC through submission of papers covering different strands of the broader definition of placements.		

	People Plan: The draft was currently with the Executive Group (EG) awaiting feedback before sharing with committee members before bringing back to the October PODC. **Education & Learning Plan - Final Draft** A suggestion for an annual assessment of the metrics to measure impact of improved people capability and services and consequent improvements on patient outcomes / service to be discussed. **Strategic Delivery Risks**: SO5 had been identified as requiring first focus and referred to increasing leaders' abilities to be culturally capable and competencies to juggle multiple workstreams with focus on active bystander training. Reporting on the different culture strands and development programme would be through PODC and Board to ensure progress was on track. **Medical Revalidation**: 59 of 69 appraisals were completed with valid reasons for those not completed. Clarity was sought on RO signature on the RO statement prior to submission. Dr Tosh stated his agreement for his signature to remain as the RO with majority tenure. Medical appraisal policy ratification to take place via chair of the People and Teams CLE group outside of meeting.
Decisions made:	None
Actions agreed:	**GSWH** new action agreed on exploring dedicated admin support for the GoSWH at September Clinical Leadership Executive (CLE). **Annual survey report** on outcomes of doctors' experience of the appraisal process to be presented at PODC by the new lead medical appraiser (LMA). **Deloitte's report** with an action plan would be brought to next PODC showing shared learning across system and place. **Comms campaign** on apprenticeship first posts for discussion at EG.

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

Report to the Board of Directors meeting scheduled for 26 September 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper I
Date of meeting:	18 September 2024		
Attendees:	Dave Vallance (Chair), Dawn Leese, Toby Lewis, Dr Diarmid Sinclair, Carlene Holden, Jo McDonough, Dr Janusz Jankowski, Jyoti Mehan.		
Apologies:	Jo Cox, Lead Governor; Ruth Sanderson, Governor		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Promise 5** – "What success looks like"; A 'Think Tank' meeting took place – to help define the ambition and end-point. Revealed a diverse set of views that needs further work to refine. Next steps were to develop the Community Involvement Framework by December 2024; and as part of delivering this new approach, the challenge of moving mindsets from attendance at NHS meetings to community engagement was recognised. This will be picked up as part of the work on Leadership Development offer; the revised 5-day induction programme and for Medical staff, the SPA time to be used for reflection on changes needed to their personal practices. **Promise 7** - Core20plus5 paper highlighted what the RDaSH contribution will be against the national targets for both children and adults. It includes action to go further eg on health checks for patients with Severe Mental Illness (SMI) and Learning Disability (LD) and reach a 95% target. Challenges exist with availability of data that links GP Registers with RDaSH data for both SMI and LD health checks - update at the next PHPIPC. **Promise 8** – paper presented on driving forward work on the "RDaSH 5". 4 of the 5 have been agreed; (1. Increase life expectancy for people with LD, especially from minority communities, through better health checks and plans; 2. Talking Therapies: Pro-actively focus on access for under-served parts of the community and their recovery rates for depression, anxiety and trauma for older adults; 3. Dementia: Increase in diagnostic rates for people with dementia and better community support for people and those who support them. This includes people from minority and rural communities. 4. Autism: to create autism-friendly services, from a patient, environment and workforce perspective. Working on finalising the fifth. Next step for senior leadership ownership at care group level. **Health Inequalities Data** – Presented an update of the data needed for each of the promises that fall under the health inequalities objective (SO2). Some baseline data is in place to measure progress against the success measures for promises; but issues with most eg promise 7 and 8 (SMI and the LD health checks data); promise 10 under-served and unrecorded communities eg Gypsy, Roma, traveller (GRT). A lot of data work is needed, and questions were raised about the team's capacity. **Strategic Delivery Risks** – Good updates on both SO1 and SO3 as they are shaping up – still more work to do now to show how mitigations are progressing, and what else is needed to hit the target scores.		

	Adult Eating Disorders - have received a satisfactory position on the contract negotiations, that is within the parameters that the board delegated to Mr Lewis (noted the considerable assistance of South Yorkshire, ICB).
Positive highlights of note:	Generally, the progress being made to refine and focus on concrete actions in what are complex areas.
Matters presented for information or noting:	The Trust's approach to Community Power (as part of Promise 5) – Mrs McDonough and Mr Lewis to consider how we take that dialogue forward both within the committee, but also within the wider board to stimulate discussion, understanding and alignment. Flourish enterprises - well sighted on delivery of financial and quality plans.
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 26 September 2024

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper J
Date of meeting:	21 August 2024		
Attendees:	Pauline Vickers (Chair), Richard Banks, Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Philip Gowland, Ian Spowart, Rachael Blake, Richard Chillery, Richard Rimmington, Jyoti Mehta, Iona Johnson		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**Vacancy and Workforce Reporting** – work to rebase Trustwide vacancy factors as part of 2024/25 planning is complete. Monthly monitoring continues to ensure a consistent approach is taken across all areas. **Adult Eating Disorder Funding from NHSE** – The AED Collaborative was overspent by £430k year to date. This includes an income accrual of £400k which reflects the YTD value of the proposed offer from NHSE on enhanced packages of care funding. The adverse variance relates to the residual pressure from unfunded EPCs, the Trust continues to negotiate with NHSE on an improved settlement with a further discussion to take place at the August Board session.		
Key points of discussion relevant to the Board:	**Month 4 Finance Report** – at Month 4, the Trust had a deficit of deficit of £1.4m (£0.09m off plan). The Trust's CIP performance at Month 4 was delivery of £0.87m of recurrent savings against a year-to-date target of £2.2m. The gap was being delivered via non recurrent underspend on vacancies and cost pressure reserves. Cash and cash equivalents at Month 4 are £32m (£1.8m variance to plan and within the normal range of variance). **NHSE Oversight Framework support segment change** – NHSE had moved the Trust from segment 2 to segment 3 of the oversight framework. This change had been driven principally by the challenges of the wider ICB deficit position. The Trust is in discussion with NHSE to agree the performance criteria required to move back to segment 2. **NHSE Investigation and Intervention (I&I) Report** – found the Trust had strong controls with respect to agency spend. The Trust is working across South Yorkshire providers to share best practice and review rostering controls. **Estates Update** – Statutory and mandatory compliance continues to improve and Estates are responding to the clinical needs of the Trust. Progress of current capital and project works noted. The future estate plan continues to progress, ready to issue the first draft of the completed phase 1 products in August, with plans for wider consultation with stakeholders on the required next steps for phase 2 in the remainder of 2024. **Strategic Delivery Risk (SDR) Report** – progress noted with the development of the mitigating plan for the allocated SDR (previously referred to as the Board Assurance Framework). SO2 has been allocated to the Committee; *Create equity of access, employment and experience to address differences in outcome*. New monitoring arrangements via DoCA and AC Chair meetings; Board assurance Committee meetings; and at the Board of Directors.		
Positive highlights of note:	**National Cost Collection 23/24** – The mandated national cost collection was submitted to NHS England on 19th June 2024. The latest Trust index published on 10th July 2024 relates to the financial year 2022/23. Highlights how costing data can form part of directorates finance assurance reports as well as how costing		

	data has assisted to support positive change within service delivery (physical health community services).
Matters presented for information or noting:	**Cyber Security –** The report provided the latest cyber security position and progress made against a six-month rolling forward plan (February – August 2024). The Trust continues to work towards national cyber security standards of safe practice and mandatory submissions including the DSPToolkit/Cyber Assessment Framework, evidenced by NHSE benchmark reporting.
Decisions made:	**Business Cases** – the Committee approved the **Elizabeth Quarter** subject to final CEO review and approval; Clinical Service Delivery and Office Accommodation Development, Relocation of North Lincolnshire Community Services (spanning four Care Groups). The Committee agreed to proceed with **Endpoint Replacement Programme 2024/25**; to replace 745 endpoint devices for the second year of a five-year centralised endpoint replacement programme.
Actions agreed:	**Cyber Security** - processes to be shared with Executive colleagues in relation to Cyber Security escalation particularly including on-call scenarios.

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

Report to the Board of Directors meeting scheduled for 26 September 2024.

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**	26 September 2024

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

The paper surveys a variety of issues that have been progressed since the Board last met: and highlights some key actions for the next period. **2 annexes are separately listed on the agenda**.

In 2023 the Trust was involved with two regulation 28 letters; and a third has just been issued (the subjects are unrelated). The restructure of Nursing and Facilities has just concluded consultation and as such we will now seek to build a governance model for safety, and quality, that is curious and impactful. In March 2025 all Patient Safety Serious Incidents will be reviewed on a whole Board basis. Consistent safety will not be feasible without stable staffing. The Board's 'fully staffed' position continues to be vigorously pursued. Revised scrutiny of rostering practices during October is intended to translate that into teams' experiences of work, recognising that our Quality Committee is endorsing the mid-year Safe Staffing report. New agency controls are proving effective (Q2 act vs Q1 and Q3 est vs Q1), but difficult decisions over some senior medical posts will be taken over the next four-six weeks to ensure that we maintain our plan for 2024/25.

Q3 is however, in my view, rightly dominated by the continued deployment of vital cultural interventions: Care Opinion, implementation of promise 5 related changes, our learning half days, the anti-racism plan, the new induction model, first drafting of our 25/26 appraisal approach, and our leadership development offer (to cite but seven).

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	**ACKNOWLEDGE** formally the scale of national funding required to provision pay awards this year (due to be paid in October)
X	**NOTE** likely draft submission of our EPPR annual return (to be confirmed in November)
X	**NOTE** the important conclusion of Lord Ara Darzi's independent review on the NHS

Impact

Trust Risk Register	x	Various, including extreme risks cited in other papers: O4/23, S4/24, NLCG11/22, RCG1/24, HI5/22, NLCG4/24, RCG14/24, MP3/22, POD4/24, CCG 3/22
Board Assurance Framework (SDR)	x	Induction, Learning Half Days and Leadership Development Offer– SDR1 and SDR 5; Health Inequalities Data - SDR2
System / Place impact	x	See text, multiple reference to system / place re: financial positions of ICB, Right Care, Right Person and within the section 'Our Communities'

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 August and September 2024
Annex 2: Current register of Trust vacancies September 2024
Annex 3: National publications August/September 2024
Annex 4: Board summary of South Yorkshire MHLDA Collaborative Board (September 24)
Annex 5: Summary of Darzi review
Annex 6: Draft EPPR submission due with ICB on September 30th 2024

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

September 2024

Introduction

1.1 A distinct annex to this report summarises **the recent Darzi review**, while a link to the full report is contained in Annex 3. It is recognised that this review needs to be considered alongside future social care policy, and the spring 2025 '10-year plan' for the NHS. The 'shifts' agenda outlined in the report is very consistent with our strategy from 2023, and the 28 promises we are seeking to deliver. We do need to consider whether the digital/analogue changes imagined are specifically understood across our services and teams.

1.2 From late October, new joiners within the Trust will benefit from a fundamentally different approach to **induction**. In part this may help us to respond to our year-one turnover metric, but it is also intended to ensure that the roughly 10% of new employees year on year have immediate access to our community-orientated vision for the Trust, an understanding of our promises and future culture, and chance to offer their own insights into the future that they wish to be part of. A separate paper within the Board explores the approach, which will be evaluated over 12-18 months.

1.3 Recognising likely changes in the approach to inspection through **the CQC**, over the near and medium term, mindful of the Dash review, the Trust has nonetheless benefitted in recent weeks from renewed engagement with local regulatory teams. This will inform our review together in October of our approach to compliance with the five domains across our services and organisation. A structured, sequenced approach to improvement will be needed, which, in a timely way also responds to immediate queries and wider thematic concerns outlined by the regulator (for example in relation to restrictive practice or disengagement).

1.4 These reports will continue to consider our position in relation to the two wider systems we work within (ICBs). **Both face financial stretch to close planned £50m gaps in finances for 24/25 recurrently**, and these expectations may be deteriorated by YTD positions. Those positions are summarised below:

- Humber and North Yorkshire ICB are reporting a YTD deficit of £60.9m at month 5, this is £1.9m off plan.
- South Yorkshire ICB are £19.4m behind the plan, with a deficit of £66.1m.

The Trust's projected financial position for year end (non-recurrently) remains in line with the plan agreed in May, albeit the downturn in targeted CIP expenditures needs to deepen in Q3. The highest profile risk remains continued underfunding of pay awards because of the formula used to disburse allocations (which fails to distinguish elegantly different sectoral pay bill proportions of turnover: our current estimate remains that a full year impact close to £10m is to be expected, with at least £6.9m of additional funds needs to avoid a deficit growth. ICB finance leads, and national finance colleagues, continue to offer reassurance that this will be met.

Our patients

2.1 Board members will recall that during 2023, the Trust was directly and indirectly party to two **Regulation 28 letters** from the coroner, intended to prevent future deaths: one related to MEED guidance and one to our approach to disengagement. These were last cited in the Board in May and July, with Quality Committee confirming it was scrutinising them. The collaborative has taken forward review work in relation to the former, and the Trust has meet with ICB quality leads to ensure that the system-wide standards compliance assessment is considered, including in funding plans for 2025/26. The latter work, led by the prior medical director, has not been progressed with alacrity, and over coming days revised governance for that work will be established. It is very important that any work we consider in response to the report into deaths in Nottinghamshire/assertive outreach review, reflects on the commitments given by us to the coroner and the impacted family. Regrettably, prior to this Board, we have received our first regulation 28 letter of 2024 in relation to the death through suicide of a patient in Rotherham. In addition to briefing Board colleagues on that situation when we meet, I will review with the chair how future regulation 28 letters might best be subject to full Board review, in the manner I would expect for a Never Event. In preparing our Quality Account for 2024/25, we will consider explicitly the annual report of the country's senior coroner to establish what learning and practice changes we should have adopted arising from consideration of care failures outside our area.

2.2 We have discussed within the board secondary waits for **prescription of medication across our ADHD services**. We are scrutinising progress to our October 7th timeline in both adult and CYP services. At the same time, we are reconsidering our best response to projections of national medication shortages through to summer 2025, alongside the implications of general practice extra-contractual action on shared care arrangements. Notwithstanding these issues, we do have plausible waiting time trajectories in all our services which see us complying with promise 14 during 2026. Practitioners involved with services have had opportunity to consider how we comply with NICE guidance in full, and yet meet the obligations agreed by the Board. We will, in due course, need to consider how we support families with ongoing needs after diagnoses. A deadline of full compliance in each service (not at or above, but at) with NICE guidance has been set as December 31st 2024. This compliance will be auditing on an ongoing basis during 2025/26 as part of our clinical audit programme.

2.3 In May's Board meeting we approved a capital programme for 2024/25, and some run through investment into 2025/26. This delegated to a specific review **our ward bedroom doors and ongoing ligature risk**, as well as providing funding for new bathroom doors. That review has concluded that the four points of elevated risk identified in prior papers can be mitigated or tolerated, and that the right course is to proceed with the existing bedroom door supplier. We have confirmed that this work can be completed inside the £1.9m provided. With the exception of segregation environments, which are subject to ongoing review, this means that during this fiscal year we will finish the Trust's door replacement programme. A file note of the discussions and conclusions will be served to the next Quality Committee meeting, to consider in due course alongside wider anti-ligature work.

2.4 **Right Care, Right Person** has been ongoing for some time within both relevant police forces with whom the Trust works. In July 2023 we agreed as a Board some indicators through which to review the operationalisation of these practices. A briefing paper with wider detail will be circulated to members of the Board, but review of data during Q1 24/25 leads us to the following interim conclusions:

- Handover at S136 suites inside one hour is poorly documented (and with incomplete data is only achieved in 4% of cases). Since July 1st, the Trust's work on HBPOS has scaled up – and we would expect to see both recording and performance improvements during 24/25.
- Of 35 AWOL cases reflected for the period in our IQPR, we cannot be confident that we have always internally followed our issued policy for actions to be taken prior to contacting the police. Reinforcement work is needed such that we can isolate inappropriate non-attendance.
- IR1 analysis does not identify RCRP related incidents in this first quarter: this may reflect under-reporting or poor categorisation.

The focus of effort now needs to be in assessing whether we have historic practices or policies, for example in relation to suspected self-harm, that anticipate responses from police colleagues on which we can no longer rely in a timely manner.

2.5 The UNICEF **UK Baby Friendly Initiative** enables public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life. Introduced to the UK in 1994, the Baby Friendly accreditation programme is recognised and recommended in numerous government and policy documents across all four UK nations, **including the National Institute for Health and Care Excellence guidance**. The programme supports maternity, neonatal, community and hospital-based children's services to transform their care and works with universities to ensure that newly qualified midwives and health visitors have the strong foundation of knowledge needed to support families. Since launched our RDaSH services have worked towards and sustained accreditation in our CYP services. Recently accreditation standards have expanded, and also there has been a need to explore the appointment of a Baby Friendly Guardian. The Achieving Sustainability standards are divided into four interlinking themes – Leadership, Culture, Monitoring and Progression. Under the UNICEF 'Leadership theme' is a standard requiring the appointment of a Baby Friendly Guardian. We have appointed Dr Judith Graham (Director for Psychological Professionals and Therapies) as our RDaSH Baby Friendly Guardian, to ensure that there is a focus from a patient facing level all the way up to Board Level.

2.6 Consistent with recent discussions across the Board, and within the Quality Committee, there is continued focus on some basics of inpatient ward management practice. It is clear that an emphasis on Grab Bag audits, Oxevision consent, and MHA Section 132 recording is positively driving behaviour. We have further work to do in exploring the safety plan, and in developing our ward managers, to examine how we systematise a wider suite of 'always' activities. The deployment of that effort requires consideration across the executive group, and a sequenced mobilisation aided by high quality data visualisation.

Our people

3.1 **Learning Half Days** commenced on September 3rd, and now proceed on a structured basis in each coming month. The CLE-sub (learning and education) will retain oversight of evaluation, adaptation and engagement. From Q4 24/25 we will become increasingly structured in assessing attendance and non-attendance as we look to ensure that those not providing a Christmas Day service are able to contribute to LHDs. The initial Trust-wide LHD went well, with no material technical hitches, and good engagement in all three places, as well as within backbone services. Of course, sustaining contribution beyond the novelty will be important. It is critical that teams have time to talk, decompress, explore, and innovate – and we will need to keep supporting managers with the skills, confidence, and sometimes material to be enable that. Primary care colleagues have undertaken a similar model of scheduled time for some time, and discussions with partners to learn from, and share, are in hand for 2025.

3.2 Some months ago, we confirmed, procured and contracted our **leadership development offer** (sometimes shorthanded to LDO). The first cohorts enter this programme from January 2025, and 10% of places will be used by community leaders drawn from local partnerships. A range of expert providers are working alongside us, including New Local, Virginia Mason Institute and the PSC. The time being taken, roughly 1.5 days a month, over 2025 and 2026, testifies to the importance of this endeavour, and to its potential. Other leadership development investment for the top leaders' cadre is ceased to make time and headspace for this work, which Ground Research will lead evaluation of. National tools like 'NHS Impact' can be subsumed and incorporated within this work, as can local models like QSIR. We are carefully planning how new joiners over the period can be drawn into the programme, and how the skills of our in-house culture team can be both used and extended through this work – as preparation for 2027/28 and exit. Given the importance of this work, I would suggest that twice a year an in-depth exploration across the Board as a whole takes places to consider whether we are generating the scale and depth of impact we are seeking: and to consider what Board behaviours best reinforce those ambitions.

3.3 Consistent with the Board's decision (March 2024) to **transfer flexible working bank arrangements** to NHS Professionals, this transfer will be completed on October 21st. Fill rates will be closely monitored over the following two quarters as we look to ensure that we maximise opportunities for flexible working. New Trust employees will be actively supported to take up bank contracts where they wish to do so: it is vital we are consistent with our mantra of being 'pro-bank, anti-agency'. During Q4/Q1, we will work through Carlene Holden to make sure that, as a Board, we can hear from some prior Trust/now bank employees, and some new joiners, about their experience of working inside the Trust.

3.4 Board colleagues will recognise, through the work of the MHA, the vital work done by **TAMs** in ensuring legal rights are able to be meaningfully exercised by detained patients in our care. Over coming weeks, we will finalise proposals with non-executive directors, to play a contributory role in that work consistent with the Strathdee Report. The recruitment of up to a further eight TAMs is currently active,

with open events to garner interest taking place. Changes to the training and support matrix for these roles should better support the development of the group.

3.5 The final draft of our (un) acceptable behaviour policy is now in place. This includes provision to bar carers and patients from Trust services and sites, including for reasons of racist behaviour or speech. **We will go-live with this from October 1st 2024**. A register of its application will be maintained from that date (including when it is considered and not applied): and will be subject to audit in 25/26. There are layers of warning/intervention, which, hopefully rarely if at all, culminate in the issue of 3-month (yellow) or permanent (red) exclusion orders from Trust services. The former is overseen at Care Group SLT level (COO appeal), and the latter by the executive clinical triumvirate (CEO appeal). This change is a welcome consistency, and therefore I would hope, fairness, in supporting our students, staff, and researchers from abuse. Whilst our approach has been being developed over the past five months, NHS England, and the new Secretary of State, have both given vocal endorsement to these protections in recent weeks.

<u>Our population</u>

4.1 Against promises 10 and 11, the Trust has looked to support extended service models with the GRT and veteran communities locally. Within the last Council of Governors meeting, I undertook to provide at the next meeting a clearer rendering of existing and future services to refugee living locally. Later in October, **the Trust will co-host work to develop Homeless Health services.** This builds on work led within the local authority, and enthusiasm from clinical colleagues within the local hospital in Doncaster. With advice from Pathway, we will seek to create during 2025 services which draw on evidence nationally (including NICE guidance) on the most effective health models, both of specialised and general care.

4.2 It is important to acknowledge the work being done to **embed Promise 5**. Board members will recognise that the new role of public governors in our work has now been matched by community attendees at our CLE and its sub committees. The development of a patient/peer led shadow-CLE will commence in 2025. Delivery at scale of our volunteering promise over the next nine months will provide significantly enhanced community insight into individual services. Our latest assessment of progress was discussed at PHPIP committee, and, with the conclusion of the Nursing and Facilities restructure, we will seek to more systematically structure our work with VCSE groups at place.

4.3 Annex 2 includes citing of the Barnsley based **pathways into work** report. Within promise 9 the Trust commits to its role in expanding the range of sometimes excluding citizens among our workforce. The laundry-scheme and apprentice-first are an initial illustration of that intent, and the recent AMM heard description of some work with refugee nursing staff. The People and Teams Plan will focus attention on the scale of that work between 2024 and 2028.

4.4 During September, the shadow South Yorkshire Joint Committee for **all-age eating disorders**, met for the first time. The Board endorsed this proposal in May, and it is further enabled by the specialised commissioning contract outlined in another Board paper. We have been explicit that we do not seek to become a provider of adult services, and we will maintain our CYP services in collaboration with peers. We

expect Navigo to provide an expanded North Lincolnshire services and to work with SHSC to develop service offers in Rotherham and Doncaster. We remain fully committed to seeing these services established; as they are critical to population health and will in time allow us to reduce dependence on restrictive, acute care within the private sector.

Concluding comments

5.1 Our adult physical health and neurodiversity care group support over 35,000 patient contacts in Doncaster each month. **As we move into winter**, we continue to seek ways to improve the experience of patients within acute pathways. The two most material steps we are taking is seeking to maximise occupancy of our virtual ward and working alongside GPs to drive up take up of flu vaccines. TUPE transfer of the community geriatric service and its expansion is progressing: this may enable us, over coming months, to develop a frailty alternative model to the acute site. This proposition comes directly from advice by the UEC leads at the DRI, as well as discussions with local primary care leaders.

5.2 After some month's consideration, our private Board considers the commercially confidential **extension of the longstanding TPP contract** with the Trust. Ensuring that our technology supports clinical practice, and gives rise to accurate and usable data, is a critical enabler of our plans.

5.3 The Trust remains a very active, if sometimes divergent, system partner locally. The work of the SY MHLDA Collaborative is gathering pace, and the planned expansion of Health Based Place of Safety is acknowledged as symbolic of that. Investment to create a community rehabilitation model in North Lincolnshire is also encouraging. **It is important however that we make the long-promised shift from NHS alliances into our communities**. We will work through the Public Health, Patient Involvement and Partnerships committee to quantify that transition, and through the Leadership Development Offer to support the behaviours needed to benefit from it. A humble supportive role as a care anchor within our neighbourhoods (a more permeable, personalised, preventive NHS) must be the logic of the shifts described by Darzi, as well as that agreed by this Board in 2023.

Toby Lewis, Chief Executive
19 September 2024

Annex 1

Clinical leadership executive – August 2024 and September 2024

There have been two meetings of this body since the Board last met; these meetings focused on our future change function, changes to how mandatory training work, our capital choices, and work on moving clozapine into the community.

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

August	September
Safety element of Q&S plan	Out of area placements
Equity and inclusion plan	Promises prioritization arrangements
Single sex accommodation	Poverty proofing
Reward and recognition arrangements	Transitional care in mental health services
Leadership development offer	Induction arrangements

In terms of decisions made, in August we confirmed recommended changes from November to our awards schemes. September's meeting considered a range of discursive items referred to elsewhere in the CEO report and acknowledged decisions made by sub-groups including Equity and Inclusion regarding ending age-specific cut-offs within services by April 2025.

There are not 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 (October/November) we will consider in particular:

- Our approach to supporting improvement in care within our inpatient wards
- The trajectories for wait time improvements during 2025
- Estate plans and issues
- How we support our work to meet core CQC standards
- Initial deployment and forward activities on Care Opinion

Toby Lewis, Chief Executive
19 September 2024

Annex 2 Current vacancy summary

This report will change further when reported in November. There remains some budget/ESR misalignment to resolve which is now being worked on personally by Izaaz Mohammed and Carlene Holden. In future, we will also report consultant posts (all professions).

Org L4	FTE Budgeted	FTE Actual	FTE Variance	RECRUITMENT	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	Offered	Start Date Given	Total
376 CCG Management	23.23	19.32	-3.91					2.00			2.00
376 CCG Mental Health	284.31	291.93	7.62		1.09	2.80	2.40	8.60	8.60	14.60	38.09
376 CCG Physical Health	272.31	266.78	-5.53		0.40	2.60		3.90	3.40	5.83	16.13
376 DMHLD Acute Services	230.81	203.99	-26.82			2.00		1.00	5.00	7.00	15.00
376 DMHLD Community Services	304.63	291.47	-13.16		6.50	9.60	2.80	5.70	4.30	7.01	35.91
376 DMHLD Learning Disabilities & Forensics	230.21	211.72	-18.49		1.00			2.00	5.80	3.60	12.40
376 DMHLD Management	10.40	8.49	-1.91			1.00			1.00		2.00
376 NLCG NHS Talking Therapies	178.13	170.72	-7.41			1.40	0.60	2.00	9.00	7.85	20.85
376 NLCG Acute Care Services	132.84	118.04	-14.80		3.30	5.00	1.00	5.40	2.00	3.00	19.70
376 NLCG Community Care Services	111.41	99.35	-12.06			3.60	1.00	1.00	3.80	5.00	14.40
376 NLCG Management	36.38	28.97	-7.42								
376 DPHG Community & Long Term Conditions	402.08	373.51	-28.57		0.20	5.13		3.40	18.5	25.6	52.83
376 DPHG Rehabilitation	320.76	299.28	-21.48		4.00	1.80	1.00	3.00	9.80	13.00	32.60
376 DPHG Management	10.00	9.35	-0.65		0.20						0.20
376DPHG Neurodiversity	27.40	26.79	-0.61				1.00	5.00	3.00	3.00	12.00
376 RCG Acute Services	249.41	215.70	-33.71		1.00	10.50	9.00	5.00	12.00	9.00	46.50
376 RCG Community Services	232.24	219.74	-12.50			3.75	1.90	5.00	2.60	7.00	20.25
376 RCG Management	22.30	15.10	-7.20			1.00					1.00
376 Corporate Assurance	31.12	35.60	4.48		1.80			1.00	1.00		3.80
376 Estates	67.30	61.72	-5.58						2.00	1.00	3.00
376 Finance & Procurement	48.49	36.19	-12.30		0.80					4.00	4.80
376 Health Informatics	73.26	71.84	-1.42							1.00	1.00
376 Medical, Pharmacy & Research	56.05	52.87	-3.18			0.71		1.40			2.11
376 Nursing & Facilities	194.76	158.49	-36.27		2.00	0.37	1.00	1.45	1.35	0.53	6.70
376 Operations	47.43	43.60	-3.83		1.00		2.00	1.50		2.00	6.50
376 People & Organisational Development	99.09	93.01	-6.08		1.00			2.00	1.43		4.43
376 Strategic Development	19.30	16.16	-3.14							1.00	1.00
376 Psychological Professionals and Therapies	6.5	4.88	-1.62							1.00	1.00
Total	**3,722.15**	**3,444.61**	**-277.54**		**24.29**	**51.26**	**23.70**	**60.35**	**94.58**	**122.02**	**376.20**

Annex 3: National publications/guidance summary – August/September 2024

NHS response to 2024 riots
(NHS England 12/08/2024)

Letter responding to colleagues request for a 'do once' approach to bringing together, and in some cases interpreting, relevant resources, guidance, and policies related to supporting staff and addressing racist or other discriminatory behaviour, whether from patients or colleagues. The annex provides guidance and information and clarifies key points of concern.
https://www.england.nhs.uk/long-read/nhs-response-to-2024-riots/

NHS emergency preparedness, resilience and response exercise programme 2024 to 2030
(NHS England 13/08/2024)

Letter outlining the national exercise programme for the NHS 2024 to 2030.
https://www.england.nhs.uk/long-read/nhs-emergency-preparedness-resilience-and-response-exercise-programme-2024-to-2030/

Independent investigation of the NHS in England
Lord Darzi's report on the state of the National Health Services in England
(Department of Health and Social Care, 12/09/2024)

Summary letter, report and technical annex.
https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

https://assets.publishing.service.gov.uk/media/66e1b49e3b0c9e88544a0049/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England.pdf

https://assets.publishing.service.gov.uk/media/66e1b517dd4e6b59f0cb2553/Independent-Investigation-of-the-National-Health-Service-in-England-Technical-Annex.pdf

NHS providers briefing on the Darzi Review
(NHS providers, 12/09/2024)

https://i.emlfiles4.com/cmpdoc/5/0/8/6/3/2/files/64220_otdb---lord-darzis-independent-investigation-of-the-nhs-in-england.pdf?utm_campaign=1862249_The%20Darzi%20Review%3A%20NHS%20Providers%20On%20the%20Day%20Briefing&utm_medium=email&utm_source=NHS%20Providers%20%28Policy%20and%20networks%29&Organisation=Rotherham%20Doncaster%20and%20South%20Humber%20NHS%20Foundation%20Trust&dm_i=52PX,13WX5,13CA62,4IU6T,1

Winter and H2 priorities
(NHS England 16/09/2024)

Letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.
https://www.england.nhs.uk/long-read/winter-and-h2-priorities/

Action to prevent future deaths reports (Regulation 28)
(NHS England 17/09/2024)

This document explains how NHS England responds to a Regulation 28 Prevent Future Deaths (PFD) report.
https://www.england.nhs.uk/long-read/action-to-prevent-future-deaths-reports-regulation-28/

Integrated care board review of intensive and assertive community treatment for people with severe mental health problems
(NHS England 29/08/2024)

Letter from Claire Murdoch CBE and Dr Adrian James.
https://www.england.nhs.uk/long-read/icb-review-of-intensive-and-assertive-community-treatment-for-people-with-severe-mental-health-problems/

Find out more about the Learning Disability Register – leaflet
(NHS England 14/08/2024)

This leaflet helps people think about whether their child or someone they care for could be considered to have a learning disability and should be on their local GP practice's Learning Disability Register, to help them get the help they need.
https://www.england.nhs.uk/wp-content/uploads/2024/08/learning-disability-register-parent-carer-guidance-200223.pdf

Flu and COVID-19 seasonal vaccination programme: autumn/winter 2024/2025
(NHS England 15/08/2024)

Letter from Steve Russell, Chief Delivery Officer and National Director for Vaccinations and Screening, NHS England.
https://www.england.nhs.uk/long-read/flu-and-covid-19-seasonal-vaccination-programme-autumn-winter-2024-25/

Updates to the consultant 2003 contract – pay progression
(NHS Employers, 19/08/2024)

NHS Employers published the pay and conditions circular (M&D) 6-2024 that notifies employers in the NHS in England of changes to schedules 15 and 23 of the Terms and Conditions – Consultants (England) 2003.
https://www.nhsemployers.org/news/updates-consultant-2003-contract-pay-progression

RightCare dementia scenario
(NHS England 22/08/2024)

This scenario focuses on an optimal pathway to help clinicians and commissioners improve value and outcomes for patients living with dementia.
https://www.england.nhs.uk/long-read/rightcare-dementia-scenario/

Virtual wards operational framework
(NHS England 27/08/2024)

This framework supports consistency across the NHS and the relevant goals in line with the Year 2 urgent and emergency care (UEC) recovery plan and the 2024/25 priorities and operational planning guidance: maintaining virtual ward capacity and optimising occupancy so it is consistently above 80%.
https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/

NHS 111 offering crisis mental health support for the first time
(NHS England 27/08/2024)

Millions of patients experiencing a mental health crisis can now benefit from support through 111, the NHS has announced. The change means the NHS in England is one of the first countries in the world to offer access to a 24/7 full package of mental health crisis support through one single phone line. People of all ages, including children, who are in crisis or concerned family and loved ones, can now call 111, select the mental health option and speak to a trained mental health professional. NHS staff can guide callers with next steps such organising face-to-face community support or facilitating access to alternatives services, such as crisis cafés or safe havens which provide a place for people to stay as an alternative to A&E or a hospital admission.
https://www.england.nhs.uk/2024/08/nhs-111-offering-crisis-mental-health-support-for-the-first-time/

Single point of access (SPoA) – guidance to support winter resilience 2024/25
(NHS England 28/08/2024)

This guidance supports systems to implement single point of access (SPoA) in their local area, as set out in the Priorities and operational planning guidance 2024/25 and the Urgent and emergency care recovery plan year 2: building on learning from 2023/24 letter.
https://www.england.nhs.uk/long-read/single-point-of-access-spoa/

Children and young people's gender services – implementing the Cass Review recommendations
(NHS England 07/08/2024)

NHS England is committed to improving and expanding gender services for children and young people to ensure that they receive safe, responsive, holistic care. The documents outline the steps that NHS England has already taken guided by interim advice from Dr Cass and sets out how they will take forward the recommendations made in the final report.

https://www.england.nhs.uk/wp-content/uploads/2024/08/PRN01451-implementing-the-cass-review-recommendations.pdf

Referral pathway for specialist service for children and young people with gender incongruence – guidance for NHS mental health services
(NHS England 07/08/2024)

This referral pathway will ensure that young people's wider health and care needs are also considered as part of their assessment for readiness to engage with the specialist gender service.
https://www.england.nhs.uk/long-read/referral-pathway-for-children-and-young-peoples-gender-services-mental-health-services/

Federated Data Platform (FDP): information governance framework
(NHS England 07/08/2024)

The purpose of this document is to set out the information governance framework for the Federated Data Platform (FDP) Programme. The framework sets out minimum information governance requirements to be applied in the implementation and operation of FDP, with the aim of ensuring a consistent approach and high standard of information governance and transparency across the FDP user organisation community.
https://www.england.nhs.uk/long-read/federated-data-platform-information-governance-framework/

Decision support tool: making decisions about managing depression
(NHS England 04/09/2024)

This tool will help to compare possible treatment options. It is for adults with depression.
https://www.england.nhs.uk/wp-content/uploads/2024/09/PRN00675-iv-making-decisions-about-managing-depression.pdf

Blog: Tackling health inequalities: Arch Healthcare's approach in Brighton
(Published 05/09/2024)

Across England, tackling health inequalities remains a priority, with one particular focus on inclusion health groups – people who are socially excluded and face overlapping risk factors such as poverty, violence, and complex trauma. Inclusion health groups are a priority group within the Core20PLUS5 population cohort, which focuses on the most deprived 20% of the population and key groups at risk of health inequalities. As part of the NHS's commitment to reducing these inequalities, all systems are asked to implement the Inclusion health framework by 2024/25, with a clear plan for doing so. In Brighton, Arch Healthcare, rated 'outstanding' by the Care Quality Commission, is leading the way by providing holistic, integrated care that addresses both medical and social needs. Their model offers crucial support to those experiencing homelessness or living in precarious conditions such as hostels or temporary accommodation.
https://www.england.nhs.uk/blog/tackling-health-inequalities-arch-healthcares-approach-in-brighton/

Annex 4

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 12 September 2024

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 12 September 2024. The main areas of discussion and subsequent action are outlined below.

Managing Director Report

The Board received an update on the Independent investigation of NHS Performance led by Professor Darzi, noting that since the report was drafted, the findings had been published. The MHLDA implications of the report will be considered by Chief Executives and discussed at the November Board meeting.

The report included an update on the work to delegate the commissioning of specialist inpatient perinatal inpatient services in Yorkshire & Humber to the Specialised MHLDA Provider Collaborative in West Yorkshire, which continues, noting this is planned to go live in shadow form in October 2024.

Delivering Our Work Programme

Board were provided with assurance that the work programmes were progressing as planned and that any delays were being mitigated.

Work on a **performance scorecard** was presented as a separate paper but provides a useful baseline for measuring improvement alongside bespoke measures for other programmes.

In particular Board noted the constructive initial meeting of the South Yorkshire Eating Disorders Joint Committee that was held on the 11th September. Following this meeting, a programme of work to get the committee to shadow form then to its final joint committee form by April 2025, would be shared.

Out of Area Placements

Following considerable work across the system, progress against the 7-point action plan was provided. In particular data issues now appear to be resolved meaning at any given time, we know who is placed out of area and can see the impact of improvements.

The Board were informed that to align with other MHLDA providers, RDaSH Board has agreed to take on the financial risk for general out of area placements in Rotherham and Doncaster from 1st October. The ICB have agreed to receive NHS alternative proposals to out of area private sector proposals to create financial and quality benefits.

South Yorkshire MHLDA Service Development Funding (SDF) Allocation

The Board received a brief on the ICB's suggested approach to managing the MHLDA Service Development Funding and potential options.

There was an engaging and open discussion raising issues about risk, parity, planning and implications of the options. It was agreed that, subject to an understanding of the recurrent (or not) nature of this proposal, the least impactful option could be agreed, but an equality and quality impact assessment would be prepared, including input from providers for ICB Board consideration.

It was noted that it was positive to have the inclusive conversation but, that in future years, there needed to be a more proactive planning approach and that a joint proposal on next year's settlement needs to be developed well in advance.

Productivity Review Procurement

A paper was received outlining the procurement of assistance to develop the MHLDA approach to productivity, with the aim of generating benefits in the medium and long term. Implementation has commenced engaging senior leaders in each organisation. The RDASH Chief Executive, Toby Lewis, will be the Senior Responsible Officer for this work and the Chair of the Collaborative will have a role in ensuring progress and adherence to the scope.

Health Inequalities

A paper on the Collaborative's approach to health inequalities was presented. The proposed option is to not move forward with this until January 2025 when the Board agree their forward priorities. To support this work beforehand, a review of current declared activities from the member organisations will be undertaken to start the change from a stronger perspective. The Board supported the proposals in the paper.

Work on pathway to employment, and other similar initiatives, will be linked into the inequalities work and also form part of a development session.

Specialised Commissioning Update

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

Leadership Arrangements

Following a review, including Trust Chief Executives and Chairs, it was proposed that Sharon Mays remains as the Chair for at least another 12 months. The Board agreed to this, and Sharon Mays accepted. The Board thanked Sharon for her commitment and leadership to date and thanked her for continuing in post.

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

Annex 5

Summary drawn from Darzi report

1. The report in stark terms outlines the issues faced by patients, carers and communities, and by public sector staff from all disciplines, through the present circumstances of NHS delivery. Whilst the chosen term of 'broken' is not welcomed by all, the report is intended to mark a break from the past, and a candid public-facing reflection of the reality of service. It is difficult to dissent from that description. Ara Darzi sources those difficulties to three roots, noting that two of these (austerity funding models and NHS reorganisation) are chosen approaches. It is important, against this, to recognise that the reorganisation of the NHS, subsequent to the 2022 Act, continues, and that 2024/25 NHS budget growth is below sums experienced during the austerity period.

2. There is recognition of the consequences of inequality, and particular emphasis on the long-term impacts of child health. The initial governmental response has restated a determination to invest in public health, and to take a health-in-all approach, for example to addressing smoking, vaping and obesity. It will be important as local NHS providers to lean into that leadership and provide our support to local government led work: as we have at RDaSH in creating our shared public health fund which is being used to tackle HWB priorities as well as objective 2 programmes.

3. The body of the report recognises the innovation, productivity and efficiency of primary care when compared to many other elements of NHS provision, including Trusts like our own. Acknowledging the importance of primary care within, for instance, our SDR/BAF formula, and noting work to join up time-spent like our LHDs, we should continue to test ourselves and consider how we lean into that pattern, which seems locally relevant as well as nationally observable. To become recognised as a sub-system where primary/secondary interface is outstanding would undoubtedly give us a recruitment and retention advantage for key roles such as district nurses, CMHTS, and health visitors, as well as social workers and AHPs.

4. The cited rebalancing of management resource into local providers, or certainly into local systems, is a significant step. It is one that will need to reconciled to 'aggregating initiatives' which have tended to dominate discussions over the last twelve months about 'system first', group models and collaboratives. For the recommendations to be delivered, and indeed our strategy, local must mean local, indeed inside neighbourhoods, not simply 'not Whitehall'. Whilst the role of Mayoral Authorities is not overly emphasised within the report, other sources suggest this may become more significant in health, and even within the NHS looking forward.

5. The report places more emphasis on social care, and mental health, than some commentators had anticipated, given the background of the lead author. Nonetheless, there will be a need to continue to make a case for parity of esteem, to better distinguish mental health/wellbeing from mental illness, and to make it feasible for policy makers, investors, and others to relate to providers such as ourselves; where quantity must matter but holding complexity over the long term will too.

Summary of report issued via Carnell Farrer

Darzi Investigation of the NHS in England

The investigation explores the challenges facing the NHS and sets the major themes for the forthcoming 10-year health plan

Context for the Independent Investigation of the National Health Service in England

- **The National Health Service is in serious trouble:** The NHS is a much-treasured public institution embedded into the national psyche but is now in critical condition and experiencing falling public confidence
- **The health of the nation is worse**: increasing long-term conditions and worsening mental health, leading to a spike in 2.8m long-term sick from 2m, while the public health grant reduced by 25% and the public health body has been split into two
- **This is not a reason to question the principles of the NHS or to blame management:** managers have been "keeping the show on the road" and there is a virtuous circle where the NHS can help people back to work and act as an engine for national prosperity

The challenges facing the NHS are interlinked…

Waiting time targets have been missed consistently for nearly a decade and satisfaction is at an all-time low

People struggle to see a GP despite more patients than ever being seen, the relative number of GPs is falling, particularly in deprived areas, leading to record low satisfaction

Community waiting lists have soared to 1million including 50,00+ people who had been waiting >1 year - 80% being children and young people. 345k people are waiting more than a year for **Mental Health** services

A&E is in an awful state and long waits contribute 14,000 additional deaths per year, while **elective waits have ballooned** with 15x more people waiting >1 year

People receive high quality care if they access the right service at the right time, without health deteriorating

- **Cardiovascular** mortality has rolled back as rapid access has deteriorated
- **Cancer** mortality is higher in part due to minimal improvement in detecting cancer at stage I and II
- **Dementia** has a higher mortality rate in the UK than OECD and only 65% of patients are diagnosed

Funding has been misaligned to strategy, with increased expenditure in acute driven by poor productivity

Too great a share of funding is on hospitals, increasing from 47% to 58% of the NHS budget since 2006, with 13% of beds occupied by people who could be discharged

The number of hospital staff has increased sharply, equal to a 17% since 2019, with 35% more working with adults and 75% more working with children

Patients no longer flow through hospitals properly leading to 7% fewer OP appts. per consultant, and 18% less activity for each clinician working in emergency

Four main drivers are identified…

It has been the most austere period in NHS history with revenue prioritised over capital

- 2010-2018 funding grew at 1% compared to long term average of 3.4%
- £4.3bn has been raided from capital budgets between 2014 and 2019
- £37bn shortfall of capital investment has deprived the system of funds for new hospitals, primary care, diagnostics or digital

The pandemic's legacy has been long-lasting on the health of the NHS and population

- The NHS entered the pandemic with higher bed occupancy, fewer clinical staff and capital assets than comparable systems
- NHS volume dropped more sharply than any other comparable health system, e.g. 69% UK drop vs OECD 20% in knee replacements

The voice of staff and patients is not loud enough as a vehicle to drive change

- Patients feel less empowered or secure and compensation claims stand at £3bn per year
- Priorities of patients have not been addressed, notably in maternity reviews
- Staff sickness is equal to one-month a year for each nurse or midwife
- Discretionary effort has fallen up to 15% for nursing staff since 2019

Management structures and systems have been subject to turbulence and are confused

- The 2012 Health and Social Care Act was disastrous
- The 2022 Act brought some coherence but there is a lack of clarity in responsibilities and in performance management
- Regulatory organisations employ 35 staff per trust, doubling in size in the last 20 years
- Framework of standards and financial incentives is no longer effective

Addressing these in the forthcoming 10-year health plan needs to include…

- **Re-engage staff and re-empower patients**, harnessing staff talent to deliver change and enabling patients to control their care
- **Change financial flows** to promote and **sustain the expansion of GP, MH and Community services** at a local level, embracing a **multidisciplinary neighbourhood care team model** that brings these services together
- **Improve productivity** in hospitals through improved **operational management**, **capital investment** and **empowering staff**
- Across the system, **tilt towards technology** through **digital systems**, especially for staff **outside hospitals**, and **embracing the potential of AI** for **care** and **life sciences**
- **Clarify roles and accountabilities** in NHS England and ICBs, **rebalancing management resource** with emphasis on the **capacity to deliver plans**, while **avoiding top-down reorganisation**
- **Direct effort** at aspects that will **drive national prosperity** by supporting people to **get back to work**, and **working with British biopharmaceutical** companies

Rotherham Doncaster and South Humber
NHS Foundation Trust

Emergency Preparedness Resilience and Response

Predictive EPRR Core Standards Statement of Compliance

2023/24

Richard Chillery, Chief Operating Officer

September 2024

Annual Core Standards Compliance

Introduction

In July the Board received an update on the EPRR core standards and progress on the work since the "hard reset" in November 2023. Due to the timings (set out below) of the Annual EPRR Core standards submission set against bi-annual Board dates then it has been determined that we submit a predictive outline of the core submission before the draft Core Standards are submitted in October, then a further update at the November Board following the peer review and formal submission on the 22nd November.

This paper is an outline of the prediction of the 60.35% achieved (determined as non-compliant) with the detail in appendix A and then broadly the workplan to achieve full compliance in the following year.

The Core Standards also required that the Trust Board sign off the revised Business Continuity Management Policy. This policy has been approved at the Operational Management Group – and this requested at this time.

Background

The NHS England Core Standards for EPRR are the minimum requirements commissioners and providers of NHS funded services must meet. In 2024/25 58 separate core standards out of a total 66 are applicable to RDASH. These are divided into 10 sections

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

Trust Position against the 2023/24 EPRR Core Standards

After a change to the submission process in 2023/24, the Trust compliance level was reduced to 21%. Previous reports have commented that this is align with a national reset for EPPR, nationally.

Core standard position 23/24			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
58	12	45	1

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

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

Trust Position against the 2024/25 EPRR Core Standards

A detailed action plan was produced following the compliance report in 23/24 to assess the work that must be done over financial year 2024/25 and 2025/26 to bring the Trust into the 'Substantially Compliant' criteria; with the aim of being as close as possible to 99%. There is doubt introduced over whether any Trust can ever be truly 100% compliant due to the changing nature of the standards (changed every three years).

In line with expectations set during the EPRR July Board Update Report, the anticipated compliance rating for financial year 2024/25 is 60.35%, with an improvement from 12 fully compliant standards in 23/24 to 35 in 24/25. Although this rating is still within the 'Non-Compliant' category, this is a significant improvement when compared to 23/24.

Core standard position 24/25			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
58	35	23	0

A full breakdown of the 58 Core Standards, and the anticipated changes in compliance are visible in Appendix A.

Throughout financial year 24/25 there has been focus on three specific areas of compliance, due to the complexity and potential impact of these areas on our ability to care for patients. As a Trust we have particularly prioritised a major Business Continuity Improvement programme, Temporary Shelter and Evacuation planning and testing and the embedding of the National Minimum Occupational Standards for EPRR.

Work is ongoing in all three of these areas, as detailed in the EPRR July Board Report. However, as part of the changes required to achieve compliance with the standards relating to Business Continuity, a new Business Continuity Management Policy requires approval by the Trust Board of Directors.

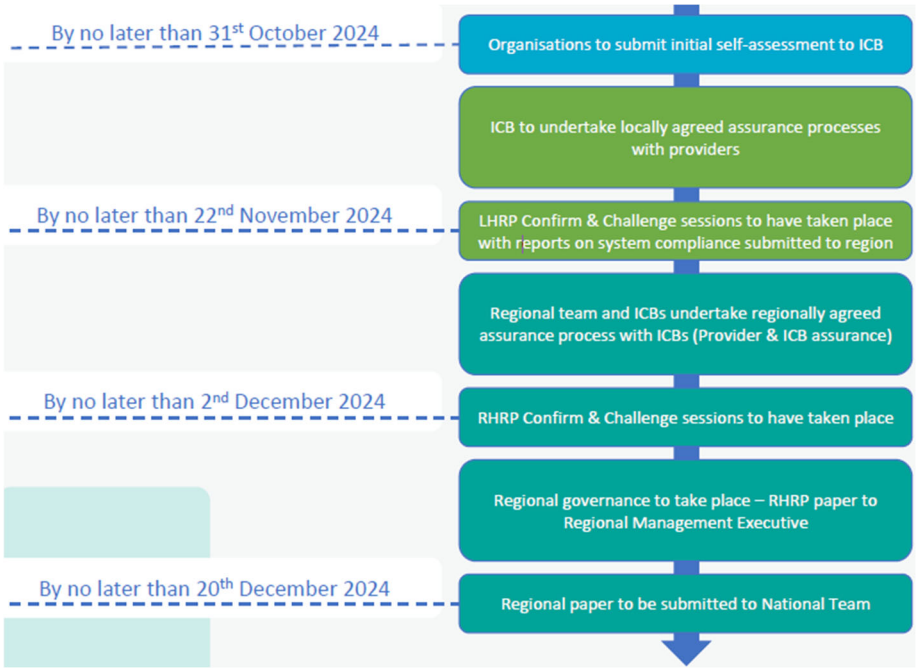
This policy has been re-written in line with international standards for Business Continuity Management This Policy meets the requirements set out within 10 specific standards and is included as Enclosure A. Approval of this Policy prior to submission allows the Trust to declare full compliance with Standard 44, 45, 49 and 52 in this financial year, and support achievement of an additional 6 standards during financial year 25/26. Without approval of this policy, overall projected compliance will reduce by 2.32%.

The Business Continuity Management Policy has been reviewed at the EPRR sub

group and then the Operational Management Group on 13th September 2024.

Next Steps
Submission Timelines

The process for submission this year starts on 30th September 2024, when the Trust will provide an email update to South Yorkshire Integrated Care Board (SYICB) detailing the standards that are anticipated to change in compliance rating. This will be followed by a draft submission, with accompanying evidence, on 31st October 2024. The draft submission will undergo a regional peer review panel ahead of the Trust final submission to the regional EPRR team on 22nd November 2024. On that basis we will provide a brief further update at the November Board.



Financial Year 2025/26 (work on the Core Standards)
The Trust will continue to work to achieve full compliance on the remaining 23 partially compliant standards throughout financial year 2025/26. This includes:

- **Standard 6** - Including lessons learnt from incidents and de-briefs in the EPRR twice yearly Board reports.
- **Standards 10, 15, 19, 30, 33** – Re-writing the Trust Major and Critical Incident Policy in line with current guidance and legislation by March 2025.
- **Standard 16** – This is a multi-staged process that will be achieved by 30th May 2025 in line with the timescales submitted to Board in the July EPRR Board report. This will provide compliance for 25/26.
- **Standard 18** – This standard expects that 'in line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.' It requires input from all inpatient areas within the organisation and, as such, will be commenced during Quarter 2 of financial year 2025/26, once implementation of the new Business Continuity and Evacuation plans are completed and embedded throughout the organisation.

- **Standard 21** – The Trust are continuing with a 3-year training program for on call staff with two half days and one full day of training per year, as detailed in the July 2024 EPRR Board Report, to achieve compliance for 25/26.
- **Standards 22, 24** – Additions have been made to MAST and the Trust Induction from October 2024 that allow for all staff to receive an element of EPRR training. In addition, this standard requires loggist training and other specialist incident training that is reliant on a regional response to develop as course content is not currently available.
- **Standard 43** – Work is ongoing with the Trust's Information Governance team and the Local Resilience Partnership to ensure robust data sharing agreements are in place by March 2025.
- **Standards 46, 47, 48, 50, 51, 53** - Work on re-writing all Business Continuity Plans has been intensive throughout financial year 24/25 and is on track to finish by 3rd May 2025, as detailed in the July 2024 EPRR Board report.
- **Standards 55, 56, 57, 58, 64** – Yorkshire Ambulance Service have been commissioned by NHS England to set specific standards and guidance for mental health and community Trusts in line with the guidance already available for Acute Trusts. RDaSH are unable to achieve compliance with these standards until this is completed. RDaSH will engage with YAS throughout financial year 25/26 to ensure compliance is achieved.

Through completing this further work to improve the organisation's compliance through financial year 25/26, it is anticipated that the organisation will move to 'Substantial Compliance', with the expectation that compliance of over 95% will be achieved and maintained.

Recommendations

- It is recommended that the Board approve the Business Continuity Management Policy, which follows this paper.
- Board is requested to accept the Trust's projected EPRR Core Standards statement of compliance for 24/25. It is suggested that any changes to this are discussed during Board in November 2024.
- That a progress update after submission is timetabled for our July 2025 Board meeting.

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

Ref	Domain	Standard name	Standard Detail	Final Submission 2023	Predicted Submission 2024
Domain 1 – Governance					
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Fully Compliant	Fully compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Fully Compliant	Fully compliant
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Partially Compliant	Fully compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Partially Compliant	Fully compliant

5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially Compliant	Fully compliant
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Partially Compliant	Partially compliant
Domain 2 - Duty to risk assess					
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Partially Compliant	Fully compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Partially Compliant	Fully compliant
Domain 3 - Duty to maintain Plans					
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partially Compliant	Fully compliant
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Partially Compliant	Partially compliant
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Partially Compliant	Fully compliant
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially Compliant	Fully compliant
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Partially Compliant	Fully compliant
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially Compliant	Fully compliant

15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Partially Compliant	Partially compliant
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially Compliant	Partially compliant
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Fully Compliant	Fully compliant
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Partially Compliant	Partially compliant
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Partially Compliant	Partially compliant
Domain 4 - Command and control					
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Partially Compliant	Fully compliant
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Partially Compliant	Partially compliant
Domain 5 - Training and exercising					
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially Compliant	Partially compliant
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Partially Compliant	Fully compliant

24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Partially Compliant	Partially compliant
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Partially Compliant	Fully compliant
Domain 6 - Response					
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Partially Compliant	Fully compliant
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Partially Compliant	Fully compliant
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Partially Compliant	Fully compliant

29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially Compliant	Fully compliant
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Partially Compliant	Partially compliant
Domain 7 - Warning and informing					
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Partially Compliant	Partially compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Fully Compliant	Fully compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Fully Compliant	Fully compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Fully Compliant	Fully compliant
Domain 8 - Cooperation					
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Partially Compliant	Fully compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Fully Compliant	Fully compliant

39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Partially Compliant	Fully compliant
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Partially Compliant	Partially compliant
Domain 9 - Business Continuity					
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Fully Compliant	Fully compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Partially Compliant	Fully compliant
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially Compliant	Partially compliant
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially Compliant	Partially compliant

48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Partially Compliant	Partially compliant
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Fully Compliant	Fully compliant
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially Compliant	Partially compliant
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially Compliant	Partially compliant
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Partially Compliant	Fully compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Partially Compliant	Partially compliant
Domain 10 – CBRN					
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Partially Compliant	Partially compliant
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Partially Compliant	Partially compliant

57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Partially Compliant	Partially compliant
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Partially Compliant	Partially compliant
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Fully Compliant	Fully compliant
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer’s recommendations The PPM should include where applicable: - PRPS Suits	Fully Compliant	Fully compliant

			- Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks		
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Fully Compliant	Fully compliant
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Partially Compliant	Partially compliant
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Partially Compliant	Fully compliant
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Non Compliant	Fully compliant

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Anti-Racism (*inc ref to WRES submission due 31.10*)	**Agenda Item**	Paper L
Sponsoring Executive	Carlene Holden, Director of People & Organisational Development		
Report Author	Carlene Holden, Director of People & Organisational Development		
Meeting	Board of Directors	**Date**	26 September 2024

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

The paper provides an update on the work and workstreams associated with Promise 26, specifically to become an anti-racist organisation by 2025.

The paper reflects on the experience of our colleagues in August 2025 as a result of the riots and the support which was implemented. Alongside an update on the workstreams/plans which have been developed to support colleagues, communities and the delivery of this promise.

The 2023 staff survey results and the negative experiences of our global majority colleagues are highlighted again, as they were in March 2024, linked to the workplans and also the submission of the WRES data, which is due by the end of October 2024.

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	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	
SO5: Help to 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:

	NOTE the content of the report and the ongoing workstreams
	CONSIDER any matters of concerns not covered in the report
	NOTE the requirement for the submission of the WRES data (31 October 2024)
	DELEGATE the submission of the WRES data to the Director of People and Organisational Development following discussion at People & Teams and POD Committee.

Impact

Trust Risk Register								
Strategic Delivery Risks	X	S05						
System / Place impact								
Equality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	TBC
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	

Appendix (please list)

N/A

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Anti-Racism (*inc ref to WRES submission due 31.10*)

1.0 Introduction

1.1 As we are aware Promise 26, in part, focuses on becoming an anti-racist organisation by 2025. We heard at Board in March of this year about the experiences of our global majority colleagues and our wider staff survey results, more responses were submitted by RDaSH colleagues, and whilst our results remained comparatively good, both within our 'sector' and locally, our WRES data contained a large increase in the proportion of colleagues reporting discriminatory behaviours by their line manager which did not correlate with a similar rise in the number of formal claims or grievances.

1.2 As part of our work associated with Promise 26, we've further explored this feedback through the REACH network and the Anti Racism Alliance (ARA). During August, **employees, patients and communities faced the riots** and violence associated with protests about immigration. The Trust's response to those events gives rise to more insights about what matters to colleagues. It reinforces concern run much deeper than how we embrace, and welcome staff trained outside the UK.

1.3 Following the riots we've held numerous sessions to further understand, hear firsthand the experiences of our colleagues and most importantly offer support. Colleagues have been supported by daily drop-in sessions, dedicated VLOGs by colleagues, line management conversations, emotional & practical support and an extraordinary REACH reflection event to name but a few. The support from most of our local Line Managers has been well received, with regular check ins and the extension of the 'how are you' to facilitate meaningful conversations.

1.4 As a Trust we have been clear on our values and **we will not accept nor tolerate racist behaviour,** but this does not remove the distress our colleagues have experienced, in August and the months/years prior. We are determined that this must act as a platform to further amplify our work on Promise 26 to make a positive difference in this area.

1.5 The detailed work associated with the promise is being taken forward through the People and Teams sub-group of CLE. As a reminder**, the promise is not only related to racism**. The wording covers all forms of discrimination, and the Trust's commitment to address and fight such.

2.0 What action are we taking?

2.1 As with any effort to create and embed change, actions are needed in a variety of domains. However, the concern is to **avoid too many actions** that can distract from full implementation of the most significant steps, which help to tackle 80% of the problem. The Trust recognises that racism is endemic in wider society, but that does not mean that we are powerless to act, nor that

we should tolerate behaviours inconsistent with our constant values. We are tackling unacceptable behaviour from our patients and relatives; this is supported with the launch of our Acceptable Behaviour Policy which is live from the 1 October 2024.

2.2 We have policies to address allegations of racism, but as highlighted by our 2023 staff survey results, **not all concerns are being escalated via the policies**, we must address this to see a change in the Trust. To support this the implementation of such policies is being refined to ensure that the pace and rigour of application matches the intention. We have reiterated that 'how offended' someone abused is, has no bearing on the case at hand: RDaSH as an institution is not neutral. This avoids unwarranted claims of mitigation based on 'not knowing someone would be offended by x'. We are hopeful that as colleagues see clear and decisive action, increased reporting will follow. As a result, our investigations relating to racism will increase, not because the issue is suddenly more prevalent but because our colleagues are now reporting it through the policy suite and not just the staff survey. To support this, we are also looking to r**etain external investigators** from minority ethnic backgrounds, who will receive further training to support any investigations.

2.3 Mandatory first line manager training starts later in 2024 at the Trust. This will include specific learning related discrimination and racism. Active bystander training, and broader space to consider issues of diversity and discrimination, will form part of the Leadership Development Offer for our most 'senior' 150 staff, which goes live from January 2025. This will be further enhanced by the First Line Managers Induction programme which also launches in October. Our manta being, '**if you walk by it, you stand by it'** and this is not an acceptable approach for any colleague, especially our managers.

2.4 The new five-day induction starts in October 2024. This too will include space for new RDaSHians to explore their expectations, and ours: this will include discussions about bystander behaviours and how we can work together at local level to set clear expectations for how we respond, including to micro-aggressions.

2.5 **Organisational training modules will remain available to all staff,** and the creation of Learning Half Days provides an additional place through which teams can learn and discuss exclusion and inclusion. We do not plan to add further mandatory training into our portfolio, from any domain, but will review that issue on a rolling basis alongside the national training review.

2.6 The Trust has been historically active in supporting reverse mentor and other programmes among employees. We wish to reinvigorate that work and are bringing reverse mentors into each of our CLE sub-groups, as we look to ensure diversity within those ten groups. This approach is not from all excluded groups: it is intentionally drawn from employees from BME backgrounds. Wave three of the reciprocal mentoring programme has recently launched in South Yorkshire, and as in previous waves RDaSH have a strong presence as part of the programme.

2.7 National policy suggests that senior leaders within the organisation have a DEI objective within their annual appraisal. This has been achieved for 24/25, with all Executive Group members adopting an individually tailored and meaningful objective for this year. During 2024/25 we intend to reframe for future years our **organisation-wide appraisal policy/approach**, and within that work consideration will be given to what approach we wish to take among line managers and potentially all employees.

2.8 The effort to give higher priority to our REACH network (and other networks), as part of the Trust People Council, speaks to a similar emphasis; as does work supporting internationally educated colleagues.

2.9 Following feedback from the REACH network and ARA, we are seeking accreditation in this area, possibly through the **Northwest accreditation** framework. This is also being explored by several local NHS Trusts, which would support collaboration, provided this does not detract from the pace of work within RDaSH. The accreditation, whilst initially on one protected characteristic, will then be considered for all protected characteristics.

2.10 We are undertaking a **review of our recruitment processes**, end to end, to ensure consistency, fairness, transparency and eliminate race discrimination. This will include the inclusion of a global majority colleague as part of the recruitment process. This is not a tokenistic measure as colleagues will be involved in all aspects of the recruitment process and not just the interview, including the job evaluation process associated with Agenda for Change job matching/evaluation. Given the scale of our recruitment, this will be implemented on a phased approach, initially focussing on Band 4 and below recruitment.

2.11 Another area of focus is the talent management of our global majority colleagues, to further enhance their promotional opportunities within and outside of the Trust, building on colleague's extensive skill sets and previous experience, whilst positively changing the diversity at a senior level across the Trust, below our Trust Board and Top Leaders Cadre.

3.0 WRES data

3.1 The Trust WRES data submission is due by the end of October 2024, this will be reviewed in October 2024 by the People and Teams sub-group of CLE and People and Organisational Development Committee. **The WRES submission focusses on 9 metrics** in total, take from Electronic Staff Records (ESR), recruitment, disciplinary and training data sets and also the NHS national staff survey. Again, as a reminder, our 2023 staff survey results, as seen in Board in March 2024, highlighted the significant work we need to do in this area, hence the work that has taken place to date and the continued work/focus in this area, the deterioration in the NHS Staff Survey scores in the area of Bullying and Harassment is reflected in the report. Given the time delay in the annual staff survey, (the 2024 survey goes live on the 23 September 2024) we are unable to analyse whether the work completed to date this calendar year has had a positive impact.

3.2 Whilst the data/results will be reviewed within our governance structure, this will not result in further actions or action plans, but a concerted effort to successfully deliver and implement the previously agreed areas.

4.0 What does success look like?

4.1 We are keen to ensure that the work in this area does make a difference to address the challenges rather than producing an action plan which has limited impact. The success measures for Promise 26 have been developed as a baseline, our collective efforts will help us to:

- Implement a suite of policies and practices to Kick Racism out of our Trust
- Tackle and eliminate our WRES gap by 2026
- Close our gender pay gap by 2027
- Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with those reflecting a global majority

4.2 All of which will improve the working experiences of our colleagues and our communities, which we expect to be reflected in improved staff survey questions in future years.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Objective 4	**Agenda Item**	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	26 September 2024

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

The paper is the fifth and final in a routine series covering each strategic objective. The item's purpose is to provide space to discuss the complexity and difficulties anticipated as we begin to implement. The item also maintains Board focus on our strategy. Over recent months, I have been convening clinical executive colleagues alongside our Chief Operating Officer, to try to structure work on inpatient improvement – hence submitting this paper in *my* name.

There are two underlying challenges faced across this objective. The first, we have debated as a board before – divergent views, or perspectives, on what is high quality therapeutic care. The second, much more practically, is the implementation or deployment model into shift based multi-disciplinary teams, providing night and day care.

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

SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

x	**RECEIVE** and discuss the issues cited in the paper

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

Trust Risk Register							
Strategic Delivery Risks	X	SDR 1 and SDR 4					
System / Place impact	X	Significant focus for ICB and NHSE efforts					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	But pre full implementation both required
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Annex A – data on current out of area placements

Rotherham Doncaster and South Humber NHS Foundation Trust

Strategic Objective 4

Deliver high quality and therapeutic bed-based care on our own sites and in other settings

Toby Lewis

Chief Executive

September 2024

RDaSH nurturing the power in our communities

1. What is the Board being asked?

1.1 All Board members have contributed to developing the strategy, and its objectives. We have agreed to use each meeting to re-discuss and explore each of the objectives. Today we want to look at Strategic Objective 4. This is part not of changing or adapting the specific objectives but having time to consider the real meaning and intent. Colleagues understanding of the objective will evolve, and new ideas will become important or have greater salience.

1.2 The Board is being asked to discuss the six promises and consider *what is difficult in each.*

2. Why have we agreed this as one of our strategic objectives?

2.1 Bed based care may be an appropriate setting for a proportion of patients, for a period. Bed use generally in UK-healthcare has reduced starkly over recent decades, and for adult mental healthcare, the 1980s and early 1990s saw a substantial shift from much larger scale, and remote facilities (sometimes labelled as asylums). Evaluations of the transition of care into less restrictive, more community-based models have tended to validate both the direction of change, and the positive impact felt by patients and carers, as well as professionals, from these changes. Arguably, 'physical health services' exploring "Darzi shifts" have something to learn from these experiences, perhaps especially the routes to public acceptance and support for change and the transition of professionals' roles and settings.

2.2 The emphasis of the bulk of promises supporting this objective are best understood under the guise of:

- Appropriateness, including value to the patient – maybe best considered under the effective domain of the CQC framework
- Suitability, including fit to need – possibly reflective of the responsive domain of the CQC.

It is assumed as a principle that we will offer safe models of care. Our promises and objectives do not seek to stretch this, as safety is a baseline, where our work assumes quality is an adaptive construct.

2.3 The promises reflect a belief that the status quo does not always achieve either a responsive or effective provision. Importantly, at promise 18 and 22 especially, we have been explicit that this is not merely a consideration of scale or location. **We are also wanting to explore the nature of the care offer we give and whether it is therapeutically relevant to a diagnosis, or diagnoses.** The Board has discussed previously the limited insight data currently gives us into our community-based services; and for inpatient care, our diagnostic coding is retrospective, and our outcomes not yet set against either patient-led expectations or peer comparisons.

Promise No.	Promise	Board committee involvement	CLE group	Which plan the Promise is in
18	From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Quality	Quality and safety	Quality and safety
19	End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Quality	Operational management group	Quality and safety
20	Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	Public health, patient involvement and partnerships	Digital transformation	Research and innovation
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.	Public health, patient involvement and partnerships	Clinical leadership executive	Equity and inclusion
22	Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Quality	Operational management group	Quality and safety
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.	Finance, digital and estates	Estate	Estate and sustainability

3. Congruence

3.1 It is worth acknowledging that the inclusion of two of these promises requires some explanation.

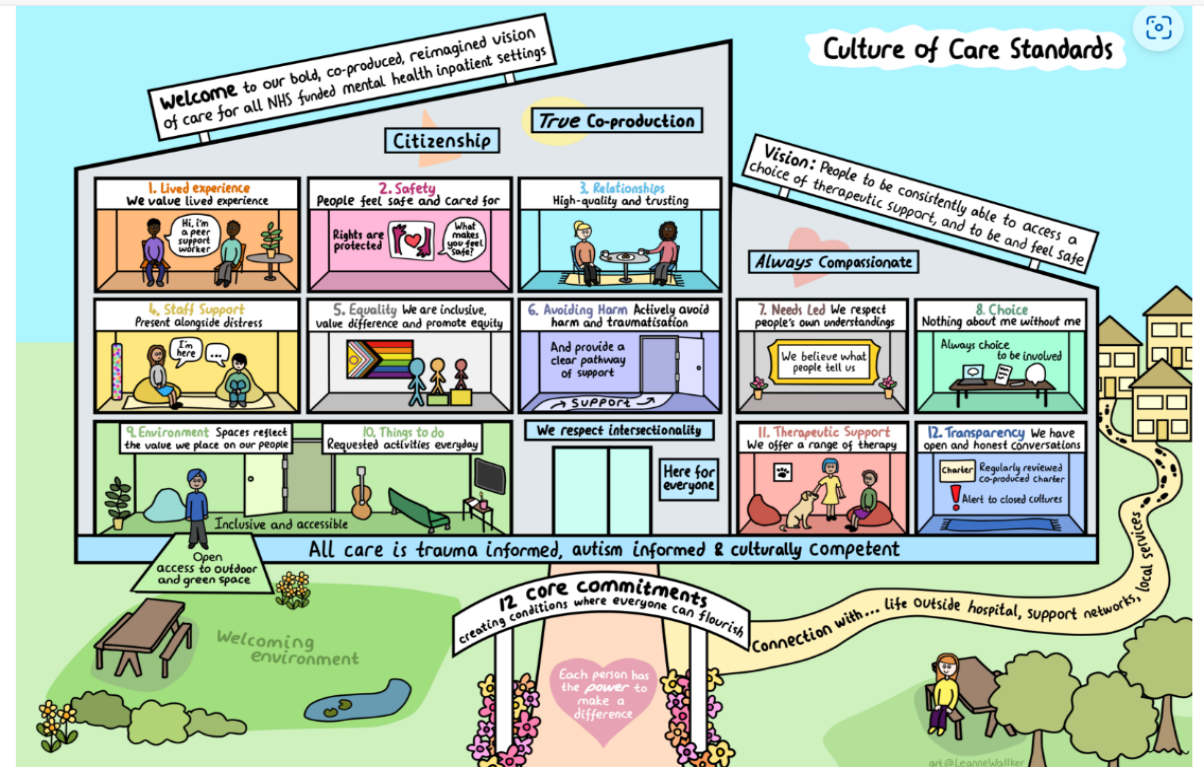
- In summer 2023, promise 23 was considered in some documents as part of the wider objective 5. Whilst potentially such investment work may well reach into a variety of pathways offered through the Trust, for example in support of home first approaches, it is now felt best consider this within our fourth objective where the bulk of current improvement work through strategic development is being focused.

- Promise 21 is undoubtedly less readily narrated and remains the single promise where we have not settled on success criteria. There are good reasons for that hiatus, as we explore priorities and plans notably with local authority and general practice colleagues. The original, and retained, intent of the promise was that it supported high quality care that was able to shaped on a continuum with primary care and the third sector: it was never envisaged that this was solely bed nor 'inpatient' focused. It does however remain important that our crisis, outreach, admitting, and discharging practice works seamlessly with primary care teams.

Promise 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.

The implication of this promise is that, distinguishing specialties or pathways or populations, we will reflect on what we currently offer and consider how it meets need and best practice. A first step in that analysis is to develop greater *consistency* across our three bed-holding acute directorates, and to continue to work to improve care within our physical health directorates. Older people's care merits particular consideration, having been recognized within our restructure feedback, as lacking profile and emphasis. CLE has considered a wide-ranging paper on opportunity (cited subsequently at Board in July 2025); and changes to the model of care within Doncaster are due for implementation in 2024.

The likely second step is to then consider systematically by diagnoses, the pathways we have that include inpatient provision. We need to have confidence that the *expertise* is available relevant to those patients, and in a timely and consistent manner. We know, for example, that we have work to do to better support patients admitted who also have autism (both from a specialist and a general training and awareness point of view). Our third dimension is to assess and enhance the *trauma-informed nature* of our ward-based care. We had intended to use the ROOTs model to assess this but are mindful of NHS-wide aspirations to test ward based care through a set of a dozen 'culture of care' standards (we are considering how we blend both approaches). The national standards are illustrated below. During November we intend to pilot an analysis, because critically we need to commit to one approach to this over time – and in a manner that is meaningful for patients, carers and colleagues, on a cross-profession basis.



Where is the challenge?

There are perhaps two material challenges to consider.

The first is highlighted within the cover sheet. Across individuals, by professional tradition, among patients and with carers, **labels like high quality therapeutic care mean very different things to different people.** We need to cohere these views without losing precision. To be effective in implementing the best models of care we need to be clear behaviourally what is sought and find a language that is shared and well understood. The Trust, in promise 1 and in this promise, has acknowledged the key role of peer support workers, and those more widely with lived experience, as offering a different expertise to that of professionals: distinct not superior. Even if we achieve greater consistency of how care is delivered, day by day, and across facilities, we need to test whether the outcomes of that care, as well as the experiences of it, are optimised. Measures such as length of stay or unanticipated re-admission are poor proxies for this, but all too often are the easiest to record and assess and compare. Our current models of analysis, for instance, peer review offer a snapshot view of experience, and some pass/fail standards, but do not seek to consider whether someone's time in our ward is improving their health or stopping deterioration. To make progress on this question we will need to marshal SPA time, research effort, and audit time in 2025/26 or 26/27 (having assessed this priority against others).

For this promise, *implementation challenges* can be highlighted. By the nature of ward-work those offering care, work shifts, are drawn from a variety of professions, and have very limited 'downtime'. Accountabilities are sometimes not wholly clear. A ward manager, for example, is responsible for some of the staff within the ward, and for the overall environment of care (but not accountable for other professions working within that space). Our wards look after a range of diagnoses and cover a number of pathways. What this means is that commonly used change techniques in these facilities (champions, promotional noticeboards etc) have very little prospective prospect of success: even if they are popular because they are visible. **We need to be truly choiceful** about how an endeavour to accomplish changes or improvements can best be deployed. There is intensive work going on to try and cohere into a single space all of the intended improvements desired for our ward-based care, so that any efforts are intentional and not sporadic or temporary. It is likely that developing ward-based leaders will itself require focus and investment to embed ongoing leadership skills within our wards. The research work on Reducing Restrictive Interventions may offer us some insights into deployment of changes techniques that can be effective within these environments, albeit this is not entirely multi-professional in nature.

Promise 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.

The context to this commitment is widely understood within the Board, and the impact of being cared for away from home is seen rightly as poor-quality care, if safe. It will be evident that during 2024 we have *not* have ended out of area placements. The adoption of revised budgeting will shortly give us some new tools to make changes in provision, and work to address extended length of stay will create capacity. There are three 'groups' of patients placed distally, albeit each is highly individual.

- General (acute/intensive care) placements: these are argued to be those that the Trust has services to accept, but capacity often means we cannot, or cannot at the moment of admission.
- Specialised/personalised placements: these may be where no suitable service exists locally.
- Choice: for some patients admission elsewhere is their preference, for example if they are known to local NHS staff through their employment.

Annex A illustrates the scale of current placement away from home. Whilst the NHS would regard any placement within RDaSH as acceptable, we chose to separately monitor so-called 'internal out of area placements' which fail a common-sense test (ie Rotherham to Barton). Over 70 patients for specialist placement are not reflected in our in-house data.

Whilst specialist expertise and capacity are highlighted as critical dependencies, timing matters too. Work done during 2024 illustrates the significance of out of hours decision making, or decision making made late in a week as discharges cease. Some interventions to hold risk and make MDT decisions about best interests have had a positive effect, but we need to avoid creating a hidden waiting list of people waiting placement at all (unless doing so is palpably better quality than placement).

Where is the challenge?

The term 'OOAP' implies singular or at least common cause, as does the summary above. In practice there is much difference among the pathways, patients, and decision making involved. Developing the skills of those involved in assessing options and problem-solving placement cannot be overlooked. Nor can **the burnout experienced among professionals involved in this work,** often day after day. Though some of those involved work for RDaSH, many do not. We need to ensure that we can create spaces to process and understand these individual perspectives as well as to manage the process and quantity issues that can be the ordinary discussion.

The creation of private sector units which then offer placements not available has not simply occurred as a function of flows of money. NHS Trusts has sometimes chosen to step back from particular cohorts of patients or forms of care, either because they are difficult to staff, or **they bring regulatory risk** through the complexity involved. In, implicitly, moving back into offering specialised short term care placements, we need to be realistic about those renewed risks, and clear-minded about whether such placements are time-limited. It should not be the case that being locally placed, or within an NHS Trust, slows down the urgency of work to create next steps that work best for a patient in recovery or during rehabilitation, but we need to be watchful that this does not occur. Whilst 'out of sight' placed away carries that risk, here at home in a 'place of safety' does too.

Promise 20: Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.

This promise sought to build on strength. The Trust has worked hard to create a virtual ward service for Doncaster registered residents, alongside the local acute hospital. There is an acknowledgement of the potential that similar programmes may offer in areas where we do provide services (AMH) and areas where we presently do not (IP Childrens' services).

Our research priorities recognise the potential for assistive technology in how we structure care and who offers care. Bearing in mind challenges raised below, we will want to consider how we build the 'case' for models that work – leaning into wider national studies, as well as maintaining our effective use of case studies (such as Mavis who front-covers our strategy).

Where is the challenge?

Many patients who experience virtual care models are very positive about them. Others, including those who never have, may be more cautious or anxious. Loved ones and relatives may experience, likewise, some anxiety about a novel model, or perceive the model as lesser, or cheaper, care. So public **acceptability** is not a barrier, but it is an issue to pay attention to.

Working through virtual models requires other individuals, and clinicians, to adapt their practice. There are specific skills needed where remote working is involved. This **adaptability** applies too to models of regulation, funding, and commissioning. For example, the present NHS Virtual Ward model privileges the supervision of a hospital-based consultant medic. This was done for reasons of acceptability and relevance to admission avoidance, but it can be a specific barrier to best use of these approaches – and there is limited experiential study of CQC approaches to understanding such models in the field. They will likely rely on our governance, and we need to make sure that we too have adapted to include such models.

The **technology** to support virtual care is in place but it is also evolving. We need to have confidence in this technology, its interoperability with other tools including records, and respond as the market evolves. Of course, it may also cause us to take an active interest in the level of digital exclusion our patients experience and the wider digital infrastructure (5G, 6G etc) in our communities.

The NHS has not yet, at any scale, **applied virtual ward** approaches to mental health services. This promise commits us to that work. We have developed an outline programme to do this, and are thinking through the relative priority, the resourcing and the right test sight for this: consistent with our wider approach to crisis provision, assertive outreach and other teams. Bearing in mind, our adoption of Oxevision, and the ethical issues this has given rise to, we need too to consider what level of intrusion, visibility and retention we might envisage.

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 foundational promise is held and owned across Clinical Leadership Executive. That reflects the many and varied ways in which it could be delivered. But it is also reflects what is essentially a commitment to deepen a set of relationships. Our own analysis, for example in the SDF, suggest that those need to be broadened in their reach, and deepened in their trust. We are working through the balance of central (corporate) action in both areas – primary care and VCSE – and care group led work. Importantly in none of our places is only one Care Group relevant – so they also need to work in concert.

The coordination of care responds to the very consistent patient feedback we receive about 'handoffs', challenges of communication, and difficulties knowing how to access help or support. Whilst this is not an RDaSH only issue, we know we have work to do to co-create, manage and evaluate some consistent standards.

Where is the challenge?

There are three ideas woven into this promise: support (not lead), coordination of care (as an experience our patients narrate) and hyper local, which implies aspects of variation. Many parts of that element are not necessarily well developed currently in our system. The LDO is intended in part to help us to develop shared leaderships skills – and the community incorporation within that deliberately picks up elements of this concern.

The NHS struggles to do 'hyper local' (small). The Board engaged in a detailed discussions with North Lincolnshire Council within our January 2024 meeting about the South Scunthorpe project – we tried to 'buck' the typical by trying to direct a very strong focus solely on the SMI population of 500 people. Hyper local should not, must not, only be seen as a precursor to scaling up or replicating – it can be a response in itself.

Yet perhaps the big challenge therefore here lies in prioritising this? Both collectively and as individuals.

Prioritising it necessarily means returning to the workplace and adapting a part of what we do, for a part of a service. That incorporation of intentional variety – and managers feeling able to go do, to go try – and that their colleagues will lean into that – is a precondition for being effective in mobilising against this promise.

Promise 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.

Variation between the care we offer overnight and that provided during the day will often be a suitable approach. Rest and sleep for patients, and the health impacts of shift work and night-time practice, are widely understood – though both may merit greater focus and structured study.

This promise focuses instead on variation across seven days. It inherently challenges longstanding patterns of bank holiday and weekend arrangements, but it also should cause us to examine support that is 'only available once a week on a Tuesday' etc. It does not insist on changes to the status quo. Nor is the word consistent the same as the word uniform. But it implies intentionality and reflective design. There are two areas of care work where we might focus initially: the pattern of care within our inpatient facilities, and the service models that support and those that impede) the urgent response standard we set under promise 14.

Our challenge

This promise is of sufficient complexity that its risks feature in our SDF. The specific risk in that SDF is **the "first mover" challenge**. Whilst often within public services and the NHS we acknowledge the need to 'smooth' workload across the full week, month or year, the human reality for teams is that that imposes significant burdens on home life. Pattern of schools, family relationships and much else reflect weekend difference for many people. Faced with an RDaSH that moves to seven days, and an SHSC/TEVS/Navigo which does not we need to recognise the retention or recruitment challenge posed.

It is not immediately obvious that the same reluctance applies to carers, families and patients. Indeed, potentially the obverse: socialisation and engagement may be increased over a weekend where loved ones are not working, and daylight travel is possible even in winter. Where loved ones live a distance away, the scope to engage may be enhanced. Some staff teams suggest that this can create issues of scale – with large, extended family involvement in care settings adding complexity to communication.

The first step must be to **win the argument that weekend discharge itself is safe**. Services locally have grown up persuaded, from experience or evidence, that the paucity of some back up support over weekends is problematic. Overcoming these concerns will require consistent and determined practical intervention. A small element of that intervention has to be to then be ready for admissions (purposive admissions) into emptied beds over Saturday and Sunday. Models of 'once a week' expert input may need to be challenged.

There is **a cost to taking this forward**, as well as a price to the status quo. NHS terms and conditions pay differently 'out of hours' (medical DCC are 25% shorter, many other roles are paid an enhanced rate). Flexible working parameters that we would want to enhance and support may create an impression that the 'extra' of weekend working will fall disproportionately on a smaller group of near-full time colleagues.

Promise 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.

The expansion of our forensic community bed base took place in 2024. Significant bilateral discussions with housing associations in respect of adult mental health have been ongoing through the year to explore options for collaboration. We would expect during 2024/25 to have probably two material proposals to determine, and taking one of these may stimulate other partnerships and ideas. Within our physical health care group, we are finalizing future proposals for neurorehabilitation, as well as considered acquired brain injury service models which contribute to promise 19 and may be progressed with a strong emphasis on community step down support. The Trust, Doncaster RI, and ICB partners are developing proposals as part of the borough priorities which include the possibility of introducing step-up frailty services locally, potentially within the future redevelopment of the Tickhill Road site.

Our challenge

Full use/full buy-in? The Trust already has existing provision outside 'hospital', in that crisis beds form part of the consistent Doncaster and North Lincolnshire offer. In Rotherham funding is intermittent. But occupancy varies. This reflects a range of factors including familiarity among clinical teams and partners, and oversight. Where provision is not led through the Trust sometimes issues of client complexity, or fit, arise. Over the past decade a variety of local initiatives relevant to this promise have occurred and ceased – projects in this field will not be new. But that impermanence itself can act as a disinhibitor to colleagues leaning into the latest iteration. There appears significant acceptance in theory of the opportunity such units/spaces could prevent, but an anxiety that their creation will deplete "core" facilities, such as wards.

We do need to consider **public and community acceptability**. By their nature, or intent, we would want such facilities to blend into normal neighbourhood life. But we want to ensure the safety of all residents (patients, carers, neighbours), and of our teams. Acknowledging stigma does not validate it. Such blending in also matters to working to avoid community-based units drawing in behaviours and relationships which are not conducive to recovery. For some patients being separated from past relationship influences and norms is very important. The closed and removed space of a ward can offer that (thought it can create different manipulations), and we need to design and consider how our community-based spaces can meet those advantages.

Fixed/flexible? There remains a capital funding challenge. IFRS16 limits the scope we have to create operating leases as a typical response to the CDEL restrictions. This may suggest that we are seeking not to own/operate but primarily to provide the clinical oversight and support to others who bring housing, social, and reablement expertise. Current discussions reflect a diversity of potential approaches. One consideration is through our patient's eyes: moving to what used to be labelled a 'discharge' or 'halfway' space is not a home. Its transience does not offer options to establish new routines because it is not for the medium term. An alternative is to work with patients to support them in a new rental, and for 'wrap around' services to then be the party that moves on somewhere else. That approach with a housing provider with significant stock would mean that the transfer is only of patient/location, not the wider MDT. This flexible abode approach may be a better model for outcomes – or certainly one that merits research and potentially trial.

Annex A: Patients placed out of area

Internal out of area

Internal out of area placements are viewable here (correct as of 18th September 2024):

Patients in Rotherham Internally OOA (7)

Name	Current Ward	Home ICB	M/F
S L	Osprey	Don	F
H G	Osprey	Don	F
C S	Osprey	NL	M
S R	Osprey	Don	M
D H	Sandpiper	Don	F
L R	Sandpiper	Don	F
G V	Sandpiper	Don	F

Patients in Doncaster Internally OOA (0)

Name	Current Ward	Home ICB	M/F

Patients in North Lincs Internally OOA (5)

Name	Current Ward	Home ICB	M/F
K S	Mulberry	Roth	F
A Q	Mulberry	Don	F
L B	Mulberry	Don	F
R H	Mulberry	Roth	M
S B	Mulberry	Don	M

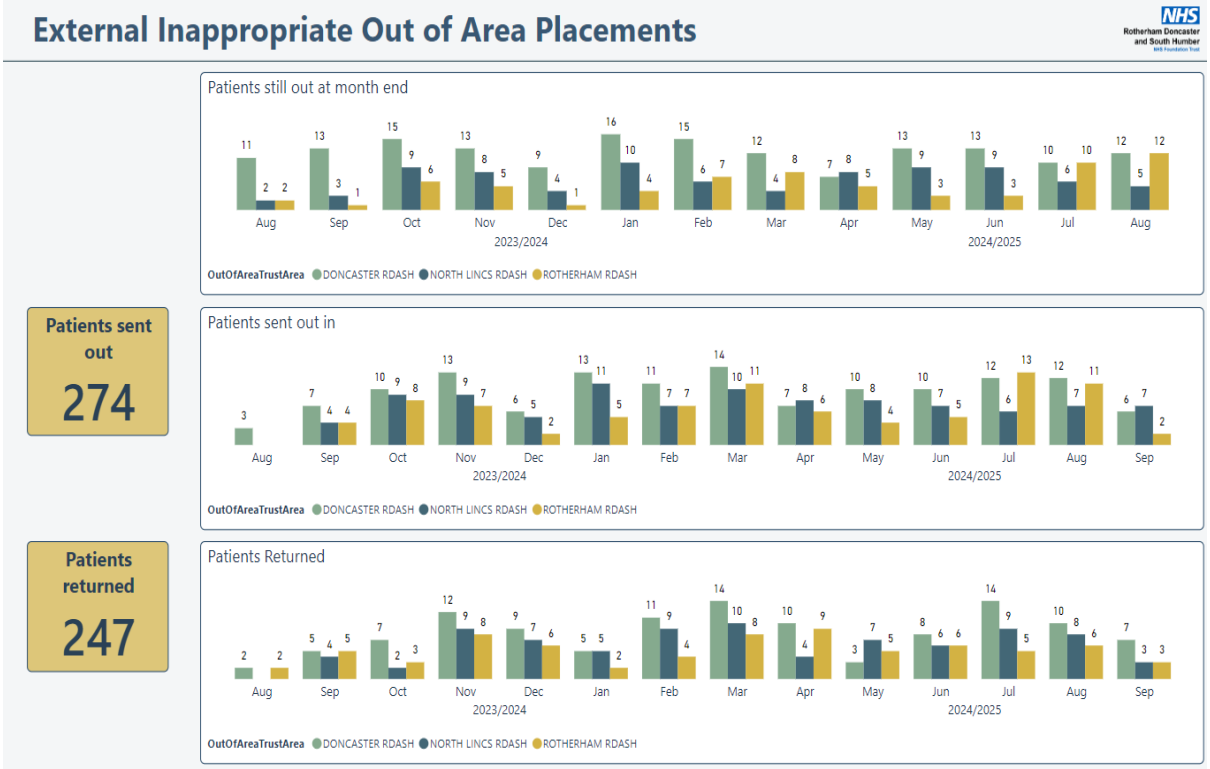
The number of patients placed internally out of area **for the past three months** is as follows:

Home location	June	July	August	September
Doncaster	15	11	7	10
Rotherham	3	4	6	8
North Lincolnshire	4	2	4	4

Inappropriate out of area (national reportable definition)

Inappropriate, or non-specialist out of area placements can be viewed for the past 12 months in the PowerBI extract below. This chart shows the number of patients still placed out of area at month end by area, the number of patients sent out of area every month, and the number of repatriations by month.

As you can see, Doncaster is our biggest area of concern every month:



'Appropriate' out of area: RDaSH only

Specialist out of area placements equally don't have the same PowerBI report access but this chart demonstrates the number of patients still placed out of area at the end of every month through our Trust. There is a much larger volume of patients (c70) managed through our ICB colleagues. A single ICB wide OOAP report commences circulation this month.

	June	July	August	September
Doncaster	1	1	1	2
Rotherham	2	1	1	1
North Lincolnshire	0	0	1	3

Victoria Takel, Deputy Chief Operating Officer

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Our future bed-based care arrangements – update	**Agenda Item**	Paper N
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Richard Chillery, Chief Operating Officer, Victoria Takel, Deputy Chief Operating Officer & Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	26 September 2024

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

Our wards, and patients' bedrooms, are places of care. Inevitably this paper considers quantity, but nothing in the paper should detract from the recognition that we need to get pathways of care optimised through the eyes of our patients and line with SO4.

The paper makes explicit that the Trust has an opportunity to:

- Reduce rates of admission and improve community services
- Reduce length of stay for some patients in our care
- Reconsider the configuration of specialty care

The paper does not consider issues of environment, nor reconsider single sex provision which is presently compliant with regulations but will be re-examined during 2025/26.

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

Previous consideration

A related version of this paper was explored at Clinical Leadership Executive – July 2024

Recommendation

The Board of Directors is asked to:

X	**NOTE** work being done in our organisation on the future bed base for inpatient care.
X	**RECOGNISE** care group changes during Q3 in rehabilitation services
X	**CONSIDER** the work's relevance to the emerging clinical model which will sit at the heart of our forthcoming Estate Plan

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

Trust Risk Register	X	O 10/19, RCG 8/24, DCGMH 5/23
Strategic Delivery Risks	X	SDR 4
System / Place impact	X	Mental health inpatient transformation programme

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

Board of Directors – September 2024

Our future bed-based care arrangements – update on *work in progress*

1. Introduction

1.1 Throughout 2024/25 we have been examining the utilisation of our bed-based resources, with a focus on adults, intensive care and older adults on our sites. This work has led directly to two interim ambitions:

- Ensuring that every person with us as an inpatient have a **meaningful expected date of discharge** (EDD) that reflects multi-disciplinary consideration, the involvement of that person and their loved ones, and that is, typically, adhered to by all agencies.

- Successful work to identify very long length of stay admissions, and expedite care packages as indicated, and now, to routinely **focus on 'complex' pathways and patients** to ensure that ward teams are supported in marshalling the resources of all public bodies.

1.2 This paper does not consider forensic services nor 'physical health'/frailty beds. The former are subject to consideration across South Yorkshire, and the latter form part of two pieces of ongoing review work: on frailty in Doncaster (led by our CEO) and on neuro-rehabilitation services (led by Cora Turner). The Board, in January 2024, held an in-depth discussion about bed-flow, and patient care, and this paper does not replicate that material.

1.3 **The paper summarises the current, and historic, use of our bed-based resources. It has been developed to scale, and specify, where action might be directed first, and what long-term bed base the Trust might seek to retain**. In 2023, we chose to close Goldcrest ward in Rotherham, and in October 2024 we will close the Emerald Rehab unit in Doncaster. In both cases reinvestment in expanded Assertive Outreach care has been the motivation for change, alongside better use of resources. However, for current and future colleagues working in inpatient care, it is important we can offer clarity about the, for example, three year forward view.

2. Strategic leadership of our future bed base

2.1 Strategic objective 4 of our agreed strategy indicates an intention to alter the bed base that the Trust has. The promises allude to a variety of change, including but not limited to:

- Introducing virtual wards to be better support patients at home
- Developing alternatives to ward environments, including on a residential basis and

- Ensuring that patients are only with the Trust on an inpatient basis when a meaningful therapeutic activity is in place

2.2 Alongside our commitment to cease out of area placements that are not the patient's choice or clinically unavoidable, the objective suggests significant changes to our *mental health* bed base: its scale, location, and role.

2.3 Graeme Tosh (now Diarmid Sinclair), Steve Forsyth, Richard Chillery, Jude Graham, and Toby Lewis have been meeting over recent months in order to consider the implied changes and to:

- Develop a process through which to **re-imagine the admitting process** to our wards
- Consider **a single programme of work with multi-professional ward teams** on the therapeutic quality of what we do, including our journey to CQC improvement
- Oversee changes to how we document, track, and **support safe discharge for all inpatients**, including complex discharges.

2.4 It is understood that the work above has implications for our wider plans. This includes our forthcoming Estate Plan, now likely to be near finalised later in 2024 or early 2025. That work is also informed by our choices over Out of Area Placement models, and funding: because addressed some specialised 'out of area placements' may require the creation of new facilities. We need to ensure that the existence and location of such future commitments is made conscious of the future shape and scale and location of existing wards.

2.5 Finance is not a prime driver here for change. However, it is recognised that we need to meet our financial obligations each year. For 2024/25 we committed to reduce our bed-base costs by £500,000 in year. Looking forward, we might expect that if we wish to develop community-based alternatives for our patients, and meet our cost improvement duties, that re-cycling some expenditure presently within our inpatient bed base may be needed.

2.6 No estimate for 2025/26 nor 2026/27 has yet been made, and the work of the Collaborative through Akeso will also inform our considerations. Colleagues, especially in SHSC, are working on their future clinical model, and once we have a draft proposal, we will examine bilaterally any synergies that may exist across South Yorkshire – and indeed across North-East and North Lincolnshire. We recognise the work being done in North Nottinghamshire and in Hull but have judged it not material to our present or future configuration of secondary care provision.

2.7 The Board will appreciate that a new Mental Health Act will be legislated for over coming months. The timetable for post-assent implementation is not yet confirmed. Nor are the implications for our work yet assessed. It may seem reasonable to anticipate that the new Act will place greater reliance on alternatives to formal admission. Currently approximately half of the inpatients we support are informally admitted, albeit a proportion of those people may be subject to detention under the current act, were informal arrangements not in place.

3. Developing our workforce

3.1 Paragraphs 1.1, 1.3, 2.1 and 2.3, above, all convey implications for our future workforce model. Discussions about our bed-base should not simply consider the number of employees needed to provide safe care, but also the scale and skill-mix of professions, as well as the role of peer support workers. The new directorate training plans being developed through Carlene Holden and Jude Graham, are informed by in particular revised career development pathways plans for AHP, nursing, support worker, and psychological professionals. In 2025 we will revisit with the Chief Medical Officer and Care Group Medical Directors the future staffing model for trainee, consultant, and specialist doctor roles. Our incoming professional lead for social work, who joins us in Q3, will be asked to explore, given changed patterns of service from relevant local authorities, what we need to retain and support among our adult social work teams within the Trust.

3.2 Our implied approach to acute care since 2023 has suggested we wish to develop greater permeability between our staffing and clinical model for inpatients, and that for other teams. Our acute directorates intentionally combined the Crisis Service and ward-based care. In older peoples' care we have seen staffing proposal developed that increasingly support staff reaching across ward units and other teams. As we develop our plan for the bed-base in 2027, we need to be mindful not only of the staffing models that are implied, but also how attractive or otherwise such 'transformed' models might be.

3.3 Without pre-judging other work which consider the future of older people's care at the Trust, we need to explore the boundaries we have established through our inpatient configurations and services. This is perhaps especially true for dementia, where ourselves, acute hospital colleagues and others, have services in place: and with rising need, we need to understand the best future scale and configuration beyond our own organisation.

3.4 The Board considered a broader analysis in May 2023 of the Trust's multi-professional workforce against peer comparators. At that time, we recognised that in some disciplines the number and seniority of certain professions was among the lower quintile per head of population or against throughput. We also acknowledged that national published safe staffing analysis errs in being uni-professional in the way in which it considers ward-based safety. Notwithstanding good work since on confirming of ward staffing safety through a nursing lens, it remains important that we seek to develop, use, and understand a multi-professional model of workforce analysis, including at ward level.

4. Scale and shape of our future wards

4.1 We have begun, recognising uncertainties of purpose and workforce outlined above, to develop a dynamic model through which to both understand use of our bed-base (in due course to be expanded if promise 23 leads to 'off-site' beds), and to consider future needs.

This work is not yet completed but it is shared across the Board such that over the coming six weeks, colleagues have an opportunity to influence analysis and future versions. Our present intent is to seek in January

2025 to formalise, and potentially finalise, a three-year view.

4.2 At table A below, three potential scenarios are illustrated. More will be developed. The scenarios shown focus on:

- Reducing occupancy rates to create flexibility to address day by day pressure
- Managing length of stay closer to expected national 'norms', mindful that we are not yet operating with diagnosis specific LOS analysis
- Moving to admission rates closer to those expected – and by implication changing how we work to achieve that.

4.3 **Taking these assumptions together, the interim analysis below would appear to suggest that in future:**

- We will have fewer older peoples' beds within our bed base in future
- Unless we can reduce our admitting rate and LOS, we would need more acute beds, but
- The implication of meeting closer to average rates of admission and LOS would make it possible to accommodate out of area placements without additional beds
- We need further discussion and debate about the role of PICU beds within our organisation before we can determine how many beds we need, where they might be, and how gender / safety is best managed.

4.4 This analysis does not include distinct consideration, which we are leading within the collaborative, about 'specialist' out of area placements. There is some 'fuzziness' potentially between some specialised placements and both our intensive care and our rehabilitation bed base. The latter is explored further below.

4.5 In November and December, we intend to engage more widely on some key principles associated with this work. This is necessary because the quantity work can too easily lead to 'aggregation' that is efficient, and may offer 'flow' benefits, or even specialist workforce gains – but may limit, or be perceived to limit, access either for patients or for loved ones and carers. We might expect that engagement work would consider three ideas, or hypotheses.

a) That care should be provided at home and in local neighbourhoods where possible to do so

b) That medium and long-term care should be located where it is readily accessible to our communities, because that is supportive of effective long-term recovery

c) That specialist intensive care on a short-term basis needs to be delivered through a model that best balances patient access and the availability of an expert workforce

4.6 The implication of our agreed strategy is that hypothesis (a) is not yet optimised. A possible conclusion from our current data/performance is that hypothesis (c) is not presently short term.

Table A

Bed Modelling - Scenario A

90% occupancy, current median LoS, 0 OAPs.

Older People's

Rotherham	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance (100% occupancy)	Bed variance (100% occupancy)	Bed variance (90% occupancy)	Bed variance (85% occupancy)
Brambles	15	63	58	5475	425	3229	2246	6.2	4.7	3.9
Glade	15	89	52	5475	336	4291.7	1183.3	3.2	1.7	1.0

North Lincs	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	Bed variance (90% occupancy)	Bed variance (85% occupancy)
Laurel	13	55	55	4745	470	2555	2190	6.0	4.7	4.1

Doncaster	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	Bed variance (90% occupancy)	Bed variance (85% occupancy)
Windermere	20	37	100	7300	202.7	3497.3	3802.7	10.4	8.4	7.4

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Adult Mental Health

Rotherham	Beds	Median LoS (days)	Annual admissions	Bed days available (100%	Leave	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 23/24	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (90%	Bed variance (85% occupancy)
Sandpiper	18	32	165	6570	488	4792	1778	4.9	64	41	2624	-1.9	-3.7	-4.6
Osprey	18	42.5	160	6570	400	6400	170	0.5						

North Lincs	Beds	Median LoS (days)	Annual admissions	Bed days available (100%	Leave	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 23/24	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (90%	Bed variance (85% occupancy)
Mulberry	18	19	243	6570	555	4062	2508	6.9	60	27	1620	2.4	0.6	-0.3

Doncaster	Beds	Median LoS (days)	Annual admissions	Bed days available (100%	Leave	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 23/24	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (90%	Bed variance (85% occupancy)
Brodsworth	20	62	151	7300	415	8947	-1647	-4.5	107	43	4601	-14.3	-16.3	-17.3
Cusworth	20	42.5	156	7300	374	6256	1044	2.9						

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Emerald

	Beds	Median LoS (days)	Annual admissions	Bed days available (100%	Leave	Bed days required	Variance (100% occupancy)	Bed variance (100% occupancy)	Bed variance (90% occupancy)	Bed variance (85% occupancy)
Emerald	16	184	19	5840	236.3	3259.7	2580.3	7.1	5.5	4.7

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PICU

	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance (100% occupancy)	Bed variance (100% occupancy)	Bed variance (90% occupancy)	Bed variance (85% occupancy)
Kingfisher	6	11	94	2190	46	988	1202	3.3	2.7	2.4
Skelbrooke	6	13	113	2190	23	1446	744	2.0	1.4	1.1

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Headline Figures

At 90% occupancy, with current median LoS and 0OAPS RDaSH has:

a surplus of 19.5 Older Adult's beds

19.3 too few Adult beds

a surplus of 4.1 PICU beds

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Bed Modelling - Scenario B

90% occupancy, three older adult's wards with 32 day LoS, across adults and older adults, 0OAPs, admission rate improved by 25%.

Older People's

Rotherham	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance (100%	Bed variance (100%	Bed variance	Bed variance
Brambles	15	32	58	5475	425	1431	4044	11.1	9.6	8.8
Glade	15	32	52	5475	336	1327.7	4147.3	11.4	9.9	9.1

North Lincs	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance - Current	Bed variance (100%	Bed variance	Bed variance
Laurel	13	32	55	4745	470	1290	3455	9.5	8.2	7.5

Doncaster	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance - Current	Bed variance (100%	Bed variance	Bed variance
Windermere	20	32	100	7300	###	2997.3	4302.7	11.8	9.8	8.8

Headline Figures

At 90% occupancy, with 32 day median LoS, admission reduction by 25%, a redction of one 15 bedded Older Adult ward and 0OAPS RDaSH has:

a surplus of 22.4 Older Adult's beds

a surplus of 12.7 Adult beds

a surplus of 4.1 PICU beds

0 impact from Emerald closure based on these parameters.

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Adult Mental Health

Rotherham	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Sandpiper	18	32	123.75	6570	488	3472	3098	8.5	64	41	2624	9.9	8.1	7.2
Osprey	18	32	120	6570	400	3440	3130	8.6						

North Lincs	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Mulberry	18	32	182.25	6570	555	5277	1293	3.5	60	27	1620	-0.9	-2.7	-3.6

Doncaster	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Brodsworth	20	32	113.25	7300	415	3209	4091	11.2	107	43	4601	9.4	7.4	6.4
Cusworth	20	32	117	7300	374	3370	3930	10.8						

Emerald

	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance (100%	Bed variance (100%	Bed variance	Bed variance
Emerald	16	184	19	5840	###	3259.7	2580.3	7.1	5.5	4.7

PICU

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	Beds	Median LoS	Annual admissi	Bed days available	Leave	Bed days	Variance (100%	Bed variance (100%	Bed variance	Bed variance
Kingfisher	6	11	94	2190	46	988	1202	3.3	2.7	2.4
Skelbrook	6	13	113	2190	23	1446	744	2.0	1.4	1.1

Bed Modelling - Scenario C

90% occupancy, 28 day Older Adult, 32 day Adult and 7 day PICU median LoS, 0 OAPs, admission rates at national lower quartile

Older People's

Rotherham	Beds	Median LoS	Annual admissi	Bed days available (100%	Leave Days	Bed days	Variance (100%	Bed variance (100%	Bed variance	Bed variance
Brambles	15	28	54	5475	425	1087	4388	12.0	10.5	9.8
Glade	15	28	54	5475	336	1175.7	4299.3	11.8	10.3	9.5

North Lincs	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance - Current	Bed variance (100%	Bed variance	Bed variance
Laurel	13	28	77	4745	470	1686	3059	8.4	7.1	6.4

Doncaster	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance - Current	Bed variance (100%	Bed variance	Bed variance
Windermere	20	28	124	7300	###	3269.3	4030.7	11.0	9.0	8.0

Headline Figures

At 90% occupancy, with 28 day Older Adult, 32 day Adult and 7 day PICU median LoS, admission reduction to the national average lower quartile, aredction of one 15 bedded Older Adult ward and 0OAPS RDaSH has:

a surplus of **11.9** Older Adult's beds

a surplus of **1.9** Adult beds

a surplus of **9.7** PICU beds

0 impact from Emerald closure based on these parameters.

Median national admission rate of 202 per 100k ONS resident

Median national admission rate of 202 per 100k ONS resident

Median national admission rate of 202 per 100k ONS resident

Adult Mental Health

Rotherham	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Sandpiper	18	32	172	6570	488	5016	1554	4.3	64	41	2624	1.1	-0.7	-1.6
Osprey	18	32	172	6570	400	5104	1466	4.0						

North Lincs	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Mulberry	18	32	210	6570	555	6165	405	1.1	60	27	1620	-3.3	-5.1	-6.0

Doncaster	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance - Current	Bed variance (100%	OAPs 23/24	LoS	Bed days	Remaining bed variance (0	Bed variance	Bed variance (85%
Brodsworth	20	32	113	7300	415	3201	4099	11.2	107	43	4601	9.7	7.7	6.7
Cusworth	20	32	113	7300	374	3242	4058	11.1						

Median national admission rate of 214.72 per 100k ONS resident

Median national admission rate of 214.72 per 100k ONS resident

Median national admission rate of 214.72 per 100k ONS resident

Emerald

	Beds	Median LoS	Annual admissi	Bed days available	Leave Days	Bed days	Variance (100%	Bed variance (100%	Bed variance	Bed variance
Emerald	16	184	19	5840	###	3259.7	2580.3	7.1	5.5	4.7

PICU

	Beds	Median LoS (days)	Annual admissions	Bed days available (100%	Leave Day	Bed days requir	Variance (100% occupancy)	Bed variance (100% occupancy)	Bed variance (90%	Bed variance (85%
Kingfisher	6	7	33	2190	46	185	2005	5.5	4.9	4.6
Kelbrook	6	7	33	2190	23	208	1982	5.4	4.8	4.5

Median national admission rate of 55 per 10 beds (22/23)

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5 Rehabilitation pathways: one of many interdependencies

5.1 During 2023/24, a decision was made to close the Goldcrest Ward in Rotherham, and to support patients differently through our assertive outreach team. Subsequent analysis through the Care Group attests to the success of these changes: more complex patients are being supported through AOT and a larger volume of patients have been supported by the expanded service. CLE continues to explore how we ensure that Clozapine management is supported on an ambulatory daycare basis Trust wide, with different models currently used across our Trust.

5.2 In July, both CLE, and then the Board of Directors, were advised of planned similar changes in Doncaster. Emerald Ward has seen occupancy over the prior twelve months between 33-39%, with length of stay variation from under 40 to over 250 days. The Care Group, considering national guidance, best practice, and feedback from employees and patients, have determined that we need to establish a clearer more purposive model of care: and that a service not based on the ward remaining open is the right step from October. Due consultative process for redeployment of individuals has taken place. South Yorkshire ICB, through the relevant place director, have been fully involved, and support the transition of service, retaining legacy income at 24/25 levels in future contracts.

5.3 A post change audit of both the above transitions, against their defined success criteria, will be commissioned in Q1 2025/26. Ongoing monitored is and has taken place since. The specific audit is important in the context of ensuring that we continue to refine our rehabilitation models, with patients, and partners – and also as part of work to build trust around change alluded to earlier in this paper.

5.4 Rehabilitation services in *North Lincolnshire* have not previously been commissioned. This has resulted in service gaps, and potentially in out of area placements. The Care Group have had a proposal funded to address this, subject to confirmation of contract term duration during October 2024. This will not be based on a bed-based model, albeit the cohort of patients considered by this service are distinct from those managed through the AOT models above.

5.5 Finally, within the specialist out of area placement work for South Yorkshire, we are considering, within the Delivery Review cycle, proposals to establish 1-2 “locked” rehabilitation wards within the Trust during 2025. Such proposals would require funding endorsement from the ICB, who retain the income for such care. Opening these units would materially reduce the population of out of area placements. However, in addition to any fiscal considerations, the executive needs to confirm that discharge from such units can be achieved to a specified pathway and timetable, or these facilities will, as some closed rehab wards cited above have, become long stay beds within the organisation.

5.6 This element of this update recognises that rehab is only one interdependency that exists within our pathways. Whilst there are many others, in the admitting phase of care, we will be looking to consider whether observation or triage ward beds have value – or indeed whether a ‘mental health A&E’ is a medium term step locally.

6. Conclusion and next steps

6.1 The recommendations for Board consideration are outlined on the cover sheet. At paragraph 4.1, the authors describe the purpose of the timing of this Board update, and subsequent paragraphs outline work that is occurring during 2024/25 to:

- Change our bed base
- Engage widely over the principles of changes and
- Formalise during 2024/25 (Q4) our medium-term arrangements

6.2 We recognise that open dialogue on issues of this nature can create anxiety. However, in exposing these considerations we are looking to establish trust. It will be important that we can describe the positive gains associated with changes that are considered; and that such gains are estimated and then tracked in practice.

6.3 Changing the scale, location, and 'model' of services is an all-too-common managerial intervention. Improving the quality of care we offer will rest rather more on the second of the three bullet points highlighted at paragraph 2.3: accordingly we need to consider carefully the sequence of change across objective 4. Work on our safety and quality plan must reinforce and prioritise these considerations, even where that requires us to derogate initiatives or instructions from outside the organisation.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	**Non-Executive Patient and Staff Security Champion**	**Agenda Item**	Paper O
Sponsoring Executive	Steve Forsyth Chief Nurse Officer		
Report Author	Steve Forsyth, Chief Nurse Officer and Rachel Kumar, Assistant Director of Nursing		
Meeting	Board of Directors	**Date**	26 September 2024

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

For the Public Board to consider the role description and the 3 key objectives/responsibilities that are to be seen and felt by our Non-Executive Director for assurance, so not to seek reassurance, this approach clearly articulates the steps and plan to ensure the Trust and its commitments to staff and patient security are experienced rather than a set of data metrics that are presented to a sub committee with a narrative conclusion. Our staff and patient safety is, our priority and hence the approach outlined in this paper, that the organisation is taking for the Board to approve.

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	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	✓
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?)

Not applicable

Recommendation

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

Board is asked to:

✓	**RECEIVE** this report
✓	**CONSIDER** the recommendations
✓	**TAKE ASSURANCE** that the current process and also the points for development

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

Trust Risk Register	✓	DCG 23/24, T 2/24, FP 23/23, N & F 12/24.
Board Assurance Framework	✓	SDR3 and SDR4
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 – national and local guidance							

Executive Summary

In December 2021, the NHS issued guidance to all Trusts regarding non-executive champion roles – 'Enhancing Board oversight, a new approach to non-executive director champion roles.' From April 2024, the Board has in place a non-executive staff safety and security champion.

By a systemic assessment of the Trusts safety and security priorities, 3 key areas have been identified:

1. Lone worker arrangements
2. Appropriate behaviour policy
3. Reducing violence and aggression towards colleagues within our inpatient areas

This role assists the Trust in understanding the **personal lived experience** of colleagues and patients through spending time with them to understand their security and personal safety concerns at the point of care. In doing so this will foster an open, listening and learning culture.

When spending time with colleagues and staff they will test whether:

a) **all we can is effective**, and **as effective as it could be**

b) **is best practice**

With this information they will ensure these are attended to and help **influence and shape our plans**. This intelligence will be used to test work undertaken on safety, risk and violence prevention across several corporate portfolios, including that of the Chief Nursing Officer.

The role will not manage the Board's wider work on security management. Oversight for the wider roles and responsibilities outlined in the report.

6 month programme of work

Over the next six months the role will spend time reviewing and assessing the priority areas. For each **visible leadership** is key. The 3 priority areas broken down in the report have some prompts for methods of assessment and approaches to glean this information over the 6-month period along with a programme of work.

The overall focus though is spending time **listening** to our colleagues, our patients, and our partner organisations including people focus group, and other voluntary sector services. This information will be used to assess whether what we are doing is **listening and learning from their feedback** and what is being told to us through our reports to committees, with recommendations to the Board on what we need to do to continuously improve our safety and security agenda.

Introduction.

The board is reminded that in December 2021, the NHS issued guidance to all Trusts regarding non-executive champion roles. This was a helpful document entitled, 'Enhancing Board oversight, a new approach to non-executive director champion roles.'
Our Chief Executive at the beginning of the year, prior to the new CNO starting, discussed the specific role ascribed to Sarah Fulton-Tindall agreeing a set of principles which saw born the role of the non-executive staff safety and security champion.

It goes without saying that the safety of our patients, volunteers, carers governors, students and employees, is of paramount importance. This demonstrated recently with the organisation's response to the racist riots and support from our CEO on our promise 26.

From our patient safety and data presented to our Health & Safety forum, we know that staff reporting violence at work is one of the largest single incident reports in the Trust. The Trust's staff incidents, violence and RIDDOR report, informed us that in quarter 1 (April – June 2024), there

were **236** incidents of violence and aggression against or by staff reported. This is equivalent to a **44%** increase in incident numbers from quarter 4 (2023-24), affecting **pre-dominantly our mental health inpatient services.**

We know that the greater percentage of our service offer takes place in what our communities describe as their home, this could be supported living or where they live on their own, with their pet(s) or family. Our colleagues in the community often visit patients **alone**, in and outside of office hours including at night, often visiting places with known and unknown risks, some of these risks can be assessed and some occur that can often be unpredicted. Ensuring our staff are safe whilst undertaking their duties is of the most important significance.
We tragically reported an incident in 2022, there was a serious incident where a member of staff working in patient's home was **assaulted** with a metal bar requiring intensive care treatment. Learning from this incident keeps in mind the fundamental priority of ensuring staff safety when carrying out caring duties in patients' homes.

Expanding on promise 26 and our commitment to being an **anti-racist** Trust as a priority, the recent racist, Islamophobic incidents of August, cement the fundamental requirement of ensuring there is Board oversight and an objective and impartial lens in place to check and challenge our biases, white privilege, active bystander approach, allyship, mechanisms and processes. This is to make sure our collective leadership view that aggressive, anti-discriminatory and racist behaviour is totally unacceptable is embedded across the organisation.

Role Description

The role will focus particularly on **three** key areas of safety and security:

1. Review the changes to **our lone worker arrangements,** to move us away from risk-assessment approach to being identified as requiring a personal protective device. From January 2024, we will be asking cohorts of colleagues to routinely use the devise because their role is inherently a lone working role.

2. Deployment of **our appropriate behaviour policy**, which will help us to tackle racism and other forms of discrimination between patients/carers and staff. This launches in October 2024.

3. Our work to **reduce violence and aggression towards colleagues within our wards**. The specific changes needed to address this remain to be identified and documented.

This role assists the Trust in understanding the **personal lived experience** of colleagues and patients through spending time with them to understand their security and personal safety concerns at the point of care. In doing so this will foster an open, listening and learning culture.

When spending time with colleagues and staff they will test whether:

a) **our support is effective**, and **as effective as it could be**

b) **is best practice**

With this information they will ensure these are attended to and help **influence and shape our plans**. This intelligence will be used to test work undertaken on safety, risk and violence prevention across several corporate portfolios, including that of the Chief Nursing Officer.

The role will not manage the Board's wider work on security management. Oversight for the wider roles and responsibilities are outlined below.

Executive director security and safety responsibilities

Sexual safety	Security	Patient safety (including patient safety incident response framework)	Reducing Restrictive Practice	Freedom to Speak Up
Director of Psychological Professionals and Therapy	Director of Finance and Estate	Chief Nurse	Medical Director	Chief Nurse

The non-executive director lead for Freedom to Speak up is the chair of people organisational development committee.

Appendix 1 provides a steer on national and local guidance which the champion may wish to be familiar with and to informally benchmark the Trust against.

Six-month programme of work

Table 1 & 2 articulates the six-month programme of work which provides a timeline for the keylines of enquiry.

Table 1

October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
• Orientate and become familiar with the local and national guidance in appendix 1 • Visit and key staff outlined in the 3 key areas of focus • Review the underpinning policies • Review WRES action plans due at POD • FTSU action plan due at POD • Health and safety report from September QC	• Continue to visit and key staff outlined in the 3 key areas of focus • Build a thematic assessment of what is missing and what is needed • Review our risk register • Review PSIIs, after action reviews, swarms aligned to 3 areas • Visit backbone services who support operational teams with the 3 key areas of focus	• Continue to visit and key staff outlined in the 3 key areas of focus • Review training and education plan at POD • Meet our retention lead • Build a thematic assessment of what is missing and what is needed • Review training to equip our colleagues with the skills to address microaggressions in the workplace • Visit backbone services who support operational teams with the 3 key areas of focus	• Continue to visit and key staff outlined in the 3 key areas of focus • Build a thematic assessment of what is missing and what is needed • needed • Review our audits and audit plan	• Attend RRI training • Attend staff networks • Meet reciprocal mentees • Build a thematic assessment of what is missing and what is needed • Review our audits and audit plan	• Build a thematic assessment of what is missing and what is needed • Meet with Chief Nursing Officer to share findings and suggest actions to support improvements

Recommendation

The September 2024 Board is asked to **receive** this report and **accept** the recommendations for the patient and staff safety security champion role. The **3 Role Descriptors** - key safety and security priorities with outlined key lines of enquiry and a 6-month workplan that provides guidance to support the role. With the intention that this role will ensure we continue to learn from those at the point of care; and in doing so achieve our overall strategic ambition to improve health and care for local people and to support our people and teams to thrive at work. An update on this work will be provided to Board in May 2025.

Appendix 1:

National and local priorities

To help inform the plan the patient safety and security champion will be orientated to national and local guidance. They may wish to benchmark against these including any annual reports.

The NHS E Security Standards to be launched in November 2024
- The NHS E Violence Prevention and Reduction Standards (December 2020)
- Build accreditation to comply the Restraint Reduction Network Standards (Related to reducing restrictive interventions training)
- The annual statement pertaining to safe staffing in accordance with the National Quality Board workforce safeguards (2018)
- The Restraint Reduction Standards (2019)
- The Use of Force Act (2018)
- Patient Safety Incident Response Framework (2022)
- NHS E Patient Safety Strategy (2023)
- CQC and compliance pertaining to staff and patient safety
- Anti-racism guidance (NMC, 2022)
- Anti-racism guidance and Equity, diversity and inclusion strategy (RCN, 2024)

Appendix 2 KLOE:

The Chief Nursing Officer will support the NED Champion to undertake the see and feel the below, this list may see extensive but reflects our Chief Executives commitment and steer to our Board's commitment to patient and staff safety.

Lone working arrangements

Keylines of enquiry:

- Visit and spend time with colleagues in our community teams, including teams who support people in our care whose needs are complex and as a result at times higher in risk. For example, assertive outreach. As well as this teams who frequently lone work, for example, home treatment and community mental health teams.
- Understand the team and personal approaches to lone working, what are their concerns and how do they manage these concerns? What best practice do they do?
- Review the lone working policy does it align with what our colleagues are informing us? Are colleagues following the policy?
- Are our colleagues who are identified as lone workers routinely using lone working devices? If not, what are the barriers?
- Spend time with the learning and development team, and observe the reducing restrictive interventions training, specifically reviewing the de-escalation training.
- For our training, are incidences reviewed, triangulated and do they inform this plan?
- Assess our annual health and safety data/report to quality committee
- Does it cover all lone working arrangements and risks?
- Review our risk register, are all lone working arrangement risks covered and are actions and controls in place to reduce the risk?
- Review our patient safety incident response framework, have there been any recent staff or patient incidences where there has been PSIIs, swarms or action reviews. Spend time at our safety huddles, are we learning from our incidences?
- Spend time with care group senior leadership team, how do they oversee lone working arrangements?

Appropriate behaviour policy

Keylines of enquiry:

- Spend time with our Freedom to Speak Up Guardian and understand where staff are raising concerns and why, and what is being done about it?

- Visit colleagues across the organisation, focusing on some teams where there have been concerns of racism raised, what local plans are in place to support colleagues? Understand the team and personal approaches to cultural competence, what are their concerns and how do they manage these concerns? What best practice do they do?
- Review our appropriate behaviour policy, how is this being implemented across the organisation?
- Check in with our reciprocal mentees as part our reciprocal mentor programme? What are they learning and what actions are they generating from it?
- How is the Trust creating equitable opportunities for career progression and access to continuing professional development for our colleagues from a global majority background?
- Spend with our staff network for our global majority colleagues and listen to their lived experience and what action is being taken to address any concerns raised?
- What training is in place to equip colleagues with the skills to address microaggressions in the workplace? And, how confident are our colleagues in challenging microaggressions in the workplace?
- Review our Equality Diversity and Inclusion champion progress to date? Meet some of our champions. How is this informing our anti-racism plans?
- Review our WRES, training and education plan, and FTSU bi-annual report from People and Organisational Development committee, do they align with what our colleagues are telling us?

Reducing violence and aggression towards colleagues within our wards

Key lines of enquiry:

- Spend time with our inpatient teams, focusing on areas where there are high reported incidences? What are the main concerns? How, do they locally manage violence and aggressions? How do they raise the alarm for help? What does the training compliance for reducing restrictive interventions for the ward? Attend a planned inpatient purposeful admission or multi-disciplinary team meeting. How are patients risks of violence and aggression managed and identified and acted on?
- Spend time with our patients, carers and families, how do they feel colleagues' approach and manage violence and aggression?
- Spend time with our patient safety partners, people focus group and peer support workers, what is their experience? What do we need to do to improve our response?
- Attend our staff safety huddles? How are our colleagues supported with de-briefs and health and wellbeing support when incidences occur?
- Review our PSIIs, after action reviews and swarms, where incidences have occurred, how have we embedded the learning? Check our audit programme feeds in this learning?
- Attend and review our reducing restrictive interventions training? Is this training up to date, and learning from patient safety incidences?
- Review our risk register, are our inpatient violence and aggression risks appropriately managed?
- Spend time with our retention lead, what plans are in place to support our colleagues?
- Does our data show plans to improve are impactful, Health & Safety data is a key measure in terms of violence against staff, also review staff survey about feeling safe at work, linking in our risk register - Does it cover all violence and aggression risks? What actions are being taken to mitigate?

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Induction of new RDaSHians into our communities / Trust	**Agenda Item**	Paper P
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**	26 September 2024

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

The paper describes the changes to the Trust Induction process which commences in October 2024.

The Induction takes place over 5 days (rather than the previous 1 day), is community based across our three main localities (rather than being based on the Tickhill Road Hospital site) and contains interactive question and answer sessions led by the experts in our services and communities. The Trust Induction Programme inducts our new RDaSHians to understand our Strategy, our 28 Promises and our future culture.

The new Trust Induction programme is a significant investment in the development of our new RdaSHians and in time will have a positive impact on the culture, retention, absenteeism and the employer brand, which is further supported by a local induction programme.

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

CLE September 2024

Recommendation

The Board of Directors is asked to:

X	**ACKNOWLEGE** the change in the Trust Induction programme and the investment in our new RDaSHians
X	**CONSIDER** any matters of concerns not covered in the report
X	**NOTE** the implementation date of October 2024
X	**RECOGNISE** the need to evaluate the Trust Induction programme over the next 12-18 months

Impact

Trust Risk Register							
Strategic Delivery Risks	X	SDR1 and SDR 5					
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

N/A

Rotherham Doncaster and South Humber NHS Foundation Trust

Induction of new RDaSHians into our communities / Trust

1. Introduction

1.1 The paper describes the proposed changes to the Trust Induction process which commence in October 2024. An employee's first impressions of the Trust have a significant impact on their integration within the team and job satisfaction. Induction is an opportunity for the Trust and colleagues to welcome new recruits, help them settle in and ensure they have the knowledge and support they need to perform their role. Whilst we are focussing on becoming fully staffed (97.5%) by January 2025 we are keen that new recruits, 'RDaSHians', have a positive Induction experience as retention is equally as important as recruitment, and a great induction experience supports retention.

2. What is Changing?

2.1 Quite simply – everything is changing! We are keen to ensure RDaSHians are inducted into the Trust in the most effective and efficient way, improving their job satisfaction and having a positive benefit on retention rates, absenteeism and our staff engagement scores.

2.2 The Induction programme may be the first opportunity new RDaSHians have to understand our Strategy, our 28 Promises and our future culture, which we recognise are different to other NHS Trusts and as such supports a bespoke Induction programme.

2.3 The current induction is mandatory and takes place monthly within 8 weeks of start date. This currently consists of the MAS Training element of Induction, a virtual New Starter Network, and an electronic Induction Booklet. Unlike previously where the first Monday of the month colleagues attended a one day, face to face Induction which contained presentations, the new format of Trust Induction takes place over 5 days, is community based and contains interactive question and answer sessions led by the experts in our services and communities.

2.4 The new Trust Induction is a roving programme which occurs in each locality every three months – Doncaster, North Lincolnshire and Rotherham. Colleagues are allocated the next available induction, regardless of where they are based.

2.5 Whilst we have made some progress with retention, our turnover rate is improving (as in declining) and colleagues leaving us within the first year has now moved to leaving us within the second year. Colleagues leaving in the first 12 months has moved from 1 in 3 to 1 in 4 leaving in the first 12 months, we recognise we have much more work to do, for which the Trust Induction forms an integral part. This is coupled with our Strategy and Promises being different to other NHS employers and our community alignment, nurturing the power of our communities.

2.6 The Trust induction programme inducts colleagues into the Trust, our Strategy, our Promises, our communities and not their role, this element is supported by the local Induction programme.

2.7 The 5-day Trust Induction programme is a significant investment in our new recruits and whilst other organisations might be reducing or streamlining their Induction programme associated with cost drivers, we are increasing our Induction programme. This offer RDaSH a further unique selling point (USP) in a competitive recruitment market to demonstrate our commitment to development, alongside the learning half days, Apprentice First, Leadership Development Offer and other similar programmes, which we will promote as part of our employer brand.

3. The Programme

3.1 In order to accommodate flexible working patterns and part-time working, it may be necessary for colleagues to complete their five days of Trust Induction across two induction programmes to ensure they experience the full five-day programme whilst balancing their personal commitments, again we will be flexible with the scheduling of Induction.

3.2 It remains mandatory for colleagues to attend the induction programme and non-attendance will be strongly monitored and managed.

3.3 The programme consists of the following:

Day 1 involves colleagues networking with each-other and asking questions of some of the backbone colleagues – the real practicalities of what they need when commencing with a new employer. If the afternoon they meet colleagues within our communities and discover local services available. Round table discussions take place on the health needs of our population, apprenticeships, peer support work, how we work with children in physical and mental health, aging, dementia and neurodiversity.

Day 2 focuses on the 5 Strategic Objectives and question and answer sessions, videos, activities are led by our experts.

1 Colleagues explore peer support work, working with carers, volunteering programme, care opinion and how to involve our communities at every level in decision making.

2 Diversity, veterans and homelessness are discussed.

3 The work we do to support people stay at home and Voluntary, Community and Social Enterprise (VCSE) are explored, along with the work of health visitors, district nurses, Community Mental Health Transformation (CMHT), Primary Care link workers and how we work with care homes.

4 Colleagues hear about trauma informed care and how we introduce consent.

5 Anti-racism, environment commitment, education and research are the focus of discussion.

Day 2 concludes with a discussion about the half learning days followed by the Chief Executive Officer (CEO) and a community representative discussing how everything explored, relates to their work.

Day 3 is held in localities at the colleagues' place of work, to meet their peers and experience a great local induction. All Directorates are responsible for planning their own local induction programme for Day 3 and we encourage a meet and greet with senior colleagues to build awareness and relationships, a key theme of the induction programme.

Day 4 focuses on Mandatory e-learning training.

Day 5 focuses on the values and behaviours framework, a consolidation of the local induction, a discussion regarding culture, Emergency Preparedness Resilience and Response (EPRR), appraisal and mandatory training, quiz, reward and recognition and self-reflection and evaluation.

3.4 Time is set aside on day 1 during lunchtime, for colleagues to network with our chaplaincy service, Freedom to Speak Up Guardian (FTSU), lead volunteers, network leads, and our wellbeing team. Similarly on day 5, colleagues network with our Executive Team and Care Group Directors. We are keen to build relationships across the Trust and the Trust Induction programme.

3.5 The induction programme will not be a series of presentations, information will be shared in advance with delegates to stimulate their thinking, which will then be followed by an interactive session as part of the induction.

3.6 The Trust Induction will be complemented by a local Induction programme which again focusses on relationships, the Directorate, Care Group/Backbone and the induction into the actual role.

3.7 RDaSHians will graduate from the Trust Induction programme as, for example, the Class of November 2024 and we will monitor their progress alongside the New Starter Network and the relationships they build as part of the cohort. Within our Trust communications we will also highlight in 12months/24 months etc how many have secured promotions, changed roles and hopefully how many (have not) left RDaSH.

3.8 As with the LDO, we will seek to evaluate the success of the Trust Induction programme over the next 12-18 months.

4. Recommendations

4.1 The Board of Directors are asked to:

1. Note the revised Trust Induction programme which commences in October 2024 and the investment in our new recruits

2. Recognise the need to evaluate the programme over the next 12-18 months.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Out of Area Placement Risk Share	**Agenda Item**	Paper Q
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	26 September 2024

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

The Board is asked to review the progress against the resolutions approved at the August meeting, noting the offer from SY ICB on general out of area (OOA) placement budgets. This offer is within the limit delegated to the Chief Executive and Director of Finance previously. There is further due diligence to undertake on the residual figure the ICB intends to hold, this is expected to be completed within 2 weeks.

Discussions with HNY ICB have started in recent weeks, with an aim to mirror the arrangements being sought with SY ICB. Although these discussions have been positive, the detailed work to arrive at a settlement is expected to take the balance of Quarter 3 to conclude.

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

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

This topic was discussed at July Board of Directors, with a detailed paper presented at the August Board of Directors meeting (private) providing further information on the merits and necessity of transferring risk from the ICB to the Trust from October 2024.

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

The Board of Directors is asked to:

X	**RECEIVE** the update on the negotiations with SY ICB on a proposed settlement for general OOA placement budgets.
X	**NOTE** the due diligence completed to date, the remaining issues to work through over the next 2 weeks, and the commencement of negotiations with HNY / North Lincs Place for a similar transfer of budget risk.
X	**APPROVE** the proposed settlement with SY ICB of a £8.7m FYE budget transfer, with a contract period 1st October 2024 – 31st March 2027.
X	**DELEGATE** to the Director of Finance and Chief Executive conclusion of the remaining due diligence on the residual £16m of budget the ICB intends to hold.
X	**DELEGATE** to the Director of Finance and Chief Executive to continue negotiating with HNY ICB / North Lincs Place to achieve an equitable OOA placement risk share, in line with the parameters agreed for SY.

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

Trust Risk Register	X	010/19, DCGMH 5/23 (out of area placements)
Strategic Delivery Risks		
System / Place impact		

Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	To be produced prior to signature
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

Out of Area Placement Risk Share

1. The Board of Directors previously (August 2024) received and discussed a comprehensive paper that outlined the status of general adult out of area placement budget arrangements in South Yorkshire. The paper set out the background, risks, and implications of a budget transfer for this activity to the Trust from October 2024, supporting strategic objective 4 and promise 19. This paper does not seek to revisit the particulars of the previous paper, instead the intention is to provide an update to the Board on the resolutions agreed in August. As a reminder these were:

    - The Board of Directors accepted the principle of matching other Trusts' risk responsibility for out of area placements and noted the timetable negotiated with Place Directors in the ICBs.

    - The Board of Directors acknowledged the equity challenges posed by the Humber and North Yorkshire ICB position.

    - The Board agreed to delegate to the Director of Finance and Chief Executive Officer to reach a conclusion of negotiation, by 15 September 2024, to a maximum budget sum of £13m and with no disbursement above £1m to the ICB.

2. Negotiations have continued in September between SY ICB and the Trust, led by the CEO, advised by the Director of Finance. Information on out of area placement budgets has been shared with the Trust, this includes actual spend figures for 23/24, YTD 24/25, forecast, and growth assumptions. Due diligence of this information has focussed primarily on:

    a. The treatment of any accrual reversals in the 23/24, and the underlying actual spend (before technical adjustments).

    b. The assumptions on growth and inflation included in the 24/25 budget.

    c. The quantum of OOA placement budgets across the ICB at Place level, split between specialist and general placements.

3. Due diligence of a) and b) has been completed in the settlement offer below, with further work on c) required over the next 2 weeks. The material query on c) relates to the balance of c£16m of out of area budget that the ICB plans on retaining for Doncaster, and which it has categorised as acute / PICU related in the latest information shared with the Trust. Discussions over the next 2 weeks will focus on whether this amount does indeed relate to general acute / PICU placements, or whether there is an issue with the way the ICB has categorised between specialist

and general budgets. If the former, then we would expect a larger transfer of budget to the Trust.

South Yorkshire Proposed Settlement

4. The proposal from the SY ICB results in a budget transfer of £4.35m in year (£8.7m FYE) against a forecast spend of £3.1m in 24/25. The proposed transfer includes SY ICB retaining £0.19m of in year OOA growth budget (£0.38m FYE) as part of the settlement.

5. The growth (10%) and inflation (9.8%) figures used by SY ICB to arrive at the 24/25 OOA budget are unusually high when compared to other organisations within the ICB, and as such the proposed partial retention of this element is acceptable in my view, and within the disbursement delegated by the Board.

HNY / North Lincolnshire Equity

6. In the past two weeks the Trust has started discussions with the Place Director and Finance Director for North Lincolnshire, with a view to agree a similar proposal as the one negotiated with SY ICB. Early discussions have been positive, with an ambition to reach an agreement by the end of November. Initial figures shared by NL Place suggest a total OOA budget of c£15m for mental health, however this requires further analysis to determine the split by service.

Resolution

7. **The Board is asked to approve the offer from SY ICB to transfer £8.7m (£4.35m in 24/25) of general adult out of area placement budgets to the Trust, with a contract period 1st October 2024 – 31st March 2027.**

8. **The Board is asked to delegate to the Director of Finance and Chief Executive to continue due diligence on the residual £16m Doncaster OOA budget that the ICB intends to retain, and reach a conclusion on negotiations to secure any further funding for placements deemed to be general acute / PICU related.**

9. **The Board is also asked to authorise the Chief Executive and Director of Finance to continue negotiations with HNY ICB / North Lincolnshire Place on the basis outlined, and within the same level of financial delegation as the SY ICB proposal.**

Izaaz Mohammed
Director of Finance and Estates
24 September 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Adult Eating Disorder Contract	**Agenda Item**	Paper R
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	26 September 2024

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

Negotiations with NHSE on a settlement for the AED contract gap have concluded, Board members are asked to note the residual risk that remains on the contract, which is within the previously agreed figure of £350k.

This is a 3 year contract that will novate to SY ICB on the 1 April 2025.

The Board are asked to re-approve contracting with NHSE on the basis of this settlement.

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.	
Business as usual	

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

This topic was discussed at July Board of Directors, with a paper presented at the August Board of Directors meeting (private) providing further information on the financial settlement offer from NHSE.

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

The Board of Directors is asked to:

X	**RECEIVE** the update on the conclusion of negotiations with NHSE on the AED risk.
X	**NOTE** the contract value gap has been negotiated down to within the tolerance previously approved by the Board. The settlement is for 3 years and novates to SY ICB on 1st April 2025.
X	**RE-APPROVE** contracting with NHSE on the basis of this note.

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

Trust Risk Register	x	S 2/22					
Strategic Delivery Risks							
System / Place impact	x						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

None

South Yorkshire Adult Eating Disorder Specialised Commissioning: 2024-2027 contract

1. Previous board discussions over several months have centred around securing non-recurrent financial support required from NHSE to deliver a balanced budget adult eating disorder specialised care model in South Yorkshire. This will sit within the agreed ED Collaborative that the Trust is spearheading. The budget for specialised services will be delegated to South Yorkshire ICB from April 2025.

2. Additional funding for enhanced packages of care has been required in 22/23 and 23/24 to achieve a financially breakeven service. Our financial plan for 2024/25, agreed in May, was predicated on separate consideration of this item. This was clearly identified to NHS England, and to the Trust's host ICB. The risks, both clinical and financial are visible as extreme (where relevant) in our risk register, also before the Board.

Settlement

3. In August 2024 the Board agreed to continue negotiations with NHS England, mindful of the wider population risks involved in service disintegration, with the aim of reducing the remaining risk of £600-800k to below £350k in year. It was accepted that the Trust would retain financial risk above that final sum, but that estimates of need suggested that the total contract value would not be exceeded in year – and our plans involve gradual reduction in use of specialised beds and funding.

4. Discussions have now been concluded, with visibility at ICB Board level through CFO Lee Outhwaite, and the contract value gap has been negotiated down within the tolerance agreed last month (forecast to be £297k based on current packages of care.) The proposal also includes the reimbursement on an actual cost basis for an individual high-cost patient.

Resolution

5. The chair asked that the matter be returned to the Board of Directors meeting in public, such that the prior decision can be ratified. The longer-term financial risks are understood and it is not possible to inoculate the wider Trust from the commissioning responsibility accepted some years ago, and shared for other services by Sheffield Children's (CAMHS) and SWYMHT (forensics). The Chief Executive has written to Robert Cornell, and briefed Julian Kelly, that should expenditure exceed the contract value tolerance, then this cannot be mitigated in-year other than through breaching our deficit plan.

6. **The Board of Directors is asked to re-approve contracting with NHS England on the basis outlined in this note, and in the more extensive paper from August 2024. This funds the actual costs of a high-cost patient (c£1.2m in 24/25), and a further £297k of recurrent funding to partly (half) bridge the remaining expected gap estimate.**

7. Our financial reporting in year will scrutinise the actual risk and separately report it: in 2025/26 we may begin to see this service commissioned led from one of our Care Groups, but there is no expectation that that CG will need to manage the financial risk held by the Trust as a whole. I am satisfied that whilst we would have sought a higher settlement, the arrangements are the best feasible offer and in the interests of system working we should now accept.

Izaaz Mohammed, Director of Finance and Estates
18 September 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises / priorities scorecard	**Agenda Item**	Paper S
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive and Philip Gowland, DOCA		
Meeting	Board of Directors (public)	**Date**	26 September 2024

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

The paper explains the genesis and timing of this first bi-monthly scorecard. Movement in assessment might be anticipated to change over one to two quarters, but not more regularly. The suggestion, as a trial, is that this form is used with CLE and with Board committees, akin to the IQPR and SDR / risk register.

The Clinical Leadership Executive, and EG, have spent considerable time exploring the phasing of promises. This recognises bandwidth, the intent for this work to be the day job, delivery of some promises to time and purpose, and the need to plan others. The promises are not a programme. They are outputs of a changed way of working in directorates, groups, across the Trust and within our communities.

For ease, the three priorities set by the Council of Governors in 2023 are shown alongside the promises, recognising the overlap in many cases, but also some distinct commitments made there – which have been renewed for 2024/25.

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 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

n/a

Recommendation

The Board of Directors is asked to:

X	**NOTE** the finalised success measures for 27 of 28 promises
X	**RECOGNISE** the move to 4 colour traffic lights / distinct plan and LOD assessment
X	**DISCUSS** the clarity of the reporting format as a routine rapid overview visual
X	**RAISE** such matters as allow assessment of 24/25 delivery YTD

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

Trust Risk Register	X	DCGMH5/23, O10/19, RCG8/24, DCGP2/23, POD1/24, POD2/24, O4/24, DCG14/20, DCGP2/22, RCG28/23, DCG14/21, 1542
Strategic Delivery Risks	X	SDR1, SDR2, SDR3
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)

Annex 1 – Promises and priorities – delivery plan and delivery self-assessment

Rotherham, Doncaster and South Humber NHS Foundation Trust

Executing our strategy 2023 – 2028

Background

1.1. Since summer 2023, several reporting formats have supported Board exploration of the development of delivery plans for our strategy and priorities. In particular:

- Through 2023/24 the governing body's priorities were reported as an annex to the Chief Executive's report in each Board meeting
- Each strategic objective has been considered in turn (today's Board meeting is our final such) – exploring deliberately what is difficult about each promise (a single composite of these five papers will be shared with Board members for ease of reference)
- The strategy and promises have been used to build the new Strategic Delivery Risks (SDR/BAF), which is reported separately to the Board, can be considered in committees and is subject to scrutiny through the new AC chair/DOCA challenge meetings three times each year
- Promises have been explored within committees, and inside the CLE structures, in the context of our eight plans. These plans remain to be collectively scrutinised, and this is now due in the October timeout.
- Over the coming twelve months, we would expect within the Board to consider progress against some individual promises – reflective of the prioritisation work done about which promises are to be achieved first.

1.2 In July 2024 we published an Easy Read version of our strategy, especially our promises. We also issued our 'success measures' (aka finish lines), which had been constructed with discussion in CLE subs, inside EG, across CLE and with patient partners. These success measures are not the only metrics of delivery, but they are a minimum and specific standard we are seeking to achieve – 'aligning to a promise' or working on it is not success. We are being specific about what is needed and increasingly will tilt work, time and funds to those measures.

1.3 Some promises are delivered once and are then done. For example, the move in April 2025 to the Real Living Wage. Others are delivered largely through central endeavour, albeit clearly with local team input – perhaps promise 3 on volunteers illustrates this. Finally, a third group, perhaps intelligible through promise 7 or 14, have to be delivered inside directorates. This difference of delivery model is important: each Care Group cannot usefully set up a 'promises taskforce'.

Pecking order and prioritisation

2.1 We all recognised as a Board in July 2023 that, over the lifetime of the strategy, other must-dos, or initiatives would arise. We committed ourselves to avoiding the typical public service model of endless adjustment – and chose the word promises on that basis, consciously and with intent. The hypothesis was that the promises were sufficiently numerous and well considered to be likely to survive and subsume foreseeable strategies

nationally and regionally. The Darzi review before the Board today is a case in point.

2.2 Over the past twelve months, there is recognition that different actors/leaders/professionals within a complex organisation take their cue and steer from different places – colleges, colleagues, communities, national bodies and so on. In addition, the interpretation of priority can vary. To assist with this common problem and to ensure common effort is cohered, a '**pecking order'** has been developed and is being deployed. This puts a hierarchy on what we do first when a clash or choice arises:

(1) Safety critical work
(2) Work that supports delivery of the Board's strategy and promises
(3) National work (only if) identified in the national planning guidance
(4) Support for the eight plans, including finance, research, etc.
(5) Local place plan priorities
(6) Local Care Group priorities
(7) Other initiatives: national, regional, professional etc.

Use of this pecking order will prove increasingly helpful to us. To date the key interpretative questions have been what is meant by (1): it means urgent matters that threaten immediate patient and staff harm. And what is "identified" in the planning guidance, as some items are hinted at therein or nuanced. The intent of the pecking order should be clear – the promises take priority, local place plans are slightly above internal plans, and other 'instructions' externally have a place but are, as they are in statute, suggestions and exhortations. The authors remain available to provide specific guidance to Board and CLE members on whether any given suggestion matches one of the seven above, or is, by definition, an eighth. This might include matters raised by the CQC, NHSE, professional leads nationally or regionally, except where formal enforcement is commenced.

2.3 Quite understandably there is a pinch point in seeking to deliver a large number of goals at the same time. This is why we are looking to expand the management capability we have, why we have expanded directorate based clinical leadership capacity, and why we are working on key enablers, whether that is self-service data analysis, or more locally hosted corporate functions. The cultural interventions outlined in the wider Board papers all speak to, and support our ability to understand, co-deliver, and narrate this complex work.

2.4 The current working prioritisation of promises recognises that:

- We have some we can, and should, deliver in 2024 and 2025.
- We others we need to plan during 24/25 for delivery from 2025 onward
- A small handful of promises could be deferred into summer 2025

In particular, delivery of those promises within strategic objective 4 are less advanced and defined to date – and can only properly be delivered on a Trust-wide basis. However, work to cohere an approach to that has been ongoing for some months and we would expect to move to pilot testing during Q3. This means, in all likelihood, a sizeable deployment of work in this space

from mid Q4 to late Q1. This makes it all the more important that we execute several other promises during Q3 and Q4.

2.5 During Q3 and Q4 we are working to make material progress with:

- Promise 3, because it is due in 2025
- Promise 4, because it underpins the wider mission
- Promise 5, because it underpins the wider mission
- Promise 6, because it is due in 2025
- Promise 7, because it is a national must do
- Promise 8, because tackling MHLDA inequalities is vital
- Promise 9, because it is due in 2025
- Promise 14 (a), because it is due in 2025
- Promise 19, because it is due in 2024
- Promise 20, because it is due in 2024
- Promise 25, because is it due in 2025
- Promise 26, because it is due in 2025

2.6 Our forward plan for Board of Directors meetings will include, in rotation, specific updates relating to Promises to demonstrate the progress we make.

2.7 Through this week leaders' conference, with CLE subs, and elsewhere, we are working to configure work on some of our bigger or more challenging promises, that need more pre-thought or structure, for example promises 2 and 1, or those that have high SDR prominence such as 15 and 22.

Scoring our work

3.1 A minority of Board members may recognise the scoring approach adopted overleaf, which reflects "deliverology" ideas most associated with Professor Michael Barber (who has just returned to assist the government in this field). This seeks to distinguish whether we know how to do something from our capability to execute it in practice. It also draws a stark distinction between being off trajectory, and understanding the deviation and route to recovery, from being off track without such clarity. Whilst formally separating 'plan' from 'likelihood of delivery' may not be enforced across all our work, the shift to a four-colour traffic light will become standard in the Trust not later than April 2025. We may wish, in due course, to explore the implications of this for 'ratings of assurance' used more commonly in our Board space.

3.2 Wherever the assessment, or assessors, are uncertain, a redder tinge has been applied. For this version of the scorecard, only the authors have formed a judgement. As we move through Q3 we will migrate in CLE subs, CLE and elsewhere to a more collective executive view, and one reinforced through delivery reviews, be they corporate directorate or care groups ones.

Conclusion

4.1 **Recommendations, or questions for the Board, are summarised on the cover sheet**. The primary intention of the scorecard today is to provide an overview visual of our work to date and expectations for coming months. Committee will recognise that individual data items exist as a level below the success measures. We will explore how best to incorporate those from 25/26.

Annex 1 - Promises and priorities – delivery plan and delivery self-assessment

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.	Red	Mobilisation has stalled and a revised approach, with the CEO acting as SRO, will be convened to establish a trajectory and plan by Feb 2025.	Amber red	The promise is hugely ambitious in number and reach. It is forecast that we can scale up, but are not yet confident of sufficient expansion.
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	Detailed work to project plan each measure will be needed during 2025.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	The route to do this is well understood. This work will be dovetailed into wider work on ward improvement.	Amber red	Putting into place what is needed is feasible – what has to be established is that it works – through the eyes of carers…
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber red	We can do more to systematise this. But our plan is likely to be incomplete given self-identification inhibition in early months.	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	This piece of work is a significant one and may require dedicated resourcing for a fixed term period.	Red	Until the planning work is done it is difficult to meaningfully estimate the LOD.
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	Since summer 2024 some intensive work has taken place to mobilise towards this promise. Six Group plans are being finalised and support resource inside N&F is configured.	Amber red	Until we are more than a third of the way to the measure (having used 40% of the elapsed time), we need to see a sizeable uptick in take up to go AG.
	For that body of volunteers to reflect the diversity of our populations.	Amber red	We have a ‘concept of a plan’. Some good ideas. We now need to document them and work out how they can be executed.	Amber green	As with the COG measure which predated the strategy, improvement is very possible against the baseline: proportionality is much more challenging.

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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.	Amber green	We have a deployment plan for Care Opinion, which we believe will improve our reach, pace and analytical capability.	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	JG has overseen a very clear plan to put this into place in acute settings during 24/25.	Amber green	MHA will continue to support this important qualitative work and there is confidence we can meet the ask.
	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Amber red	We now on a 'push' basis how this can be executed. Work is taking place through 24/25 to test the level of 'pull' from inside DMTs to make this work a reality.	Amber red	Given that 18 months+ exists, this can be delivered: but the meaningful change means we need to have achieved the push/pull use in mid 2025.
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 is structured and is in hand: documenting the process of 2024 peer support and creation of 2025 shadow forums will take place in Q3.	Green	Board and CLE changes are in place – CG governance changes planned for Q1 25/26.
	Deliver the Board's community involvement framework in full.	Amber green	Work to refine this is well advanced but final documentation is needed, routed in, VCSE analysis which is presently being finalised.	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 is not yet in place because of delays adopting the policy approval Operating Model. This will be remedied in 2024.	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.	Amber green	Work in summer 2024 has developed a hypothesis about how to do this which is now being consulted with members	Green	This work is on track and will be developed.
	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 24/25 we would expect to meet the measures we set in 23/24.

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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).	Amber green	Pilots have commenced. AR may be a more realistic view of the rollout plan but a further discussion within CLE will take place in November 2025.	Amber green	E&I sub, and CLE, have supported the ‘pre-agreed/indicative’ changes we would expect to make for 25/26 based on initial analysis.
	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	An initial proposal is almost in place which has strong support among partners.	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.
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	These measures have been defined, and agreed with all groups via the E&I sub. Most measures reflect continued improvement rather than sizeable changes of trajectory.	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 green	The plans to deliver this measure are reasonably clear but with a concern over data quality emerging.	Amber red	Success relies on the Trust changing how we work and who we work with. During Q3 it will become clearer how feasible this is and over what timeframe.

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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”).	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Green	This specific measure, in contrast to the one above, is a more boundaried change, where those involved offer confidence that they can deliver.	Amber green	Resource to support this work is in place: we now need to see whether we are able to reach those previously excluded.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber red	We have further work to do, and site visits continuing, to establish a cogent plan grounded in work elsewhere.	Red	This is not simply a supply side change, and clearer influencing strategies need defining to move the LOD assessment.
	Improve access rates to talking therapies among older adults.	Amber green	Teams have worked hard to establish how this can be done and a defined data point is agreed. Executing the plan is commencing and needs ramping up.	Amber red	Movement on the key metric is needed in early 2025 to establish confidence in the work we have done to date
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.	Green	A clear plan and delivery model is in place	Green	We are meeting our trajectory YTD and expect to do so at year end
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber green	Work to meet this measure is planned and in part deployed.	Amber red	The scale and sustainability of the work being done needs further stress testing during Q3
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber red	The timing of this measure remains feasible but further work is needed in 24/25 to cohere our plans	Amber red	The rating reflects the evolving picture of planning outlined
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	This scheme needs further dedicated work and the right community based partnership. This remains to be planned and is not simply an extension of the schemes above	Amber red	This can be delivered, given not required until 26/27. But schemes elsewhere have sometimes struggled, and we may need to bring forward a trial scheme.

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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.	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	The standards go beyond ourselves and a shared assessment is being documented presently.	Amber red	It will certainly require change to meet the standards, and the homeless health conference in Q3 will be used to kickstart those investments.
	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	Data completeness, as well as access itself, makes it very difficult to rate this measure at base. Consideration being given to 'mystery shopper' work.	Red	Rating reflects planning gaps identified.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	Plan not yet fully defined, including for refugee groups and sex workers. E&I sub needs to pick up thinking work over remainder of 24/25.	Amber green	Time assists this input metric. Over period possible to put in place what is needed.
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 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.	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.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	A little more work might be merited to document the plans and their trajectory, but the component parts of what is needed are well understood.	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.	Amber green	Plan to do this are actively being debated with the key issue being whether it occurs before end of 24/25.	Green	This measure can be met when we find released funding to make it happen.
	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…	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.	Amber green	A delivery priority for next financial year.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Red	Planning, visibility and emphasis on this measure is below where it needs to be: delivery review discussion in September to begin to cohere approaches.	Amber red	Comment reflects known unknowns outlined in planning segment.
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Amber green	Work is in place to document, count and manage our waiting lists: due to report to Board in Jan 2025.	Amber green	The scale of change remains significant. But initial data offers optimism that it could be accomplished.
	Meet 4 week standard from April 2026 across all services.	Amber green	Rating reflects prior measure at this stage.	Amber green	As left.
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	We have work to do, and partnerships to finalise, to move this goal forward and will not achieve it in 24/25.	Red	As left.
	Restructure Trust services into those INTs during 2025/26.	Red	This rating reflects comment on prior measure.	Amber red	As left.
	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	As left.

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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	The work has started (Sept 24) in the field in training teams, and a well structured delivery plan exists.	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.
	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber green	CNO clear that our quality plan will be finalised during 2024.	Amber red	This has proved a difficult measure to establish despite work on it for over 12 months.
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.	Amber red	This is a very challenging and multi-factoral target. The delivery plan is due review at November's E&I group.	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan.
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber red	This is a very challenging and multi-factoral target. The delivery plan is due review at November's E&I group.	Amber red	Improvement in SR has been consistently achieved over recent years, so there is good evidence in support of further improvement.

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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.	Amber green	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.	Amber green	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	Draft plans relevant to this exist in 'top of the office' form. Discussions among clinical execs, COO and CEO to confirm the calibre of the plan.	Amber red	Mobilising this work will be a significant endeavour in Q1 25/26, after pilot phases over next two quarters.
	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 in H1, 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	We do know what we need to do. The plan gap is resourcing doing it, and securing our delivery chain internally around LOS.	Amber red	The scale of change required remains immense. Substantial improvement is possible, a revised timetable for elimination wil be assessed in Q1 25/26.

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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.	Amber red	Other priorities have delayed this work, and AOT work has taken primacy. An assessment is being made of how/when this is best mobilised.	Amber red	This rating reflects comments on the left.
	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 – documenting these ambitions needs attention in late Q3 as part of IF process.	Amber green	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.	There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.

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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	We do not have a defined plan, delivery chain or implementation model in place as yet.	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.	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	Good work has taken place to build relationships and this then ties into the bed-plans outlined before the Board.	Amber red	The challenges to implementation are outlined in another paper and remain significant.
	Expand the scale of our residential forensic rehabilitation service.	Amber 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.
	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.	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.

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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.	Red	Expectations remain unclear and relation between this plan and funding rollout nationally undefined.	Red	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)	Amber green	No identified reason why assessment outcomes would change over coming period.
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.
	Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We know what needs to be done. Most complex issue is banding reviews of band 2/3 which is needed in Q3/4.	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.	Green	Measure defined, suppliers aware, procurement on plan with transition by end of Q4.

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26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	Implement suite of policies and practice to Kick Racism Out of our Trust.	Green	Clarity across CLE about what we plan to do, first policies change go live in Q3.	Amber green	Practice as well as policy change needed, but visible and compelling start made.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber red	Paper presently with Board and whilst LDO work may assist with managers' behaviours, not yet persuasive that we know fully what is needed.	Amber red	A complex and longstanding issue, which, as yet does not provide have a clear trajectory to success.
	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.
	Tackle our gender pay gap.	Amber red	Board is well versed in this topic. JG/womens network working through a draft delivery plan that helps to tackle workplace benefits gap.	Amber red	Once the plan is visible we can consider the scale of difficulty required: Likely to require behaviour change beyond just the Trust – ie among colleagues hence base rating at AR

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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).	Red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our forthcoming estate plan.	Red	Estimated £18m investment is not 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 dour course this work can be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are not 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 Q4/Q1. Our ‘remote’ policy and practice will be crucial to success.	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 investment and employment to our local community.	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
	Deliver metrics contained in the Trust’s Research and Innovation plan.	Amber red	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.	Amber green	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.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

Council of Governor priorities

Priority	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 or fully elaborated	Comments on likelihood of delivery
<u>Community involvement</u> GB1: Objective one of the Clinical and Organisational Strategy (C&OS) becomes a real part of how RDASH works and relates to others	High levels of awareness among employees of the strategy's promises (60%+) by survey, including recognition among top leaders' cadre (n150) of the critical role of objective one	Amber green	Promotion of the strategy to employees has been extensive and from November 2024 the basis for new joiners induction will be our strategy – work on objective 1 forms part of the September leaders' conference 2024	Green	Whilst endorsement of the strategy will vary: we should be confident that awareness of the promises is high among our teams and partners.
<u>Community involvement</u> GB2: Every Trust service by 2027 will have peer support workers within it (promise 1 in the C&OS)	15% improvement on current baseline in adult and older adult mental health services	Amber green	The Trust's promise 1 postdates this measure and subsumes it. Existing expansion plans for 24/25 would appear to meet this metric.	Amber green	The first recruitment after investment against promises 1 has been within these services.
<u>Community involvement</u> GB3: Promises within C&OS describe commitments to widening access and to expanding apprenticeships	Fully deploy the apprentice levy sum and create new targeted schemes for vulnerable groups (care leavers, homelessness, and refugees)	Green	The plan to deliver the levy is in place, and ringfenced schemes are being developed. They do vary in their maturity, as suggested under the promise 9 assessment	Amber green	There is confidence that these schemes can be executed over coming months through 2025.
<u>Health promotion and prevention</u> GB 4: The Trust is committed to ensuring health checks are conducted annually for a) local people with a, learning disability who are registered as such with their GP and b, those registered with a serious mental illness)	Meet for both a) and b) and in each of three Places the standard set within the Core20PLUSfive programme	Amber green	The national standard of 75% is likely to be met based on prior work patterns. And the elevated 'promise' standard is well reflected in planning.	Amber green	The standard can be met in 24/25.
	Expand our work to tackle poverty in local schools through targeted action, likely to include the 'glasses for classes' campaign	Amber green	Existing initiatives exist: further consideration is needed as to how a forward plan of possibilities can be developed.	Green	The glasses for classes scheme has been implemented.

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<u>Health promotion and prevention</u> GB5: We are mapping community assets in all three communities. Our estate plan will then relocate some services to those assets. This work is also supported by our community MH transformation work and our partnership with Leisure Centres.	Invest in community estate in Rotherham to expand the number of consulting rooms and shared spaces available in the town	Amber green	This work is actively progressing and our estate plan will finalise our arrangements from 2025-2028 in the borough	Amber red	The only reason for this rating is timing on the delivery side: main proposals may be subject to procure/build periods which are extended.
	Present finalised asset map to CLE, BOD and COG.	Amber green	This work has been advanced and resource to do so has been in place from Q1 24/25. Outputs are now to be tested in CLE environment.	Amber green	This work can be delivered – a timetable to finalise it to a degree of completeness remains to be established (October delivery review)
<u>Health promotion and prevention</u> GB6: We are working with three local public health departments and others, to assess the calibre of promoted/certified mental wellbeing advice available to both children and young people (CYP) and adults in our three Places. Our new website goes live in December 2023.	Six clear access routes to certified information are 'endorsed' by RDASH 3xCYP and 3xadult and their use is tracked and scaled up, in part through our work.	Red	This work requires an identified resource and is paused with the Chief Executive. This work will be incorporated with patient communication workstream	Red	This aim can be met – but presently won't be until a project to do so is created. This is unlikely before Q4 25/26.
	Grounded Research engaged with each Chamber of Commerce to explore our role with employers in promoting evidence-based wellbeing interventions.	Amber green	Grounded research engagement has taken place and work on this through the Chamber is advancing with local businesses.	Amber green	We will use our R&I plan work to ensure we remain active in supporting this measure – and indeed ensure that our own work meets these standards.
	Funding route for current time-limited support in schools service is established (funding expires 2025).	Green	This has been satisfactorily resolved in 23/24 and 24/25.	Green	This is now identified as an HMG priority and funding models should be considered secure.

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<u>Volunteering</u> GB 7: Our system for recruiting and rapidly enrolling volunteers needs to be effective and pacey. The VSM is making progress with this and internal audit will undertake a review in December/January to ensure that our systems are fit for purpose	The management have confidence that anyone applying to volunteer with us would have a decision and be enrolled within defined, published, and attractive timescales.	Amber green	Arrangements to deliver the changes in process between departments to both speed up and scale up have been agreed. A final flow chart, to permit process step timeliness checking to be monitored is being finalised through the CNO.	Green	This can be met in early 2025.
<u>Volunteering</u> GB8: We have committed in the C&OS to expand volunteering from 50 to 350 people (c10% of headcount)	100 active volunteers working within RDASH by March 2024, with a clear path to 250 by March 2025 [ie. we know how we would use a further 150 rewardingly]	Amber green	Group plans to create placements are advancing well. Support plans corporately to enrol and support this scale of volunteers are assumed within N&F restructure.	Amber red	Promise 3 seeks to reach 350 volunteers in 2025: the cautious rating here reflects LOD by March to 250.
	The diversity of our volunteer base is improving against 2023 baseline	Amber green	No detailed plan to meet this aim is yet in place. However, the ambition is modest given the uniformity of the baseline. Ideas to finalise a plan are being documented through the CNO's team.	Amber green	Progress to improve diversity will be met – fully reflecting our population represents a more challenging objective.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks 2024/25: Q2 Report	**Agenda Item**	Paper T
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	26 September 2024

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

Strategic Delivery Risks are those risks that have the potential to impact on the achievement of the board's strategic objectives. Formerly referred to as the Board Assurance Framework – the SDR Reports will describe the risks and the mitigations (controls) being put in place and the assurances by which the Board knows those controls are working.

The Board has received a paper on the SDRs in each of its last four meetings and in July 2024, discussed the latest position in respect of all five risks. Since then, lead Executives have progressed on their respective risks, with an updated position being presented to Committee in September for three SDRs. These three form the focus of this report, with the next report to Board (November 2024) covering the other two. Creating a rhythm of regular scrutiny and presentation will ensure that the Board remains sighted on the SDRs throughout the financial year.

The three attached SDRs include further detail about the controls being established and the assurances that will confirm the controls are working. The discussions in September at Committee and the planned discussions with the lead executive and Chair of the Audit Committee have identified broad actions to further enhance the process and the reporting (format) of the management of the risks – specifically aimed at recording the planned actions and to identify measures of success (to highlight that the risk is not impacting).

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

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

This paper is the latest in a series of papers presented to and discussed by the Board on the topic:

- Board of Directors in March 2024, May 2024 and July 2024; and
- Board of Directors timeout session – April 2024;

Specifically, SDR 1 and SDR4 were discussed at the Public Health, Patient Involvement and Partnerships Committee in September 2024; and SDR 2 in the Quality Committee in September 2024.

Recommendation (indicate with an 'x' all that apply and where shown elaborate)								
The Board of Directors is asked to:								
RECEIVE and **NOTE** the progress with the development of the mitigating plans for the three of the Strategic Delivery Risks (being SDR1, SDR3 and SDR4)								
NOTE the planned next steps specifically the enhanced format of reporting with the progress in managing the stated SDR.								
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register								
Strategic Delivery Risks	x	SDR1, SDR2 and SDR4						
System / Place impact	x	All three 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 (Formerly referred to as the Board Assurance Framework)

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 intention is that 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, with a new oversight model in place to support the effectiveness of that work.

2. Strategic Delivery Risks (SDR) 2024

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 Previous papers to the Board have included all five of the SDRs. As we progress through the year it is important that the Board of Directors remains sighted on all five, but the scheduling of Committee meetings (at which further scrutiny and oversight occurs) creates an opportunity for the risks to return to the Board in rotation for the rest of the year, affording focus at each meeting on a different cohort of SDR.

2.3 During September 2024, SDR1 and SDR3 were presented and discussed at the Public Health, Patient Involvement and Partnerships Committee; and SDR4 to the Quality Committee. The respective reports from those Committee, included in the agenda packs for today's meeting make reference to this and the latest position in respect of each is attached in the Appendix to this paper.

2.4 During October 2024, SDR2 and SDR5 will be received at the Finance, Digital and Estates Committee and the People and Organisational Development Committee respectively. An update on these will be presented to the Board of Directors in November 2024.

2.5 Alongside these reporting schedules, the Audit Committee will remain sighted on the progress with the overall SDR management (Next at October's meeting) and the Chair of the Audit Committee will continue to hold meetings alongside the Director of Corporate Assurance with each of the respective Executive leads. Such a meeting has taken place with three of the five leads to date, each proving a useful opportunity to discuss the planned work, progress and the future delivery of assurances – all of which is pointed towards the management and indeed mitigation of the SDR.

2.6 As a result of the discussions at Committee and with the Chair of the Audit Committee, three key actions, linked to the process and reporting in relation to the management of these risks, have been identified. These are:

- Greater detail to be included about specifically what action will be taken, by whom and when – current entries simply state a task;

- 'How do we know if it is working?' – SDRs are potentially going to stop us achieving our strategy or key elements of it or the associated plans. We need to better understand the measures of success relevant to each, that will show that the risk is <u>not</u> halting progress. As much as is possible these will be linked to associated reporting to the Board of Directors on the delivery of the Strategic Objectives and on the delivery of the Promises (through such as Paper U on today's agenda); and

- Linked to the two points above, to identify touchpoints (dates) at which progress is likely to be sufficient to consider the risk score being reduced.

Essentially the three points above form a 'map' of expected progress of action, reporting and reassessment in the management of these SDRs.

By way of examples – within SDR1 there is an action linked to the Leadership Development Offer. There will be greater detail incorporated as to the implementation, attendance and completion of this across 2025 which will ultimately result in circa 130 colleagues completing this development. We will look to the feedback from those colleagues and to the feedback from the communities and to other measures that show that our leaders have and continue to, identify, communicate and engage effectively with our diverse populations to enact change – that they are indeed nurturing partnerships with patients and citizens to support good health.

Similarly, with respect to SDR3, we will establish feedback mechanisms with GPs that confirm strong alignment on Primary and Community MH services and adult and children's community nursing, hence demonstrating that our action to provide colleagues with the necessary skills and confidence to experiment and overcome barriers has been successful. Our ability to show the successful delivery of the agreed practical programme of change and the expansion of our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services.

In each of the above examples we will identify the recipient of such reports (CLE Groups, Committees etc) and the planned date of such reports, with the documentation then updated once this is completed.

3. Next Steps

3.1 Actions referred to previously and above will continue on an ongoing basis, namely lead executive work on each risk, scheduled reports to Committee and to the Audit Committee; meetings with lead executives and the Chair of Audit Committee / Director of Corporate Assurance. The Board of Directors will receive a report at each of its meetings, which will, in rotation, cover all five SDRs.

3.2 The format and content of the reporting will be enhanced to reflect on the points identified in 2.6 above.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the progress with the development of the mitigating plans for the three of the Strategic Delivery Risks (being SDR1, SDR3 and SDR4)

NOTE the planned next steps specifically the enhanced format of reporting with the progress in managing the stated SDR.

Philip Gowland
Director of Corporate Assurance
19 September 2024

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 (July 2024)					Target (March 2026)				
	I	4	L	4	16	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	
Stakeholders	• Stakeholder Management Matrix • Roles, Responsibilities, Authority and Capacity of identified leaders to participate • Reporting mechanisms to (CLE Groups, EG and the Board of Directors)
Educating our staff	Leadership Development Offer Component, "Compassionate leadership to unlock community power' – confirmation through delivery report that the cohort of circa 150 have completed this component.(CPD accreditation) – LDO launches September 2024 Induction - Revised induction process to 5-day event that will focus on the introduction to the Trust and its communities. – New induction launches from October 2024. Learning Half Days – forward plan the inclusion of related matters linked to this Strategic Delivery Risk and the mitigating actions needed.
Cultural Shift	Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed Recruitment processes that focus on the appointment based on alignment to the Trust's Values
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.

	Working in this area to ensure that we: • Understand the current profiles and agree focus of action to address any identified shortfall. • Confirm communication methods (two-way) and frequency to achieve engagement including the engagement through the Staff Networks

Assurance – How will we know the controls are working?	

Management reporting to Committee or Board or via CLE and its Groups	• PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each PHPIP meeting)
	• PHPIP Report relating to implementation of Stakeholder Management matrix (confirming establishment and fulfilment of expected engagement – especially focusing on the diversity of those with whom we are engaging)
	
	• Strategy Progress Reports on related (promise) deliverables (multiple promises)
	  ○ Promise 4 (Quality – Quality and Safety Plan)
	  ○ Promise 5 (Board – Quality and Safety Plan)
	  ○ Promise 6 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 8 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 10 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 11 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 26 (POD – People and Teams)
	
	• Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group)
	• Induction Feedback and Evaluation
	• Learning Half Day Feedback and Evaluation
	
	• IQPR reporting improvements in sickness absence and turnover rates;
	• Improved WRES data
	• Patient and wider community partner feedback
	• Complaints profile

Independent Third party Assurance	• Internal Audit work on Partnership Governance and Risk management (Q4) • Internal Audit work on Patient Experience, Engagement and Inclusion (Q3)

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 (July 2024)					Target (March 2026)					
	I	4	L	4	16	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?		
Stakeholders	• Stakeholder Management Matrix – focus explicitly on Primary care partners such as GP forums, confederations, PCNs • Roles, Responsibilities, Authority and Capacity of identified leaders to participate • GP leadership positions within the Trust's structure	
Regular and well established touchpoints within each of the three places with GP representatives	Doncaster	Complete.
	Rotherham	By Q3 – currently in progress
	North Lincolnshire	By Q3 – currently in progress
Facilitate insight into General practice within …	Board	By Q3 – to complete – appointment to Physical Health Care Group Medical Director In place: 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 appointed and commences in role on 1 November 2024.
	Care Groups	GP related appointments into Care group structures

	Wider workforce	Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care.
Practical programme of change	Trust Wide	By Q3 this programme will be in place and include programmes focused on referrals and communication; and Roles (DN / PC MH team) By Q1 25/26 – this programme will be delivered / implemented.

Assurance – How will we know the controls are working?	

Management reporting to Committee or Board or via CLE and its Groups	• PHPIP Report relating to implementation of Stakeholder Management matrix (confirming establishment and fulfilment of expected engagement – especially focusing on the Primary Care partners
	• PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)
	• Report relating to the delivery of the practical programme of change with primary care and the benefits of such a programme
	• Strategy Progress Reports on related (promise) deliverables:
	  ○ Promise 12 (PHPIP - Equity and Inclusion Plan)
	  ○ Promise 15 (PHPIP - Equity and Inclusion Plan)
	  ○ Promise 21 (PHPIP - Equity and Inclusion Plan)
	
	• Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group)

Independent Third party Assurance	• Internal Audit work on Partnership Governance and Risk management (Q4) • Internal Audit work on Patient Experience, Engagement and Inclusion (Q3) • Feedback mechanisms with GPs confirm strong alignment on Primary and Community MH services and adult and children's community nursing

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 (July 2024)					Target Score (March 2026)					
	I	4	L	3	12	I	3	L	2	6	

Controls – What will we put in place to mitigate the risk?	
Service provision (RDASH)	**Data** To review the current data in terms of number of discharges in relation to days of the week, and timing of discharges by wards to create a base line (Q2) Develop a “live” Flow Dashboard (Q2) **Enhance the Current Offer** To support enhanced discharges during weekdays with a focus on improving morning discharges, using current infrastructure. -This will include using EDD’s more consistently and appropriately (Q2) -To introduce weekly meetings with senior nurses to review EDD (Q2) -To introduce a complex CRFD forum with the 3 Local Authority Partners and 2 ICB (Q3) **Developing New Models** To ensure therapeutic discharges 24/7 are part of the inpatient improvement programme “the middle bit” (Q3 onwards) Pilot programme on one ward to test the ability, capacity and affordability of proposed changes. This will require possible consultant cover at weekends or using nurse led criteria discharges. This will require workforce flexibility, funding and policy changes (2025-2026) As part of the pilot to consider if other clinical or backbone services need to align with this new way

	of working being tested out, for example pharmacy; HTT and AOT services.
Alternative Service provision (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. 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
Staff Engagement	• Unions and Staff Side – consultation / engagement processes discussed and agreed (depending on when the pilot is being launched this will go through JCC. This will be RC to lead) The points below will be discussed at POD in Q4 and will require HR support • Revised ‘standard’ terms and conditions to create opportunity for more flexibility • Ensure changes are clinically led. • Ensure JD reflects new ways of working. • Consider if change can be managed in part through staff turnover and investment as opposed to mass service consultation • Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety

Assurance – How will we know the controls are working?	

	• QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)
	• Strategy Progress Reports on related (promise) deliverables:
	  ○ All linked to SO3 – Promises 13 to 17
	  ○ All linked to SO4 – Promises 18 to 23
	• IQPR reporting improvements in patient flow metrics (reduction in waiting lists, OATS and delayed discharges)
	• IQPR reporting improvements in utilisation of Talking Therapies
	• Staff Survey outcomes (Q4 2024/25)
	• Peer Review process
	• Complaints (reduction in those that relate to access to services) and improved patient feedback
	• Regulatory Inspection reports
	• ROOT and Culture of Care metrics

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – August 2024	**Agenda Item**	Paper U
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jill Fairbank – Head of Contracting, Performance & CQUIN Victoria Takel – Deputy Chief Operating Officer Richard Chillery – Chief Operating Officer		
Meeting	Board of Directors	**Date**	26 September 2024

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

There are a number of metrics, including those within our Top Ten showing improvement. A reduction in breaches of our own S136 stay measure for example. Perinatal mental health delivery is worsening, though on a full year basis remains in line with the standard. Talking Therapies services continue to experience challenges regarding Reliable Recovery (OP03c) which has seen variable performance against the 48% target this year, with performance in August at 42.79%.

The new RTT pathways for mental health (OP08d) have seen a further improvement from 79.19% in June to 89.52% in August. Patients waiting over 18 weeks are now known with hotspots being in the North Lincolnshire Memory Services. An action plan is in place within the Care Group to further improve this position and this will be addressed within delivery review.

There is a reported increase in racist incidents (QS29) reported as 5 in August compared to the 3 in July and 1 in June – more reporting is undoubtedly a positive step. On 1st October the Acceptable Behaviour Policy will be launched which will create a framework to warn, bar and ultimately exclude carers and patients who abuse employees, students and Volunteers with Care Group leaders empowered to apply these sanctions. The new metrics to report the vacancy rate report as 7.48% against the target of 2.5% for August. This month we are reporting 278 vacancies across the Trust – albeit the position is best reflected in the CEO annex before the Board.

Alignment to strategic objectives	
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

Previous consideration

Clinical Leadership Executive and relevant committees of the Board

Recommendation

The Board is asked to:

X	**NOTE** reported delivery and consider areas of prolonged under achievement

Impact

Trust Risk Register	x	O10/19, DCGMH6/23, O1/20, NLCG5/24, RCG8/24, DCG20/23, DCGMH5/23, 1524, NLCG1/23, NLCG11/23, N&F10/24, RCG1/24, RCG13/24, WF1/20, RCG3/23, CCG11/24, RCG2/20, CCG4/22, NLCG2/20, O 8/19, PCG18/24, RCG21/23, CCG1/24, CA1/24, E4/24, NLCG17/23, RCG21/23						
Strategic Delivery Risks	x	SDR2 and SDR4						
System / Place impact								
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed		

Appendix (please list)

Integrated Quality Performance Report

September 2024 Review

Data as at 31st August 2024

Draft Version 4

Contents

1.0 Executive Report

This report outlines the August 2024 position against the operational performance, quality, workforce and finance data.

The Trust continue to focus delivery on ten key metrics (LTP01-LTP10) on the understanding that all performance is a priority. There remain a number of key performances metrics.

Where there are areas for development and action, these are noted below:

Physical health services continue to perform well against the new RTT consultant led Physical Health pathways OP08c, OP10c. There are 0 patients waiting over 52 weeks. It is also worth noting that month although we have not met the 80% occupancy target, the occupancy for our Virtual Ward on the 1st, 15th and 30th of the calendar month has risen month on month over the last 15 months with 65% occupancy on the 15th of August 2024. For those people in a physical health crisis (OP05) all patients have been assessed within 2 hours. The 8 breaches identified in the reporting are all data quality related.

The update for Children's Services shows that although we are seeing all our most urgent children and young people (CYP) in our eating disorder services within 1 week (OP15), and 92.86% of all children within 4 weeks, we continue to report a month on month drop in our performance over a number of indicators. For CYP accessing our Children and Mental Health Services (OP13a) we are reporting 9,666 against the target of 9,783, (RDaSH 8,839, Kooth 766/Mind 61). It is noted that there is a downward trend in performance across several metrics within Children's services and a multidisciplinary meeting with the Care Group, Clinical Systems team and Performance is taking place on the 10th September to discuss and identify any themes of non-compliance.

Our Mental Health services continue to experience progress and challenges. In terms of OP13e, the metric in relation to adults and older people accessing community mental health services with 2+ contacts, we continue to substantially exceed the target Trust wide, reporting 9,661 against the target of 8,533.

Talking Therapies services have seen a deterioration across several indicators in month and, whilst the Trust has historically underperformed against access to Talking Therapies services metric (OP03a) which is a stretch target from existing performance, the performance for August 2024 has fallen below standard variation based on the Trust's performance. Whilst some seasonal variation is expected during the month of August, the level of variation is beyond this and therefore the service is undertaking investigation as to the cause with a report to be provided on this in the October 2024 IQPR. It is also noted that performance against the Reliable Recovery (OP03c) has been variable during 2024/25 to date, with performance in August 2024 falling below the 48% target. It has been identified that the reduction in performance is attributable to two main factors, the Doncaster service had agency workers within the service until August 2024, patients who were on these caseloads were all discharged in August on completion of treatment and have achieved lower recovery rates than the wider service and also there were a number of complete treatment episodes in August 2024 overall due to peak annual leave, meaning this had a more significant impact on reliable recovery than it would within further months. Then service forecast this to stabilise in September 2024 with a continued focus on the North Lincolnshire service where reliable recovery rates are below the other two services in the Trust. The weekly Operational Oversight Group continues and will lead this analysis and the implementation of remedial action as required. Positively, the service is developing stronger links with Primary Care and is now scheduled to present at the Doncaster TARGET meetings with Local GPs, with Rotherham and North Lincolnshire to follow.

Our focus on inappropriate out of area placements remains an area of significant concern and we are currently reporting 35 individuals placed out of area as at the end of August which has risen from 32 in July. A multi-staged improvement programme is being developed, led by several of the Executive Team. There have been workshops with external partners and internal clinicians during August from which the findings are being pulled together to inform some potential initiatives for admission avoidance to support with improvement of patient flow.

1.0 Executive Report

The percentage of VTE assessments completed within 24 hours has shown an increase to 93.08% (121/130) in August from 92.25% 131/142) in July. The change request submitted to clinical systems team to add an alert to patient records to notify when the assessments are uncompleted at 6/12/24 hours to assist with completion within timeframe and to provide an exemption for hospice patients in the last 24 hours of life is waiting for approval by the system optimisation group in September. Once approved this will be implemented and rolled out across the Trust. In the interim, Care Groups are conducting daily deep dives and weekly audits which are acted on if the VTE assessment is not fully completed and continue to feed back to doctors concerned.

The number of detained patients who abscond from an acute adult and OP inpatient mental health units (QS20) has seen 3 detained patients abscond in August. Following a deep dive one patient absconded when attending an acute hospital appointment. The patient shared they were going to leave the hospital and staff appropriately implemented the AWOL procedure and the patient was returned to the ward. A debrief was completed with staff and patient to devise a support plan for future appointments to acute hospital.

The 3 recorded incidents (QS27) are graded as near miss and therefore this target has not breached the target for August and there has been no recorded ligature incidents in month. Ligatures were identified and removed by staff during appropriate security checks as per the policy. Following a deep dive it was noted that there is an identified cohort of patients who engage in repeated ligature attempts. Upon validation of data entry all three incidents were classified as near miss incidents where ligatures were identified and removed by staff during appropriate security checks as per the policy. Following a deep dive, it was noted that there is an identified cohort of patients who engage in repeated ligature attempts.

The Trust is reporting an increase in racist incidents (QS29) reported as 5 in August from the 3 in July and 1 reported in June. As part of promise 26 and in response to the recent racist attacks across the country and in our local community the Chair and Chief Executive supported by the leadership executive have collectively produced written communications and a series of video's supported by the central communications team to highlight this unacceptable behaviour to see change and signpost those affected by this behaviour for support. On 1st October the Acceptable Behaviour Policy will be launched which will create a framework to warn, bar and ultimately exclude carers and patients who abuse employees, students and Volunteers with care Group leaders empowered to apply these sanctions.

The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for August. Upon investigation, an increase can be seen for August reporting 75% (6/8) from the 66.67% (4/6) in July and 66.67 (4/6) in June. However, following a deep dive by the Mental Health Act Manager we can report 100% (7/7) patients received an MDT assessment within timescale for August. Showing an increase from 71% in July (5/7).

There is a decrease to 58.70% for individuals receiving a MUST assessment QS36 (81/138) in August following the increase to 67.76% (103/152) in July. The change to add an alert to patient records to notify when the assessments are uncompleted at 6, 12 and 24 hours to assist with completion with the exemption requested for hospice patients who are in end-of-life care has been requested for approval at the change meeting in September. Whilst this change is processed Care groups continue to conduct daily deep dives and weekly audits which are acted on if the MUST assessment remains uncompleted. Daily monitoring is taking place across all care groups.

There is a slight decline to 92.77% in August (77/83)) from the 96.55% in July (84/87) for the number of Inpatients receiving a falls assessment within 72 hours. However, following a deep dive (80/83) 96.38% of patients received a falls assessment within 72 hours in July. Three patients didn't receive their MFRA on time (3 x patients on mental health wards) but these have been completed out of timescale. Therapy staff are being monitored to check MFRA completion as part of patient's initial assessment within 24 hours.

1.0 Executive Report

One fall (QS38) was reported as being moderate or above for August having been identified by the falls panel as requiring a structured review. This fall has been through fall panel and a structured review (after action review), the actions and learning has been identified. Moving forwards this parameter is not aligned with the new PSIRF approac to patient safety incidents and a request is being worked on and will be presented to update this metric.

From a people perspective we have seen a slight improvement in performance for the number of our employees receiving a performance and development review (POD18) with performance slightly below the 90% target at 89.04%. The year-to-date sickness absence (POD10) % has increased slightly from 5.70% to 5.85% which is an deterioration of 0.15% from the position in July of 5.7%.The Physical Health Care Group showed a small improvement in the sickness absence figures from 6.4% to 6.37%, the other care groups all saw a small deterioration. The new metrics to report the vacancy rate is reported as 7.48% against the target of 2.5% however it is noted that the budgeted establishment has increased across all directorates, this month we are reporting 278 vacancies across the Trust.

The trust is reporting a deficit position of £139k at the end of August 2024. The adverse position is driven by £425k of unfunded enhanced packages of care (EPC's) within SY Adult Eating Disorder Provider Collaborative. The position excluding this is a year-to-date underspend against plan of £286k. This has improved compared to M4 due to additional income of £0.3m agreed by NHSE to support this. £125k of this is included in the M5 position. The position excluding these costs (FIN02) is a year to date underspend against plan of £286k. All care group are underspent at the end of August, except for North Lincs & Talking Therapies, who has plans in place to recover this position in future months.

2.0 - Performance – In Focus

Indicators for August 2024/2025 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		8/12	66.67%		83.00%	>= 60%	80.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1125		2624	>= 9374	6587
OP03b (L)	LTP 02 a (ii)	People accessing Talking Therapies - Cumulative Quarterly			1125	Q2 >= 3955	2624		6587
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		261/610	42.79%		46.00%	>= 48%	47.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		403/641	62.87%		66.00%	>= 67%	68.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		11/19	57.89%		58.00%	>= 70%	58.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			547		547	>= 598	547
OP08c (N)		18 weeks RTT for consultant led Physical Health services		399/432	92.36%		94.00%	>= 92%	94.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		188/210	89.52%		82.00%	>= 92%	81.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			15		15	= 0	15
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			5		5	= 0	5
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		53/71	74.65%		78.00%	>= 60%	80.00%
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			8839		8839	>= 9783	8839
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		819/4289	19.10%		19.00%	>= 20%	19.00%

Narrative

OP03a – This is a place target however, only includes RDaSH activity reporting 6,587 for the cumulative year to date up until the end of August against a target of 9,374. When compared with activity in the same period last year we are reporting slightly behind last years actual which was 6,592 up to the end of August 2023. Ieso are subcontracted to support with Rotherham Place activity to deliver 108 for the 2024/25 financial year.

OP03b cumulative quarter to date talking therapies access target for August is 3,955 and remains 1,331 below the QTD target reporting 2,624.

OP03c – There has been a drop in performance to 42.79 % in August and the YTD position remains below the 48% target. Monthly performance has been below the 48% target for 3 out of the 5 months in this financial year.

OP03d - There has been a drop in monthly performance to 62.87% in August however the YTD position remains above the 67% target reporting 68%.

OP05 – Performance has been validated and no patients in crisis have been assessed over the 2 hour target. All the 8 breaches are data quality related.

OP7b – PLACE TARGET ACHIEVED - a rolling 12 month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (547) and Maternal Mental Health Service (SHSC) (255) is counted the number of women receiving support is 802, remaining above the target of 598.

OP08d – Performance has been validated and current performance is reported as 89.52%, slightly below the 92% target.

OP10C - of the 15 breaches reported, all patients have been seen within 52 weeks.

OP10d – of the 5 breaches reported, all patients have been seen within 52 weeks. There is a meeting with the community directorate in Doncaster MH+LD Care Group to understand the reason for these data quality errors on 10th September 2024.

OP13a – PLACE TARGET NOT ACHIEVED. A Place target, focus on this metric continues with performance at place (9,666) slightly below the 2024/2025 target of 9,783 (RDaSH 8,839, Kooth 766/Mind 61).

2.0 - Performance – In Focus

Indicators for August 2024/2025 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13d (L)	LTP 01 a	Adults accessing community mental health services (DW)			9661		9661	>= 8533	9661
OP13e (N)	LTP 01 b	CMHT access rate (DW not MHSDS) (>=1 Contact)			9661		9661	>= 7331	9661
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		91/98	92.86%		93.00%	>= 95%	93.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		3/3	100.00%		100.00%	>= 95%	100.00%
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			35		35	<= 16	35
OP54a (L)	LTO 06 a (i)	Virtual ward occupancy - on day 1		37/60	61.67%		66.00%	>= 80%	66.00%
OP54b (L)	LTO 06 a (ii)	Virtual ward occupancy - on day 15		39/60	65.00%		58.00%	>= 80%	55.00%
OP54c (L)	LTO 06 a (iii)	Virtual ward occupancy - on day 30		34/60	56.67%		59.00%	>= 80%	60.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			4453		4453	< 4918	4453
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			2608		2608	<= 2353	2608
OP73a (L)	LTP 10 a	Section 136 Breaches – Occupancy hours lost to breaches			54		432		1353

Narrative

OP14 - Children and young people with routine eating disorders seen within 4 weeks has increased slightly in month from 92.66% in July to 92.86% in August. However after investigation 1 of the 7 breaches are as a result of data quality and the patient has been seen be the required timescale. Once corrected performance will be reported as 93.88%, remaining slightly below the 95% target.

OP15 - Urgent cases are seen within 1 week with performance remaining at 100%.

OP17c -The number of inappropriate adult acute OAPs is reported as 35 an increase on previous month of 32, reporting above the target of 16.

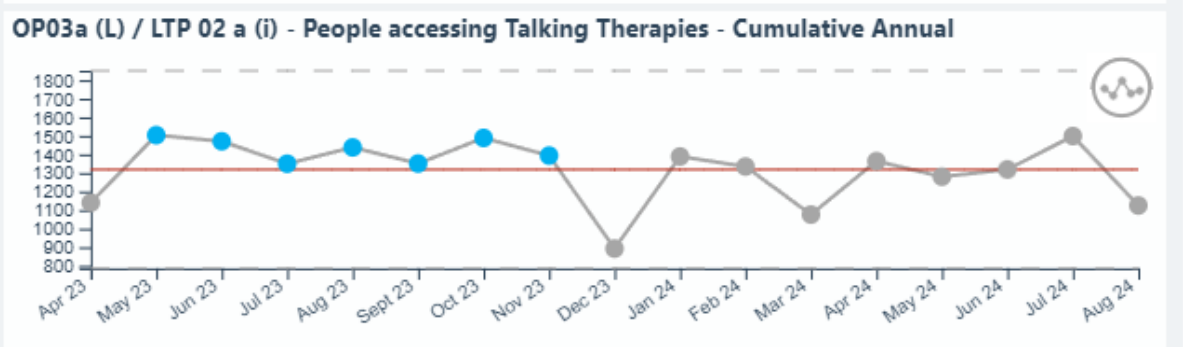
OP54a/OP54b/OP54c – The metrics introduced in April 2024 measure occupancy of the Virtual Ward at 3 points in the calendar month. The service are working towards the occupancy rates with day 1 reporting 61.67%, day 15 at 65% and day 30 at 56.67%

OP59a –The metric measuring performance against the Adult ADHD waiting list trajectory is reporting ahead of the target with 4,453 individuals waiting for assessment against a target of 4,918.

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target and is reporting 2,608 CYP waiting against the target of 2,353. This is primarily due to the delays to recruitment of the additional staffing required to deliver the trajectory. The Care Group have redeveloped the trajectory to support with the delivery of the 4 week wait by April 2026 and the revised draft has been presented however has not yet been approved.

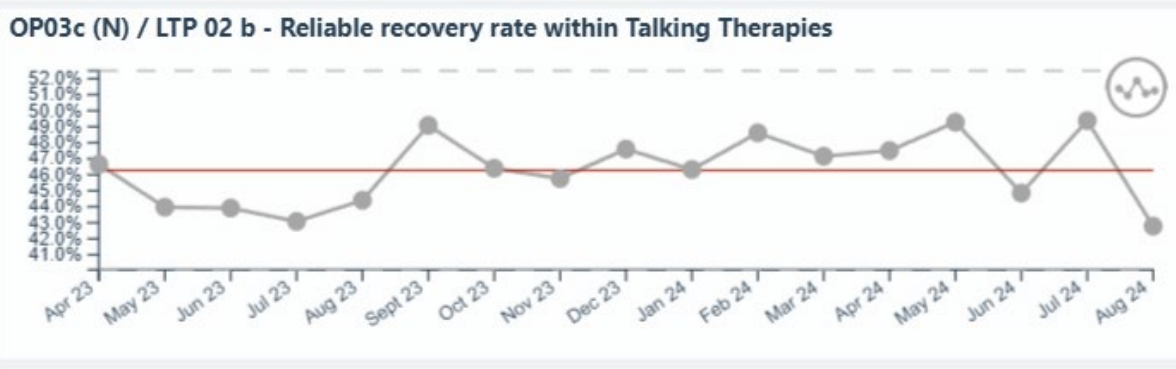
OP73a – decrease to 54 hours lost this month in our S136 suites due to patients staying in the suite over 24 hours, closures, or misuse.

2.1 Performance In Focus - Exceptions



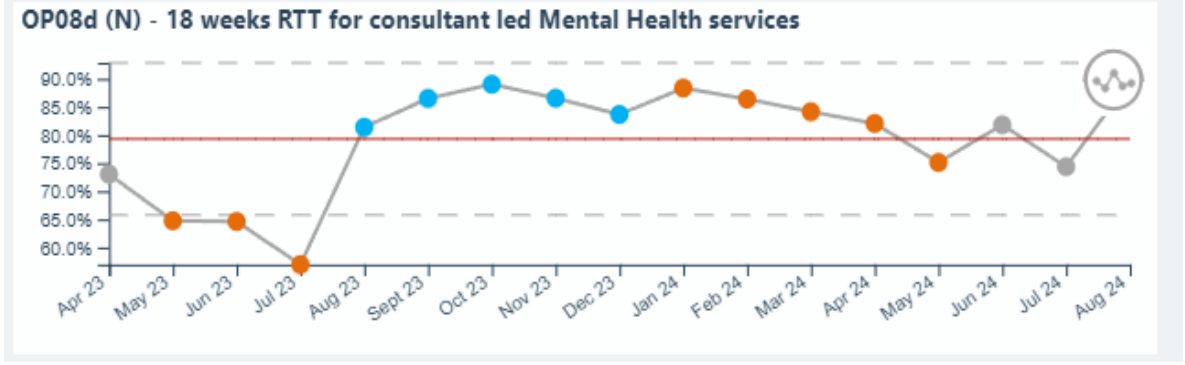
Trend, Reason and Action

OP03a It is noted that the whilst the Trust has historically underperformed against this metric, which is a stretch target from existing performance, the performance for August 2024 has fallen below standard variation based on the Trust's performance. Whilst some seasonal variation is expected during the month of August, the level of variation is beyond this and therefore the service is undertaking investigation as to the cause with a report to be provided on this in the October 2024 IQPR.
The weekly Operational Oversight Group continues and will lead this analysis and the implementation of remedical action as required. Positively, the service is developing stronger links with Primary Care and is now scheduled to present at the Doncaster TARGET meetings with Local GP's, with Rotherham and North Lincolnshire to follow.



Trend, Reason and Action

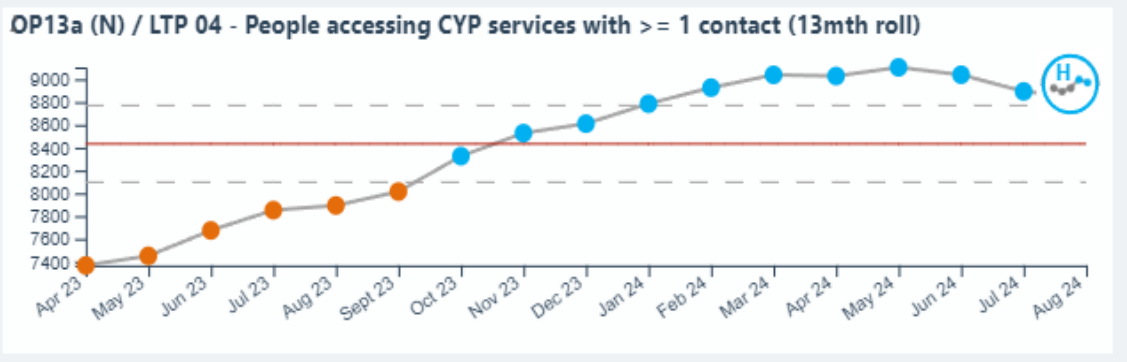
OP03c It is noted that performance against the Reliable Recovery KPI has been variable during 2024/25 to date, with performance in August 2024 falling below the 48% target.
For august 2024 it has been identified that the reduction in performance is attributable to two main factors: the Doncaster service had agency workers within the service until August 2024, patients who were on these caseloads were all discharged in August on completion of treatment and have achieved lower recovery rates than the wider service and also there were a number of complete treatment episodes in August 2024 overall due to peak annual leave, meaning this had a more significant impact on reliable recovery than it would within further months. Then service forecast this to stabilise in September 2024 with a continued focus on the North Lincolnshire service where reliable recovery rates are below the other two services in the Trust.



Trend, Reason and Action

OP08d – The Trust wide performance is reporting at 89.52% with individual Care groups reporting at: Rotherham Adults and Older People Mental Health Care group (99.07%), Doncaster and Learning Disability Care Group (83.91%) and North Lincolnshire & Talking Therapies Care group (56.25%) . There is an identified issue within waits in Memory Services in North Lincolnshire which is driving this, with the Care Group actively investigating to put remedial actions in place to address. The longest wait on this pathway was at 24 weeks at the end of August. Although these breaches are investigated monthly to determine the reasons behind the waits, the waiting list improvement programme which commenced in January 2024 and the move of the waiting list validation programme to work with patients waiting under 18+ weeks will support with further improvement.

2.1 Performance In Focus - Exceptions

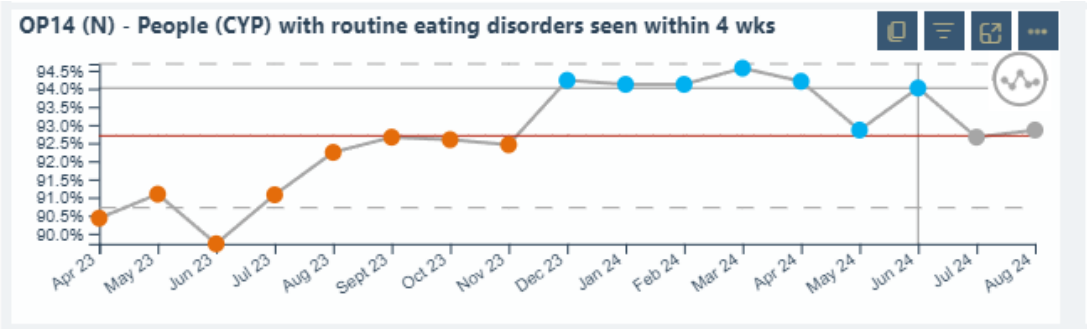


Trend, Reason and Action

OP13a The children and young people access rate (OP13a) is the place target and activity needs to reflect all NHS funded activity across the 3 places. The graph represents the RDaSH contribution of 8,839 and when the activity from Kooth in Doncaster 766 and Mind 61 North Lincs is factored in the performance is reported as 9,666 against the target of 9,783. A performance clinic will be held in September to identify the root cause and to ensure that appropriate mitigations are in place to rectify the performance.

Trend, Reason and Action

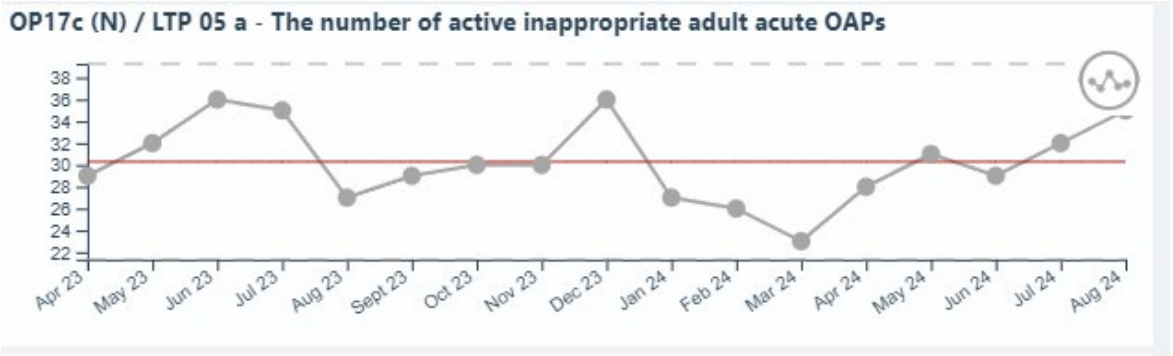
OP13b The CYP access 2 contacts and a paired scored has seen a deterioration over the last 3 consecutive months, this will trigger the requirement for the performance team to hold a performance clinic with the Care group which will take place in September to identify the root cause and to ensure that appropriate mitigations are in place to rectify the performance.



Trend, Reason and Action

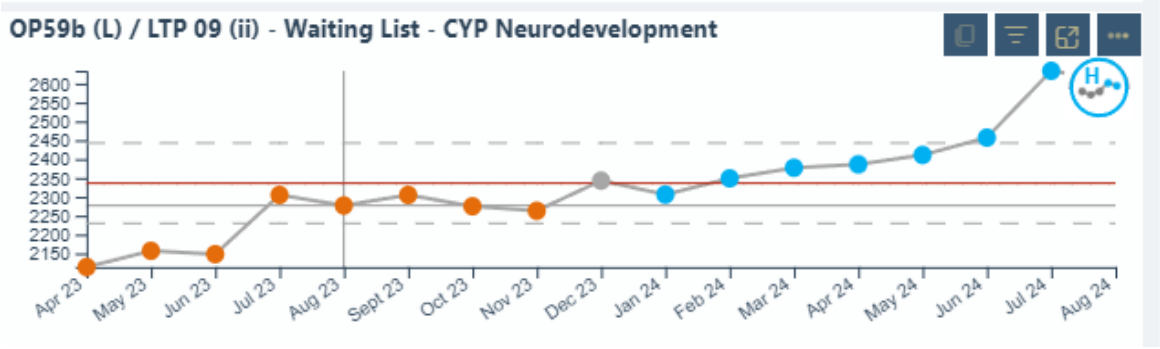
OP14 Children and young people with routine eating disorders seen within 4 weeks has improved slightly in month from 92.66 % in July to 92.86 % in August. However after investigation 1 of the 7 breaches are as a result of data quality and the patient has been seen be the required timescale. Once corrected performance will be reported as 93.88%, remaining slightly below the 95% target.

2.1 Performance In Focus - Exceptions



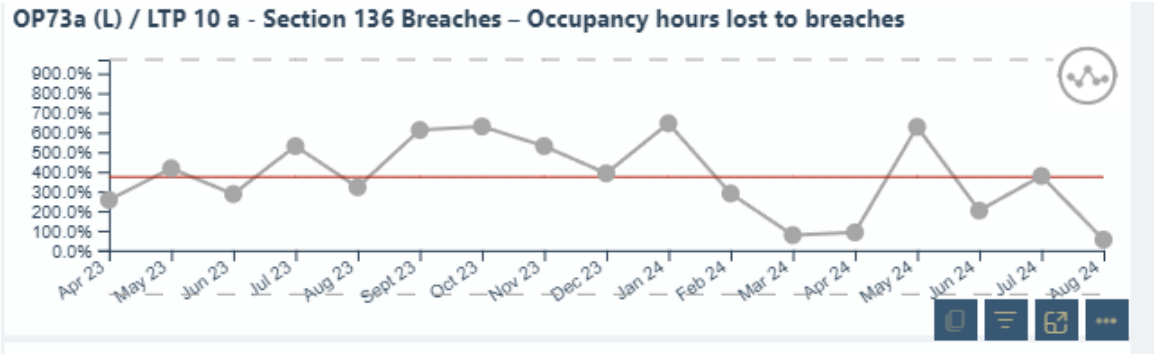
Trend, Reason and Action

OP17c The number of inappropriate out of area placements has increased from 32 in July to 35 in August at the end of the calendar month and remains above the trajectory of 16. A multi-staged improvement programme is being developed, led by several of the Executive Team. There have been workshops with external partners and internal clinicians during August from which the findings are being pulled together to inform some potential initiatives for admission avoidance to support with improvement of patient flow.



Trend, Reason and Action

OP59b This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target and is reporting 2, 608 CYP waiting against the target of 2,353. This is primarily due to the delays to recruitment of the additional staffing required to deliver the trajectory. The Care Group have redeveloped the trajectory to support with the delivery of the 4 week wait by April 2026 and the revised draft has been presented however has not yet been approved.



Trend, Reason and Action

OP73a – the metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, 54 hours were lost this month, a significant improvement when compared to July's total.

3.0 Quality & Safety In Focus

Indicators for August 2024/2025 TRUST — Quality & Safety

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS05 (N)	Number of MRSA infections (Monthly)	= 0		0	Q2 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q2 = 0	0	= 0	1
QS07 (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q2 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	121/130	93.08%	Q2 >= 95%	93.00%	>= 95%	91.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		15/18	83.33%		83.00%	>= 90%	87.00%
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			3		6	= 0	12
QS21a (L)	Physical aggression incidents mod or above to staff (%)		1/22	4.55%		3.00%		19.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats (%)		0/26	0.00%		100.00%		67.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		0	Q2 = 0	0	= 0	0
QS27 (L)	Ligature incidents mod or above all inpatient areas		3/24	12.50%		13.00%	<= 10%	12.00%
QS29 (L)	Number of racist incidents against staff members			6		10	= 0	19
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		6/8	75.00%		66.00%	= 100%	52.00%
QS36 (N)	Inpatients that have a completed MUST assessment		81/138	58.70%		63.00%	= 100%	62.00%
QS37 (L)	Inpatients commenced with falls assessment in 72 hrs		77/83	92.77%		95.00%	= 100%	96.00%
QS38 (L)	Moderate/High falls requiring a structured review	= 0%	1/2	50.00%	Q2 = 0%	50.00%	= 0%	50.00%

Narrative

QS08 -The percentage of VTE assessments completed within 24 hours has shown an increase to 93.08% (121/130) from 92.25% (131/142) in July and the 91.16% in June.

QS15 –Safer staffing has sustained a three-month position at 83.33% (15/18 wards) from June – August.

QS20 – Reporting 3 detained patients absconding in August from acute adult and OP inpatient mental health units which has breached the zero target.

QS27- Upon validation of data entry all three incidents were classified as near miss incidents where ligatures were identified and removed by staff during appropriate security checks as per the policy.

QS29 –Reporting an increase in racist incidents reported as 5 in August from the 3 in July and 1 reported in June.

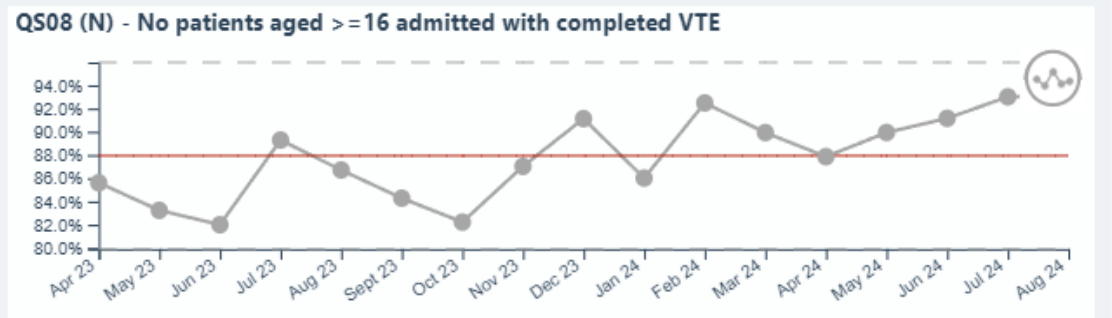
QS31 - The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for August. Upon investigation an increase can be seen for August at 75% (6/8) from the 66.67% (4/6) in July and 66.67 (4/6) in June. However, following a deep dive by the Mental Health Act Manager we can report 100% (7/7) patients receiving an MDT assessment within timescale for August. Showing an increase from 71% in July (5/7).

QS36- Reporting a decrease to 58.70% (81/138) in August following the increase to 67.76% (103/152) in July

QS37 Reporting a slight decline to 92.77% in August (77/83) from the 96.55% in July. Following a deep dive by the Falls lead (80/83) 96.38% of patients received a falls assessment within 72 hours in August.

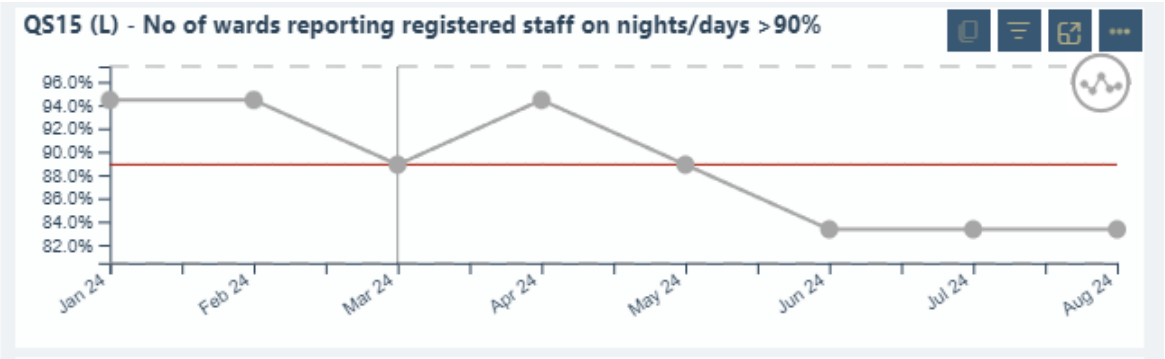
QS38 – Reporting 1 fall moderate or above for August having been identified by the falls panel as requiring a structured review. The fall caused no permanent harm and the actions and learning have been identified.

3.1 Quality and Safety In Focus - Exceptions



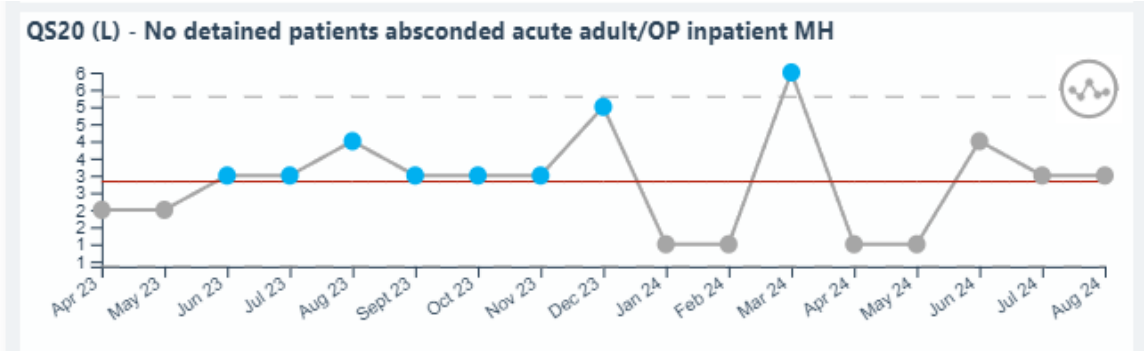
Trend, Reason and Action

QS08- The percentage of VTE assessments completed within 24 hours has shown an increase to 93.08% (121/130) from 92.25% (131/142) in July and the 91.16% in June. The change request has been circulated to all Care Groups for discussion at their change request meetings and will be going to System Design Authority 12/09/24 to add an alert to patient records to notify when the assessments are uncompleted at 6/12/24 hours to assist with completion within timeframe. A change request has also been submitted as an exemption for hospice patients in the last 24 hours of life. Care groups are conducting daily deep dives and weekly audits which are acted on if the VTE assessment is not fully completed and continue to feed back to Doctors concerned. There is a focus on VTE assessments in Junior Doctor's Induction and training across all Care Groups.



Trend, Reason and Action

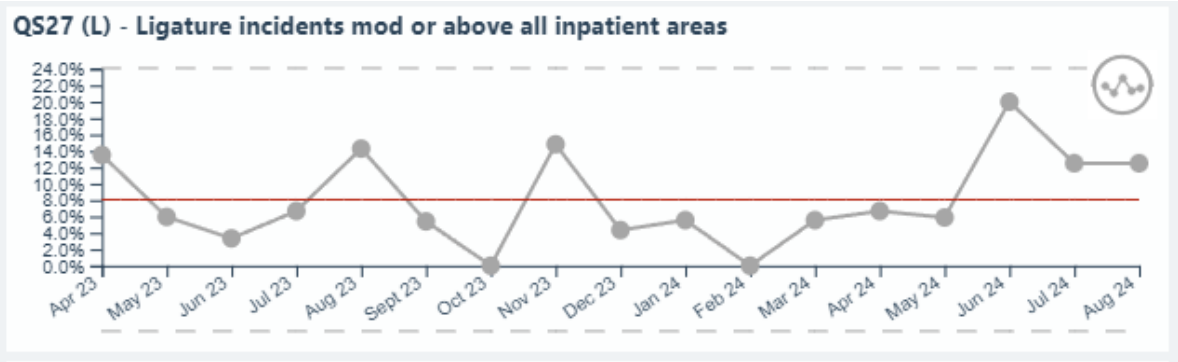
QS15 –Safer staffing has sustained a three-month position at 83.33% (15/18 wards) from June – August. The new safe staffing reporting approved by the Trust board is being completed monthly.



Trend, Reason and Action

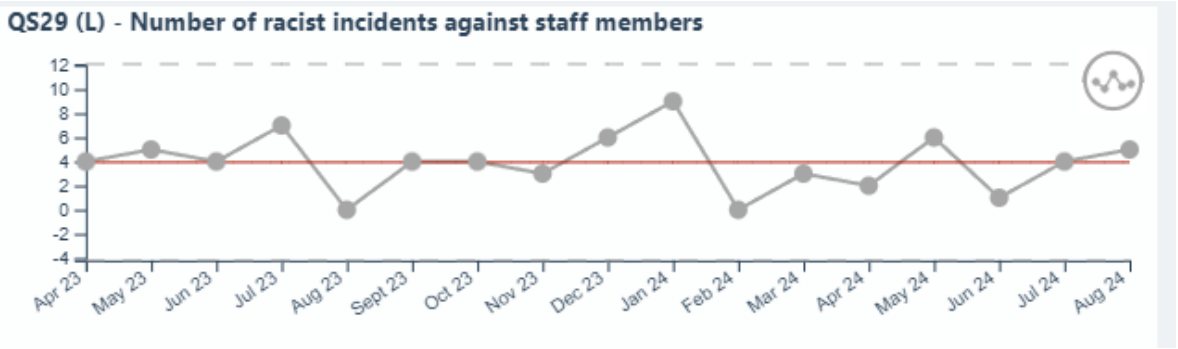
QS20 - 3 detained patients have reported as absconding in August from an acute adult and OP inpatient mental health unit breaching the zero target. Following a deep dive one patient absconded when attending an acute hospital appointment. The patient shared they were going to leave the hospital and staff appropriately implemented the AWOL procedure and the patient was returned to the ward. A debrief was completed with staff and patient to devise a support plan for future appointments to acute hospital.

3.1 Quality and Safety In Focus - Exceptions



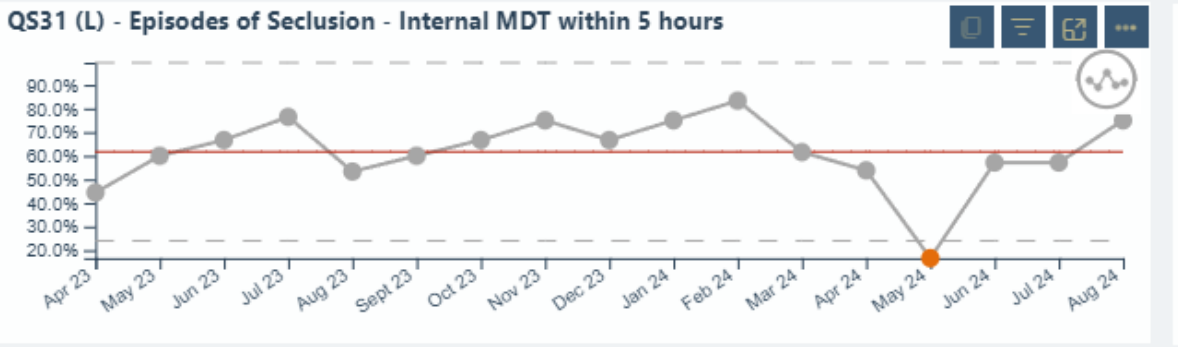
Trend, Reason and Action

QS27 –The 3 recorded incidents are graded as near miss and therefore this target has not breached the target for August with no recorded ligature incidents in month. Upon validation of data entry all three incidents were classified as near miss incidents where ligatures were identified and removed by staff during appropriate security checks as per the policy. Following a deep dive it was noted that there is an identified cohort of patients who engage in repeated ligature attempts.



Trend, Reason and Action

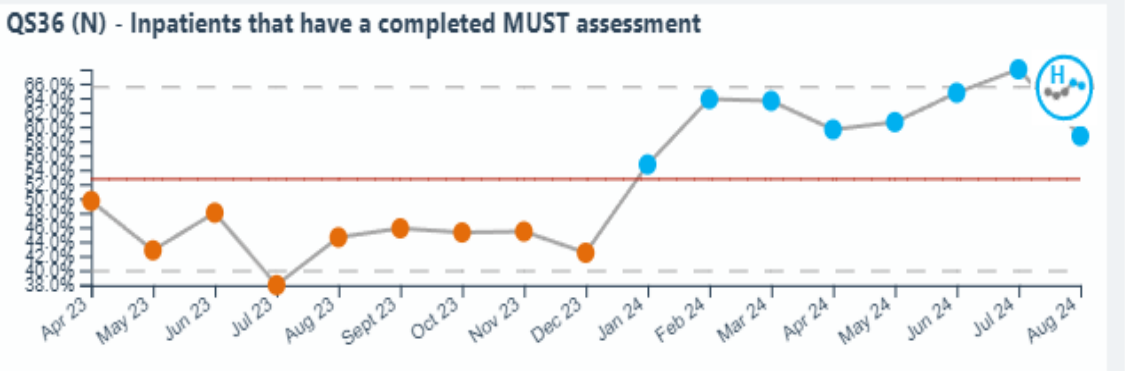
QS29 – IQPR is reporting an increase in racist incidents reported as 5 in August from the 3 in July and 1 reported in June. As part of promise 26 and in response to the recent racist attacks across the country and in our local community the Chair and Chief Executive supported by the leadership executive have collectively produced written communications and a series of video's supported by the central communications team to highlight this unacceptable behaviour to see change and signpost those affected by this behaviour for support. On 1st October the Acceptable Behaviour Policy will be launched which will create a framework to warn, bar and ultimately exclude carers and patient's who abuse employees, students and Volunteers with care Group leaders empowered to apply these sanctions.



Trend, Reason and Action

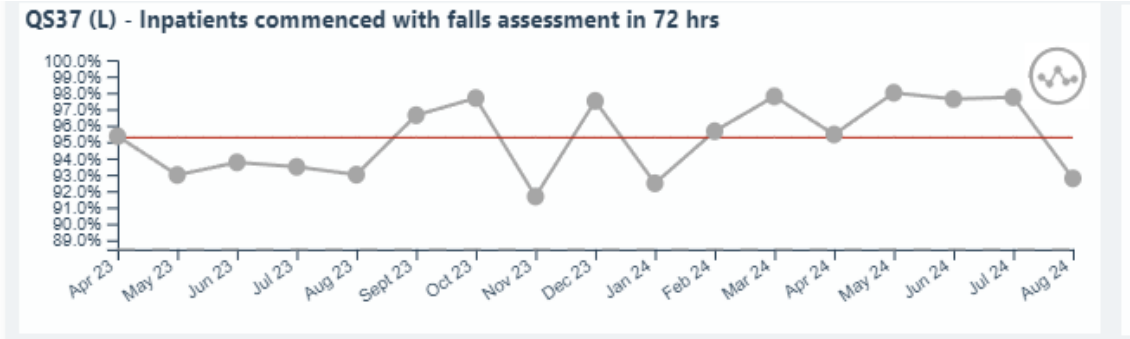
QS31 The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for August. Upon investigation an increase can be seen for August reporting 75% (6/8) from the 66.67% (4/6) in July and 66.67 (4/6) in June. However, following a deep dive by the Mental Health Act Manager we can report 100% (7/7) patients receiving an MDT assessment within timescale for August. Showing an increase from 71% in July (5/7).

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS36 – Reporting a decrease to 58.70% (81/138) in August following the increase to 67.76% (103/152) in July. The change to add an alert to patient records to notify when the assessments are uncompleted at 6,12 and 24 hours to assist with completion with the exemption requested for hospice patients whom are in end of life care has been requested for approval at the change meeting in September. Whilst this change is processed Care groups continue to conduct daily deep dives and weekly audits which are acted on if the MUST assessment remains uncompleted. Daily monitoring is taking place across all care groups.



Trend, Reason and Action

QS37 – Reporting a slight decline to 92.77% in August (77/83) from the 96.55% in July (84/87) for the number of Inpatients receiving a falls assessment within 72 hours. However, following a deep dive (80/83) 96.38% of patients received a falls assessment within 72 hours in August. Three patients didn't receive their MFRA on time (3 x patients on mental health wards) but been completed out of timescale. Therapy staff are being monitored to check MFRA completion as part of patient's initial assessment within 24 hours.

Trend, Reason and Action

QS38 – Reporting 1 fall as being moderate or above for August having been identified by the falls panel as requiring a structured review. The fall caused no permanent harm and the actions and learning have been identified. Moving forwards this parameter is not inline with the new PSIRF approach to patient safety incidents and a request is being worked on and will be presented to update this metric.

4.0 People and Organisational Development – In Focus

Indicators for August 2024/2025 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	9.63%		10.00%		10.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.85%		6.00%		5.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	14		14		14
POD16 (L)	Qualified nursing vacancies	<= 10%	7.53%		8.00%		8.00%
POD17 (L)	Support worker vacancies	<= 10%	10.67%		11.00%		9.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	89.04%		89.00%		89.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	90.36%		90.00%		90.00%
POD23 (L)	Number of individuals currently suspended from employment		1				
POD24 (L)	Average suspension length in calendar days	<= 150	31		31		31
POD25 (L)	Recruitment completed within 12 weeks	>= 95%	96.19%		96.00%		96.00%
POD26 (L)	Compliance for safeguarding children's training		77.10%		77.00%		77.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		81.17%		81.00%		81.00%
POD28 (L)	Total Vacancies		278		278		278
POD29 (L)	Total Vacancy Rate %		7.48%		7.00%	<= 2.5%	7.00%

Narrative

POD10 - In August the year to date sickness absence % increased slightly from 5.70% to 5.85%.

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

POD17 - Support worker vacancies have breached the 10% target and are reporting at 10.67%, reduced from 11.13% in July .

POD18 - Individual Performance and Development Reviews have dropped slightly below the 90% target reporting 89.04%. All areas remain above 80% however the lowest areas are Rotherham Care Group and Finance.

POD24 – The average number of days suspensions is significantly impacted by one long standing case, which is associated with a situation outside of work.

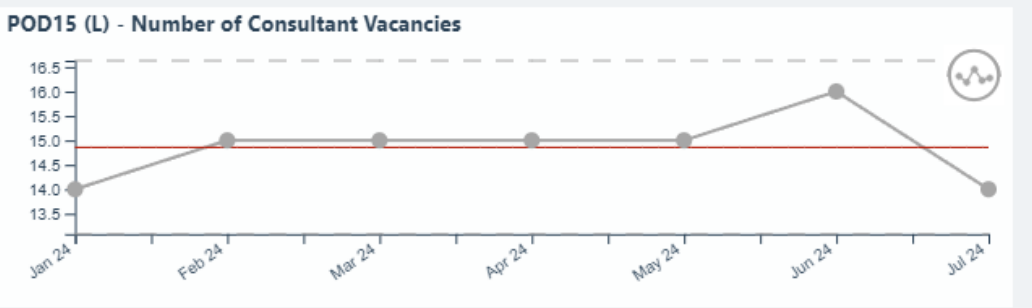
POD26 and POD 27 - Trust Level 1 and 2 (both adult and child are compliant) but level 3 for adult and child are amber. The safeguarding team have made available bespoke sessions to the half day LEARN event calendar.

POD29 – reporting as 7.48% against the target total vacancy rate percentage of less than or equal to 2.5%.

4.1 People and Organisational Development - Exceptions

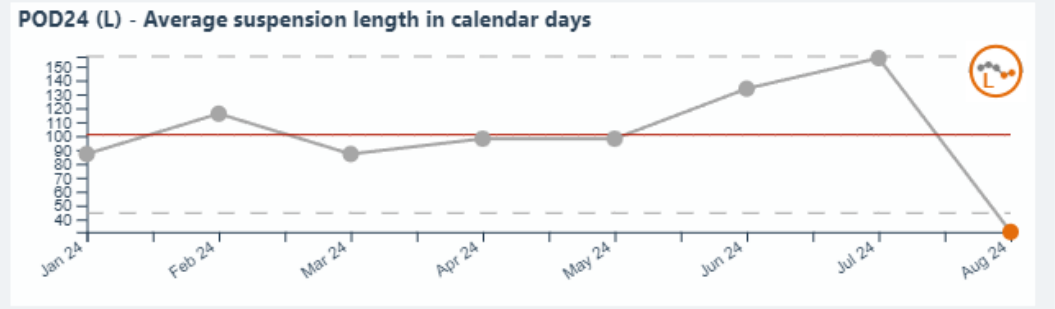
Trend, Reason and Action

POD10 - The sickness absence rate for August is 5.85% which is an deterioration of 0.15% from the position in July of 5.7%.The Physical Health Care Group showed a small improvement in the sickness absence figures from 6.4% to 6.37%, the other Care Groups all saw a small deterioration.



Trend, Reason and Action

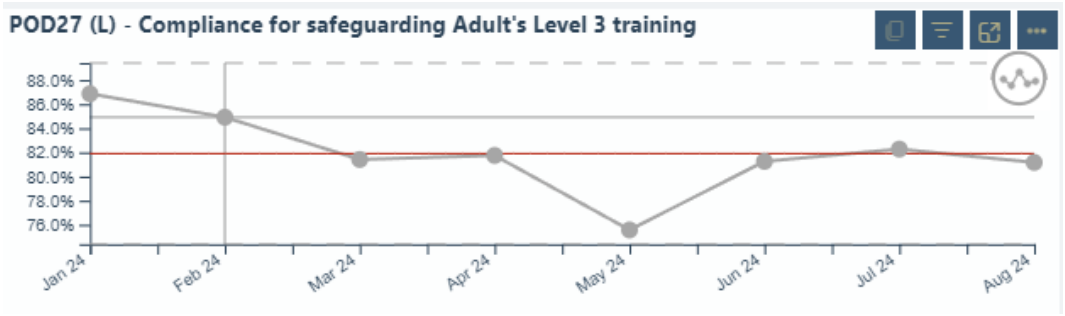
POD15 – The Trust continues to experience challenges recruiting to Consultant vacancies. We have secured GMC sponsorship and have a pipeline of 12 ST4 doctors to join us through 2024. NHS professionals engagement is assisting with improved medical cover (and reducing significant costs too)



Trend, Reason and Action

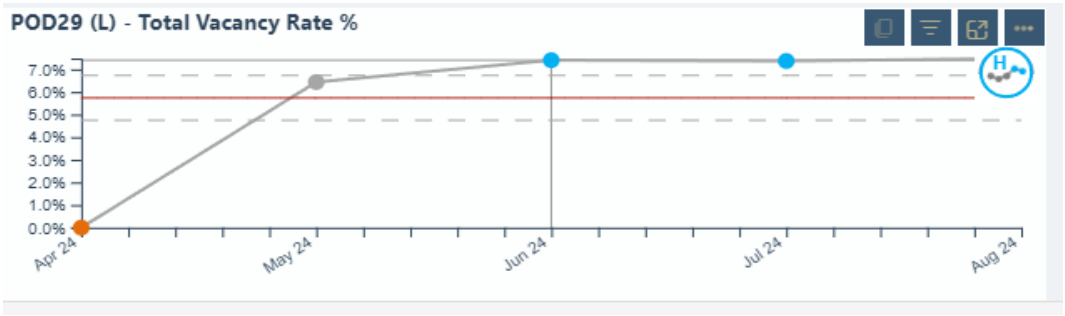
POD24- – As expected, the average number of days has significantly reduced as the one long standing case, associated with a situation outside of work has now been resolved.

4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

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 safeguarding team have made available bespoke sessions to the half day LEARN event calendar.



Trend, Reason and Action

POD28 and POD29 - there are currently 278 vacancies across the trust with a vacancy rate of 7.48%.

4.0 Finance – In Focus

Finance

Indicator	Metric	Target £000	Actual £000	Variance £000
FIN01	Year to date actuals vs budget	1,570	1,709	139
FIN02	Year to date actuals vs budget - excluding AED	1,570	1,284	- 286
FIN03	Forecast outturn vs budget	3,758	3,758	-
FiIN04	Annual savings target vs schemes identified	6,622	5,252	- 1,370
FIN05	Agency spend as % of total pay bill - year to date	3.6	3.1	-0.5%
FIN06	Year to date capital plan vs spend	2,479	1,427	- 1,052
FIN07	Annual capital plan vs forecast spend	7,146	7,146	-

Narrative

FIN01 - The position at the end of August is a deficit of £1,709k, £139k adverse compared to the plan. The adverse position continues to be driven by an overspend of £425k linked to enhanced packages of care (ECP's) within SY Adult Eating Disorder Collaborative. This has improved compared to M4 due to additional income of £0.3m agreed by NHSE to support this. £125k of this is included in the M5 position.

FIN02 - The position excluding these costs (FIN02) is a year to date underspend against plan of £286k.

FIN03 - No variance to report at month 5

FIN04 - The value of schemes identified for 24-25 is £5,252k, this is £1,370k less than plan. A savings target of 0.5% has been delegated to each group and a vacancy factor of 2.5% has been applied to all staffing budgets. Central schemes such as managing inflation, non pay savings & agency reductions are progressing, with the gap to target to be identified & currently being delivered through full year effects of prior savings schemes and additional income opportunities in year.

FIN05 - Agency costs at the end of August are 3.1% of the total pay bill. An agency ceiling has not been set by NHSE in 24/25, therefore the target for 2023/24 of 3.6% has been provided for comparison purposes. The trust savings plan assumes a £1m saving linked to agency premium, the Trust must keep agency spend at or below 3.6% of the total pay bill to achieve this.

FIN06/7 - The year to date variance on capital is expected to be recovered as key capital projects such as Great Oaks are progressed from Q3 onwards. The capital forecast remains in line with the plan

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.

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**	26 September 2024

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

The Operational Risk Report presents the update to the Board of Directors on the current extreme rated risks. Each has been subject to review trough the Risk Management Group and reported to the Clinical Leadership Executive (CLE) during September 2024. Whilst a number were included in the last report to the Board, the paper outlines both the mitigation (i.e. moderated away from extreme) and identification of others (i.e. new extreme risks) – demonstrating a live and active approach.

In November, this report will be extended to include the low likelihood/high impact risks – as agreed in the revised Risk Management Framework at the Board in March. Current analysis of these shows a dozen inclusions, and the new Head of Risk Management is validating those, and any omissions, with senior teams including those in estates and informatics. Risk registers for corporate functions are included within the work of RMG but are also stress tested in bi-monthly delivery reviews. For a number of such standing risks, the key mitigation will be our work on business continuity which is covered elsewhere on the agenda today

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)

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.

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

Trust Risk Register	x	As detailed in the report						
Strategic Deliver Risks								
System / Place impact	x	O10/19, S2/22, S4/24,						
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

At the last board meeting, we reported a total of 8 extreme risks. Since then, 4 of these risks have been de-escalated, while 1 new extreme risk has been escalated. As a result, the current total number of extreme risks now stands at 5. These changes had previously been reported to, and supported by, the Risk management group (RMG) and the Clinical Leadership Executive (CLE)

1.1. Previous Extreme Risks

DCG 11/17	Speech and Language Therapy Service	**4 X 4 = 16**
Description	If the Speech and Language therapy service is unable to meet the target for priority one referrals, which indicate overt signs of aspiration and high risk of secondary health symptoms, this could lead to hospital admission and possibly death.	
Accountable Director	Care Group Director – Physical Health and Neurodiversity	
Updates	This risk is still classified as extreme following the last board meeting. While progress has been made in reducing the waiting list, there are still significant delays. The ability to further reduce the waiting list remains constrained by current capacity limitations and we continue to explore options to mitigate the risk by end of October 2024, when newly appointed staff will commence in post.	

O 10/19	Management of Out of Area Placements	**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	Two recent workshops—one held internally and one externally with partner organisations—focused on reducing out-of-area placements. Feedback from these sessions will be summarised, and strategies to reduce out-of-area placements will be agreed upon. Despite these efforts, 30 patients remain placed out of area, and as a result, the risk remains classified as extreme. Aiming to reduce this risk in line with the promise 19 (by March 2025) and links to the Out of Area Placement Risk Share paper on today's agenda.	

PCG 10/24	Implementation of New ADHD Model	**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	The centralised triage system is expected to increase the capacity of existing staff. There is a clear plan to reduce the significant waiting list, currently meeting trajectory and with sustained performance, the risk will reduce (from extreme).

PCG 9/24	Diagnosis of ASD Patients	**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 significant waits, therefore, remains extreme due to lack of investment.	

1.2. New Extreme Risks

CCG 3/22	Neuro Waiting Lists	**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	
Updates	The ongoing review and monitoring of demand and capacity continue. Since the introduction of the streamlined assessment process, the longest wait times in the Rotherham diagnostic pathway have been steadily reducing, with further reviews ongoing. A senior team conducts weekly reviews to ensure that assessment targets are met in line with the projected trajectory.	

1.3. De-Escalated Risk

The following risks has been de-escalated from extreme status since the last board meeting.

E4/24	Increase In Energy Cost	**3 x 3 = 9**
Description	Due to the potential rise in energy costs from 2024 onwards not being fully funded, there is a risk that the Trust's inflation reserve will be depleted, which may result in the Trust being unable to absorb any further inflationary increases in pay and non-pay costs. This could impact financial stability and the Trust's ability to maintain services within budget.	
Accountable Director	Director of Finance and Estates	

Updates	The Estates directorate has been allocated an additional £800k budget, reducing the expected deficit to £300k. Energy saving initiatives continue to be formulated and implemented. As a result, the risk score has been reassessed to reflect the impact of the additional funding.

S 2/22	Provider Collaborative Funding	**4 X 3= 12**
Description	If there is insufficient funding available or demand exceeds the financial envelope, then the Trust will incur a deficit in relation to the provider collaborative and the viability of the collaborative may need to be reviewed.	
Accountable Director	Director of Strategic Development	
Updates	Following further negotiations with NHSE, the estimated deficit for 2024/25 has reduced from circa £1.6m to circa £400k. Further discussions will be taking place with NHSE and others regarding the potential estimated deficit, but reduced impact has been reflected in the new risk score.	

S 6/22	Quality of Commissioned AED Care	**4 X 3= 12**
Description	If one of the specialist inpatients eating disorders service does not implement the recommended improvements, then there is a risk to patient safety and reputational damage for the collaborative and the Trust as lead commissioner.	
Accountable Director	Director of Strategic Development	
Updates	Whilst there has been some progress made by the provider to address quality concerns, we are not assured sufficiently to significantly de-escalate this risk. However, the restrictions placed upon the provider by CQC regarding admissions means that the number of patients being supported has reduced meaning a change in likelihood of this risk occurring.	

S 4/24	Insufficient Community AED Services	**4 X 3 = 12**
Description	If there are insufficient Community Adult Eating Disorder Services in each of the four ICB places, then demand and length of stay for specialist inpatient services will remain high, leading to a poorer experience for patients and an unaffordable model of care.	
Accountable Director	Director of Strategic Development	
Updates	The inaugural meeting of the joint committee on eating disorders in South Yorkshire has now taken place. This will start to take forward activity to begin to mitigate this risk. With that in mind, we will look to transfer and close this risk over the coming month.	