NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 24 July 2025 at 10.00am
Enterprise Suite, The Arc, 2 Lichfield Avenue, Scunthorpe, DN17 1QL

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Rachael Blake, Dr Jude Graham	Note Information		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Staff / Patient Story				
5	Staff Carer story	Information	CH	Verb
Standing items				
6	Minutes of the meeting held in public on the 29 May 2025	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Quality Committee	Assurance	RF	D
9	Audit Committee	Assurance	KG	E
10	Mental Health Act Committee	Assurance	SFT	F
11	People & Organisational Development Committee	Assurance	PV	G
12	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	H
13	Finance, Digital & Estates Committee	Assurance	PV	I
14	Remuneration Committee	Assurance	KL	J
15	Trust People Council	Assurance	DV	K
16	Chief Executive's Report	Information	TL	L
17	Older People's Care Quality Indicators	Decision	DS	M
BREAK				

RDaSH nurturing the power in our communities

18	Promise 24: Education at RDASH	Information	CH	N
19	Learning Update	Information	TL	O
20	Productivity at RDaSH	Information	IM	P
21	Promise 2 – Carers : delivery plan	Information	SF	Q
22	Promise 14 – Delivering a 4 week wait for all referrals	Information	RC	R
23	CQC Readiness	Information	SF	S
24	Plans • People and Teams • Digital	Decision	CH RB	T
Operating Performance / Governance / Risk Management				
25	• Integrated Quality Performance Report (IQPR) • Health Inequalities – Review of IQPR	Assurance	TL JMcD	Ui Uii
26	Promises and Priorities Scorecard	Assurance	TL	V
27	Board and Committees – Agendas Sep 25 to Mar 26	Decision	PG	W
28	Strategy Delivery Risks	Assurance	PG	X
29	Operational Risk Report	Assurance	PG	Y
Supporting Papers (previously presented at Committee)				
30	Accountable Officer for Controlled Drugs Annual Report 2024/25 Health, Safety and Security Annual Report 2024/25 Mortality Guardian of Safe Working Hours Report	Information	KL	Z
31	Any Other Urgent Business (to be notified in advance)		KL	Verb
32	Any risks that the Board wishes the Risk Management Group to consider			
33	Public Questions *			
34	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	
35	*Minutes of the meetings held on the 29 May and 26 June 2025 (private session)*	*Decision*	KL	AA
36	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
37	*Reflections on the staff story*	*Discussion*		Verb
38	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC
39	*Development of Plan B / 26-27 CIP*	*Decision*	IM	DD
40	*Board Timeout and Development Sessions*	*Information*	PG	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 25 September 2025 10am – CAST Theatre, Doncaster

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	24 July 2025

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

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.
- There are changes to the register since the last meeting that include additional declarations for Maria Clark and the removal and an additional declaration for Rachael Blake.

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

Paper presented to each public Board meeting

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

The Board is asked to:

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

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

Business as usual	x

Alignment to the plans: (indicate those that this paper supports)

Business as usual	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

External and partnership risks	**Regulatory**	**Averse**	**We do not tolerate non-compliance with regulatory standards and reporting obligations.**	x

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

System / Place impact (advise which ICB or place that this matter relates to)

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 • Chair of the Advisory Board Space2BHeard CIC HULL • Non-Executive Director at Locala Community Interest Company
Toby Lewis, Chief Executive	• Nil
Richard Banks, Director of Health Informatics	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Rachael Blake, Non-Executive Director	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • ~~**Elected Member - City of Doncaster Council**~~ • Director - Bawtry Community Library • **Bawtry Mayflower School Governor - Co-opted**
Richard Chillery,	• Nil

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

Name / Position	Interests Declared
Philip Gowland, Board Secretary and Director of Corporate Assurance	• Wife is Primary Care Strategic Lead employed by RDaSH.
Dr Jude Graham, Director of Psychological Professionals and Therapies	• Trustee for the Queens Nursing Institute • Executive Coach – registered and accredited with the European Mentoring and Coaching Council • ImpACT International Fellow for the University of East Anglia
Carlene Holden, Director of People and Organisational Development	• Governor and Vice-Chair at Brighter Futures Learning Partnership Trust – Hungerhill School, Doncaster
Jo McDonough, Director of Strategic Development	• Nil
Izaaz Mohammed, Director of Finance and Estates	• Chair of Governing Body – Westmoor Primary School, Church Lane, Dewsbury, West Yorkshire
Dr Diarmid Sinclair, Chief Medical Officer	• Nil
Sarah Fulton Tindall, Non-Executive Director	• Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield • Age UK Readers' Panel member
Dave Vallance, Non-Executive Director	• Nil
Pauline Vickers, Non-Executive Director	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Associate Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders • Director of Marsh and Vickers Coaching Limited

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 24 July 2025

Item 5

Staff Carer Story

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING
ON THURSDAY 29 MAY 2025 AT 10.00AM
THE CENTRE, BRINSWORTH LANE, BRINSWORTH, ROTHERHAM, S60 5BU

PRESENT

Kathryn Lavery	Chair
Rachael Blake	Non-Executive Director
Richard Chillery	Chief Operating Officer
Maria Clark	Non-Executive Director
Dr Richard Falk	Non-Executive Director
Steve Forsyth	Chief Nurse
Kathryn Gillatt	Non-Executive Director
Carlene Holden	Director of People and Organisational Development
Toby Lewis	Chief Executive
Izaaz Mohammed	Director of Finance and Estates
Dr Diarmid Sinclair	Chief Medical Officer
Dave Vallance	Non-Executive Director
Pauline Vickers	Non-Executive Director

IN ATTENDANCE

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

2 members of staff and 1 Governor were in attendance

Ref		Action
Bpu 25/05/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting and to Maria Clark, Non-Executive Director, at her first Board meeting. Apologies for absence were noted from Sarah Fulton-Tindall, Non Executive Director.	
Bpu 25/05/02	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 25/05/03	**Declarations of Interest** Mrs Lavery presented the declarations of interest report which outlined that there were changes to the register declared since the last meeting that included the removal of interests relating to Professor Janusz Jankowski and the addition of Maria Clark to the register. Clarifications relating to Ms Blake and Ms Clark declarations of interest were noted and would be included in the paper at future meetings. **The Board received and noted the changes to the Declarations of Interest Report.**	
	STANDING ITEMS	
Bpu 25/05/04	**Minutes of the previous Board of Directors meeting held on the 27 March 2025**	

	The Board approved the minutes of the meeting held on the 27 March 2025 as an accurate record.	
Bpu 25/05/05	**Matters Arising and Follow up Action Log** There were no other matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed. With reference to Out of Area Placement (OOAP) Risk Share (open action Bpu 24/09/21), Mr Lewis advised that although a funding agreement had been reached with South Yorkshire, the position with Humber and North Yorkshire (NEY) Integrated Care Board (ICB) was unlikely to achieve the same position within this financial year despite considerable efforts. Work would continue to reach an agreement and Mr Lewis envisaged this could be achieved by December (to enact the following financial year). It was noted a detailed update on OOAP would be presented later in the meeting. A quality and safety impact assessment statement (QSIA) and equity impact assessment (EIA) in respect of the CIP plan for the OOAP would be undertaken in June, and a risk had been registered on the risk register with responsibility of the action transferred to Mr Lewis and Mr Chillery.	
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
Bpu 25/05/06	**Report from the Quality Committee (QC)** Dr Falk presented the paper and gave the key highlights. The committee meeting format had been refreshed creating a new structure aligned to the quality and safety plan, with focus on four domains of quality, safety, experience and the patient safety incident response framework (PSIRF). The committee would aim to avoid duplications and have streamlined processes. An evaluation of the new meeting format would be undertaken within the next twelve months to review its effectiveness. Concerns had formally been raised relating to the failure to receive medicines management reports on two occasions, as well as at the quality and safety group. Dr Falk acknowledged the work pressures faced by the committee and reporting authors, with the need for interim updates to ensure no significant issues or concerns were missed. Mr Lewis stated he was aware of the concerns raised and that an interim update was expected by 13 June. Dr Sinclair provided an update following recent meetings of the medicines management committee and medicines optimisation group. There had been isolated incidents relating to medicines management with action plans underway to address those. Dr Sinclair acknowledged the importance of medicines management reporting and work was underway to address the issue of non reporting. **The Board received and noted the report from the Quality Committee.**	**DS**

Bpu 25/05/07	**Report from the Audit Committee** Ms Gillatt presented the paper and gave key highlights to the Board. There were no matters of concern or areas to escalate to the Board. Internal audit progress was positively received, noting strong performance with three reports issued including two rated as significant assurance (MAST training and Promises 3, 4 and 5). The interim head of internal audit opinion 2024 to 2025 gave an indicative opinion of moderate assurance. This was an improvement compared to the previous year. The final opinion would be received in June 2025. Preparations were underway and on track regarding the preparation and audit of the annual report and accounts 2024 to 2025. Ms Gillatt recognised the importance for completing these prior to required submission in June 2025. It was noted that after further discussion, there was no need for accounts to be restated or prior year adjustments made in respect of the St John's Hospice building. The external audit planning was underway, and no change in key risks relating to accounts. There had been positive developments of the risk management and embedding good practice across the organisation. The audit committee would continue to have governance and oversight of clinical audit, and to ensure the committee did not duplicate the work of the quality committee. Regarding the Counter Fraud, Bribery and Corruption Progress, Mr Mohammed advised the Counter Fraud Functional Standard Return had been finalised and would be prepared for approval and submission within the next week. The Charitable Funds and Flourish Audits were due to be completed and submitted by the end of June. Mr Mohammed advised work was underway to close down significant risk areas. Both exercises were on track. Mr Lewis referred to the clinical audit programme developed the previous year and the positive progress achieved, and agreed to seek clarification around the approach and prioritisation of the clinical audit work. **The Board received and noted the report from the Audit Committee.**	
Bpu 25/05/08	**Report from the Mental Health Act (MHA) Committee** Dr Falk, on behalf of Ms Fulton-Tindall, presented the paper and highlighted key points. Dr Falk commended the chairing which Ms Fulton-Tindall provided. With respect to the key indicators for seclusion within the integrated quality performance report (IQPR) Dr Sinclair explained the timeframes for medical reviews of patients in seclusion, noting the target had been met in respect of patients in seclusion waiting to be reviewed within five	

	hours. Dr Sinclair acknowledged the compliance rate for independent reviews beyond eight hours was significantly below the desired level, advising there were various workstreams underway to address the issue including potential policy changes and discussions at senior doctors' meetings. Mr Lewis emphasised the need for the Clinical Leadership Executive (CLE) to see the outcome of this work by the end of June. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 25/05/09	**Report from the People & Organisational Development (POD) Committee** Ms Blake presented the paper and highlighted key points. The freedom to speak up (FTSU) update highlighted the need to continue building trust, responding to colleagues concerns, how issues raised were taken seriously by the organisation and preventative action taken. It was noted a FTSU report would be presented separately later on the agenda. Staff survey results gave a 56% response rate. Key areas had been identified for directorates to focus and understand the concerns raised within the survey, and addressing the 'other discrimination'. The consultant vacancy position target reported within the IQPR had seen positive improvement following a significant period below the desired target. **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 25/05/10	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Mr Vallance presented the paper and highlighted key points. The volunteers recruitment journey continued to make good progress against the trajectory set to meet the target within Promise 3. The committee would expect an update to ensure this was having a positive impact across services for both patients and volunteers. Work continued to produce comprehensive health inequalities data to be reported from July 2025. It was noted this linked to the Strategic Delivery Risk 2 (SO2), the revised IQPR and associated Health Inequality measurements and indicators. Mr Lewis stated there would be three key steps to successful achievement as outlined within his chief executive report. Flourish financial performance showed improvement, and the committee were reassured by the financial position noting the reduction in deficit. Thanks were given to those colleagues who had supported the progress made.	

	Mr Chillery referred to the volunteer journey and a positive note this provided a volunteer to career pathway. Mr Chillery shared a few examples where volunteers had successfully secured paid employment within the organisation following their experiences as volunteers. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 25/05/11	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper and highlighted key points. With regard to estates, the organisation had been successful in securing £1.8m of national capital programme funding to support the provision of a high dependency rehabilitation unit (HDU) and Phase 4 of the Great Oaks project. At Month 12 (2024 to 2025) the financial position was £512k surplus, better than plan, with all care groups and corporate directorates meeting their targets. The finance plan 2025-2026 was a balanced plan, recognising the additional recurrent funding required to arrive at that position. Future finance reporting would be provided by directorate ('think directorate') with focus on achieving key saving schemes to achieve plan. The cyber security update provided significant assurance against the processes in place and highlighted the importance of learning and staying updated following recent cyber incidents outside of the NHS framework, in particular across the retail industry. Mr Banks explained the role and function of the South Yorkshire Cyber Security Board, which the trust was a member of. Mr Lewis referenced the finance plan, noting this was a balanced plan but questioned what effect the national pay award announcement, made since the FDE committee met in April, would have. Mr Mohammed responded the additional cost (above current assumptions) would be £2.7m. It remained unclear whether this gap would be funded by the system allocation. Mr Mohammed estimated a pay award funding gap of between £0.8m and £0.9m. Mrs Lavery acknowledged the growing concerns at a national level across the public health sector following the pay awards announcements and potential financial shortfalls this could create. Mr Mohammed explained the system allocation would be reserved for the ICBs to resolve with regards to mental health and ambulance trusts. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 25/05/12	**Report from the Trust People Council (TPC)** Mrs Lavery presented the paper and highlighted the TPC continued to grow in maturity. There was a progressive debate around Promise 26 and work to tackle the wider aspects of discrimination and promote inclusion.	

	The health and wellbeing vision had been refreshed and continued to be shaped. Consistent feedback was to get the fundamental basics right of what should be expected within the workplace. Mr Lewis felt it important for the board to be aware this meant staff having essentials to work such as a designated base point, office and kitchen facilities, debrief areas for community colleagues, flexibility and supportive remote working. Mr Chillery stated care group colleagues continued to seek clarity around remote working. Ms Holden responded that although the wider workforce had benefited since flexible remote working had been introduced it was acknowledged not all areas were, such as bed based areas. In quarter 3 and 4 work would progress to address flexible working with a consistent approach seeking equity across the organisation. Ms Holden advised the need to operationally change the organisational workforce and reported an innovative pilot taking place in St John's Hospice. This had seen positive results whereby staff self-roster, giving them responsibility for the autonomy of shift cover arrangements. Dr Graham noted this work linked to a number of promises around workforce reflecting the diversity of our populations. This would require leaders to think differently and space would be built into learning half days and the learning and education group to explore this further. Mr Gowland raised the reporting arrangements from the TPC and Board Committees to the Council of Governors. It was important to ensure reporting was timely in order to keep Governors informed on key issues across the organisation. This would be discussed at the next Council of Governor Meeting to be held in June. **The Board received and noted the report from the Trust People Council.**	**PG**
Bpu 25/05/13	**Chief Executive's Report** Mr Lewis drew attention to the five key items within his report The NHS reset and changes across the ICB roles and workforce continued to attract attention. This should not distract from the organisational strategic mission. Board members were reminded of the importance for staff and managers to hear the long-term commitments which the organisation has made, and to hear that they would not change as a result of the NHS reset. In early May, the CQC made an unannounced inspection of the acute mental health and PICU services across Rotherham, Doncaster and North Lincolnshire. Formal feedback following the inspection was not yet available, albeit informal feedback was positively received noting that staff were welcoming and open to the CQC inspection process across ward areas. Mr Lewis advised space would be created for the senior leadership team in July for reflective learning from the CQC inspection. The distinguished service awards (DSA), previously known as long service awards, had relaunched. Thanks were given to colleagues' contributions towards the first celebration held in early May. There	

	would be retrospective awards for the years 2022 and 2023 to close the gap. The awards differ as they respond on an individual level and are more generous and extensive in celebrating staff anniversaries. All directorates had achieved budget sign off. Mr Lewis was pleased to report that teams had embraced the budget sign off exercise, but reported that a learning exercise would take place in July, amongst the senior leadership team, with a view on future budget setting rounds. The poverty proofing 2024 to 2025 reports had been published on the public website. These build from the pilots undertaken and demonstrate a response towards the trust's values and promises. In response to Ms Fountain, Mr Lewis confirmed the organisation had made progress against promise 23 by investing in Rotherham with the South Yorkshire Housing Association (SYHA), creating the specialist mental health and housing support partnership. Work had commenced to create similar models in Doncaster and North Lincolnshire, developing pathways to care for patients closer to home. Mr Lewis explained a detailed briefing paper was shared at the Clinical Executive Leadership (CLE) and agreed to share the paper for information. The Board recognised this work aligned to the organisational strategy and promises, to be overseen via the PHPIP committee. Regarding the NHS reset with revised operating and financial model, Ms Blake expressed her concern that smaller third sector organisations may be negatively impacted, and questioned how the organisation could provide support. Mr Lewis confirmed the organisation had no part in any plans the ICB decide. Efforts were being made to understand the reset process and EIA documentation had been requested for further insight. Executive colleagues continued to work closely with the ICB to support, understand and consider its contribution to collaborative working in the future. The organisational values would remain, focus to tackle inequalities and working with partners. Other practical responses, collaborative bidding and opportunities may arise for the third sector through investment bids and the Hearts and Minds charity. Dr Graham referred to the publication contained within the annex of the report. The guidance *Leading for all: supporting trans and non-binary healthcare staff* would be considered through the appropriate staff networks to understand what the changes, if any, mean with an organisational response to be produced towards the end of July. The *ICB Blueprint* provided a summary to help ICBs produce plans by the end of May to reduce their running costs by 50%, shifting ICBs towards strategic commissioners and delivering the 10 year plan. Mr Lewis understood staff consultations would begin in June but no details on future functions or roles were available with those discussions remained internal to the ICBs. The Board noted the NHS 10 year plan was yet to be published. Mrs Lavery recognised the major transformational changes in delivering the NHS reset, with operational and financial challenges, and change in statutory responsibilities. Mrs McDonough was pleased to see the establishment of a community leadership executive and queried how this would be developed. Mr	**TL** **TL / JG**

	Lewis confirmed throughout June a series of meetings would take place to create space, hear community and patient voices with support from executive colleagues. These would be used to influence and impact on decision making (promise 5), in addition to the patient and governor representation within the organisational committee and sub meeting structure. Mr Chillery referenced the well led work to be discussed later in the meeting, noting the strengths and improvements made linked to partnerships and communities. This included hearing the voices and connecting with younger people. Mr Lewis drew attention to the Patient Safety Incident Response Approach (PSIRF) policy. Following reflective review by clinical executives and the chair of QC the policy had been refreshed to include learning models across the trust, reflective of postgraduate medical education with adverse event procedures for resident doctors. This was key to improving patient safety and learning, a matter for the Board, and if approved to be implemented from June 2025. An internal audit of the PSIRF application would be deployed and Mr Lewis stated he would hope to have a view on how well or otherwise this had been operationally implemented in quarter 2. **The Board approved the revised PSIRF policy for the Trust (a matter reserved for the Board)**. **The Board noted the first bi-monthly Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) report**. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	
Bpu 25/05/14	**Staff Survey – Areas of Focus** Ms Holden presented the paper and gave key highlights. Following the staff survey results presented to the Board in March 2025, there were nine suggested areas of focus for improvement to be above average, building on the people promises and learning from other organisations. These areas of focus linked to the organisational strategy and promises to be delivered over the next three years. The annual staff survey provided a detailed set of results across the Trust (provided within the annex) but more importantly by directorates to understand the areas of success and the areas of focus. It was important to note the data could be broken down by protected characteristics and by staff groups. The results were the first to be received at directorate level and had been shared with all directors and engagement commenced with colleagues. Each directorate had been asked to identify a small number (two or three) actions which they wish to focus on this year, and then in future years it would be teams within the directorates. Ms Holden drew attention to people promise 5 *we are always learning*. Despite the investment in learning half days and ringfenced training	

	budget in 2024, this was the lowest ranking from the staff survey results. The best performing result was people promise 6 *we work flexibly*, acknowledging there remained areas within directorates where this scored very low. In response to Mr Vallance, Ms Holden confirmed each directorate had details of each question and the response rates. However the national staff survey was a set survey questionnaire with set timeframes, with the ability to analyse and compare against 210 organisations. It was recommended that the development and subsequent monitoring of the work was delegated to the POD committee and TPC. In addition, the workforce race equality standard (WRES) and workforce disability equality standard (WDES) data and the associated national submissions to be reviewed by the POD committee in August, in advance of the national reporting deadline in October 2025. The Board discussed the value of learning from previous staff survey results, other organisations, and other sources such as staff feedback from peer reviews. Ms Holden explained other triangulated factors would be explored and whether there were any additional learning and areas to improve. **The Board delegated the development and subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council.** **The Board delegated to the People and Organisational Development Committee the review and submission of the 2024 WRES and WDES data.** **The Board received and noted the staff survey results and areas of focus, and recognised the work and commitment required to facilitate the suggested improvements across the nine areas.**	
	James Hatfield joined at 11.40am	
Bpu 25/05/15	**CQC Readiness: Safe, Effective, Caring and Responsive** Mr Forsyth presented the paper which provided a summary of the current self-assessment in thirteen directorates against four domains *Safe, Effective, Caring and Responsive*. The self-assessments were developed with a triangulated view against the CQC domains based on data and intelligence through various safety and quality reporting and associated action plans (as part of the quality and safety plan, IQPR safety metrics and always measures). Each domain had been scrutinised and challenged through a triangulated process with each care group. The findings highlighted areas for improvement and part of a clear and honest self-assessment of each care groups positions. There was recognised need to address unwanted variation across the organisation ranging from how rosters were completed between wards, how care planning was personalised and produced through engagement with people and families, access and waiting times, and staff training and supervision.	

	Mr Forsyth welcomed the Board to consider the self-assessment and each CQC domain separately. ***Safe*** required improvement across the organisation and this was consistent with the finding from the 2019 CQC inspection, including safeguarding training compliance and the need for improvement in medication optimisation and safe systems. Mr Forsyth reflected on the good practice identified in physical health rehabilitation service demonstrating a safe environment. Mr Lewis observed the number of services which had self-assessed as required improvement around safe system, pathways and transitions. This had been discussed during the recent care group delivery reviews. Mr Chillery reflected there was a lot of good practice evidenced but mindful there was transformational and improvement change occurring with the implementation of PSIRF and incident management, risk and audit system. Mr Chillery stated he would be concerned if the safe domain required improvement. ***Effective*** assessed as required improvement across the organisation, focusing on consent processes and the need for standardisation across the organisation. ***Caring*** assessed as good. The Board recognised the strengths in the caring domain and the aspiration to achieve an outstanding rating. The Care Opinion roll out had added value and evidence upon listening to and responding to patient experience and feedback. Peer reviews on wards also recognise the quality of care provided was of a good standard. Good practice was demonstrated in the Children's Care Group of working with people who had neurodiverse needs. Improvement areas had been identified with communications and in the culture of care assessment baseline, with variations across directorates of ability to respond to diverse needs of people. In response to Mr Lewis, Mr Forsyth advised within the CQC assessment framework, the caring domain did include workforce wellbeing and enablement, with some care group areas identified for improvement. ***Responsive*** assessed as good, recognising strong pathways and relationships between services. Improvement areas were identified to improve and embed equity of access consistent use of clinical patient outcomes measures across services through Dialog+. Health inequalities data would support these areas. Mr Vallance noted the underlying themes and areas which required improvement. Training and related supervision, safe and effective staffing, personalised care plans and long waiting times had all been a longstanding concern. In response Dr Falk stated as Chair of the QC he was fully supportive of the draft self-assessment and methodology used, that it gave an honest reflection and detail of commonalities which required consistency and improvement. The Board noted the strands of improvement works underway to strengthen what worked well. There would be longer term pieces of work linked to transformation and change management processes,	

	whilst continuing to develop a learning culture. Mr Forsyth confirmed a further report would be presented to Board in July 2025. **The Board received and noted the update and status report in respect of the CQC Safe, Effective, Caring and Responsive questions.**	
Bpu 25/05/16	**Freedom to Speak Up (FTSU) update** James Hatfield introduced the paper and key highlights. The biannual report provided an overview of FTSU key areas, the nature of concerns raised, emerging themes, latest findings from the staff survey with actions for the FTSU guardian, and the learning and improvements that had been implemented as a direct result. The NGO 2025 FTSU recruitment framework standardises how NHS trusts recruit and support FTSU guardians. Implementation was essential for a robust FTSU function, crucial for safety and quality of care. Visibility of the FTSU guardian continued to be strengthened and promoted across the organisation to develop trust amongst staff. The FTSU data of colleagues going through the FTSU process was above the national average, with the top three themes had been civility/bullying/harassment, leadership and culture. James advised each concern could have multiple concern themes within it, they would be investigated and addressed within the care group leadership. Ms Blake stated it was good to see that each concern was listened to and addressed, noting the actions taken and improvement of feedback mechanism for detriment for FTSU concerns. In response to Mrs McDonough, Ms Holden confirmed the staff survey results and actions for the FTSU guardian had been broken down by directorates and again by protected characteristics. Mr Lewis was pleased to see the good culture of FTSU, the visibility of the FTSU guardian and other functions such as FTSU champions and support in place for staff. Mr Lewis noted the improvement in feedback on FTSU concerns, and recommended strengthening timescales to four weeks to give care groups and services ownership as well as manage concerns raised. James responded FTSU training and support would be provided to managers and the implementation of Radar would support that initiative with better data management. Regarding the 96 FTSU concerns raised in 2024 to 2025, Mr Lewis queried whether there was a comparison of data with peer organisations. James responded there was comparable data which the POD committee had oversight of. In response to Dr Falk, James confirmed he had not seen evidence of vexatious reporting of people feeling they had been detrimentally effected as a result of raising FTSU concerns. In response to Ms Gillatt, James advised any concern related to patient safety would be investigated and addressed with the support of the Chief Nursing Officer.	**SF / JH**

	Dr Graham explained the FTSU champions network was diverse and Mr Chillery confirmed the FTSU guardian role was frequently connected to care groups, teams and the executive leadership, and continued to use opportunities in identifying and responding to staff concerns such as service or model change. **The Board received and noted the FTSU update, noting the Trust People Council would continue to work on the Trust culture. Board members were encouraged to champion speaking up through respective Board committees and networks.**	
	James left at 12.45pm	
Bpu 25/05/17	**Plans for Approval:** • **Quality and Safety Plan** • **Equity and Inclusion (E&I) Plan** Mr Lewis presented the paper and explained Board members would be familiar with both draft plans which had been previously considered through different forums including Board committees and time out. Both plans would require support from colleagues to implement the changes and chosen priorities for the organisation. The E&I Plan had been shared at the PHPIP committee and acknowledged some wording would slightly change to reflect feedback received, but the majority of the plan presented would remain. The majority of the plan was framed around the promises and strategy, with focus around inequalities and tackling exclusion. Work had already been deployed and advanced, and the PHPIP would continue to have oversight of its delivery. There were fundamental changes to the quality and safety plan (as noted under Item Bpu 25/05/06). Dr Falk drew attention to 'getting things done' and timetable of the work to be adopted through 2025 to 2026 and beyond. These key areas would remain of focus for the Quality Committee and inform future agendas. Dr Falk was fully supportive of the plan as Chair of the QC. Mr Vallance confirmed the PHPIP committee had endorsed the E&I plan, and embedding work into practice was advancing. As Chair, he fully supported the plan. **The Board delegated to the Quality Committee approval of the final list of Always Measures.** **The Board received and approved the Equity and Inclusion Plan and Quality and Safety Plan. Delivery oversight of these plans would be given to their respective Board Committee, in line with their already agreed terms of reference.**	
Bpu 25/05/18	**Patient story – Human Trafficking and Modern Slavery – Multiple Trust Services**	

	Mrs Lavery welcomed Dr Graham to share a patient story about a person who had been subject to human trafficking and modern slavery, therefore had accessed both physical and mental health services. Support was offered to anyone who needed or was distressed by this agenda item. Dr Graham referred to material shared prior to the Board meeting and proceeded to give a presentation via pre-recorded video. The video highlighted the patient's journey as a 14 year old travelling across borders from their home country in Eritrea to Ethiopia, being captured by the military and subjected to torture. The story highlighted the multitude of offences associated with modern slavery and human trafficking, the impact of trauma with victims in the UK who had experiences and accessing physical health services (hepatitis, TB and dietician services) and mental health services, and people who may also work with us. The story emphasised the need for healthcare providers to be aware of the different ways healthcare is offered in other countries, and to make information accessible in different methods and languages. It was important to learn about peoples' experiences and not make assumptions to better understand their needs, with reliance on social media or other sources. It highlighted that newcomers to the UK may not necessarily be aware of access to basic healthcare medicines like paracetamol were available via the pharmacy or supermarkets rather than visiting a doctor or hospital. The story highlighted that family and carer involvement could provide valuable insight and help improve a persons care. Mrs Lavery and the Board thanked members for taking the time to listen and watch the video, and noted the intended reflection time later on the agenda.	
Bpu 25/05/19	**2024/25 Serious Patient Safety Incidents – Learning update** Mr Forsyth presented the paper and gave key highlights. Following the Board in March 2025, there were eighteen patient safety incident investigations (PSIIs) to conclude. The report provided the outcomes and learning of all patient safety incidents occurring in the previous twelve months. There were nine key areas of learning to take forward and Mr Forsyth proceeded to draw the Board's attention to the significant issues from the PSIIs. Themes include communication issues, involvement of family and carers, record keeping and support for people in crisis. The model of learning would change as part of the PSIRF deployment, with a new 50 day standard put in place to enable faster learning and delivery of actions. Key learnings would be shared as part of delivery reviews. In response to Mr Vallance, Mr Forsyth advised the learning from the PSIIs was in relation to both avoidable and unavoidable issues. With respect to unavoidable, there could be other contributory factors and complex comorbidities. Dr Falk recognised the importance of the primary care role of listening and signposting patients to relevant services who required mental health support or who were in crisis.	

	Mr Lewis was encouraged by the PSIRF process whereby learning from PSIIs and actions would be more precise with learning embedded into practice, stating the timely sharing of information was important and ensuring that lessons were implemented effectively. Mr Forsyth acknowledged there were areas in the organisation where mistakes could be avoidable with an example of medicines management in community services. With regards to ensuring learnt lessons being implemented effectively, this area would improve with the new 50 day standard to enable faster learning and audits to ensure actions were put in place with measures of success. Mr Forsyth highlighted a number of consistent organisational changes made following PSIIs with policy changes and development of patient pathways, and summarised the learning model would continue to be embedded through deployment of the PSIRF policy, the safety and quality plan, the education and learning plan, learning half days and learning systems like Radar. There would be an audit of PSIRF to test out its deployment, Mr Forsyth stated this would include ensuring actions taken were embedded and sustained (discussed above Bpu 25/06/13). The Board discussed embedding learning from PSIIs and sustained changed. Mr Lewis recommended learning from PSIIs for peer teams and other partner organisations to be considered within the learning system, in order to minimise similar incidents occurring. Dr Graham responded that a learning matrix would be developed whereby themes identified from PSIIs would be shared across care groups and relevant teams. Mr Forsyth referred to peer reviews, whereby board members would be able to check and challenge learning and actions from PSIIs ensuring sustained changes had been made. Mr Forsyth agreed to share the nine key areas of learning with partner organisations. In response to Ms Blake, it was noted the number of PSIIs resulting in mortality and suicide had not seen an increase compared to 2022 to 2023. The PSIIs were mostly middle-aged males who died via suicide and compared to last year the number had reduced. Mr Chillery recognised there was a system wide suicide prevention strategy across place to support services and partners. Mrs Lavery summarised the role of the QC would continue to have oversight of the PSIIs, and the Board would receive a biannual review of those where patients came to serious harm with outlined learning and response to the learnings. **The Board received and noted the annual review of the serious harm to patients during 2024 – 2025 and outlined actions in response to the learnings.**	**SF**
Bpu 25/05/20	**CQC Readiness: Well-Led** Mr Gowland presented the paper and gave key highlights. Following the previous well led assessments provided in May and November 2024, the assessment focused on the Well-Led key question, a part of the overall CQC's single assessment framework.	

	The report highlighted the good progress made against several pieces of work detailed within the assessment into 2025 to 2026, including the leadership development offer and promise 5. The report recognised further areas of improvement with future planned actions identified. External partners the Good Governance Improvement (GGI) and internal audit had provided related feedback and assurances. Mr Gowland explained the report complimented the previous discussion relating to safe, effective, caring and responsive key CQC questions (Bpu 25/05/15). Key to the work underway was the development of the maturity matrix approach across the care groups in support of the well led framework, alongside 'think directorate'. Mr Gowland highlighted it was important to note that foundation trusts were strongly encouraged to undertake reviews of their leadership and governance using the well led framework. It was noted the trust had previously commissioned external partners the Office of Modern Governance and GGI. During quarter 4, a formal, externally commissioned, well led review would take place. Mr Lewis requested a subset of leaders should be agreed to oversee this work. The well led assessment would continue to progress, noting a further paper would be scheduled to come to the Board in November 2025. Mr Vallance referred to the current assessment of the quality statement *learning, improvement and innovation* and identified future areas for improvement, noting there remained a gap. Dr Graham responded that solutions were being identified. The learning and education plan together with the learning model continued to be developed and triangulated with other factors such as PSIRF, Radar and the quality and safety plan. Mr Lewis referred to recommendation 3 within the GGI report, and acknowledged there was appetite to take this forward through the leadership development offer and for us to be clear what people's roles were in meetings. It was acknowledged the Board would spend time at its next meeting to focus on learning and education. **The Board received and noted the CQC Readiness Well-led update and status report in respect of CQC well led key question, noting the next steps planned and a report would be provided to the Board in November.**	**PG**
Bpu 25/05/21	**Reduction of Inappropriate Out of Area Placements (OAPs)** Mr Chillery presented the paper and gave key highlights, acknowledging the ethical, clinical, and financial case for reducing OAPs. The paper outlined the key steps required to reduce inappropriate OAPs, the changes required, the scale and complexities of the programmes of work underway in preparation to reduce OAPs from 1 July onwards. The trust had previously agreed to take the financial ownership for South Yorkshire OAP, from the South Yorkshire ICB. There were opportunities	

	identified but also potential barriers relating to large scale systemic change. The bed base focused on the five adult mental health wards across Doncaster Rotherham and North Lincolnshire. Enhancing and reconfiguring the community services to support the inpatient settings, so create opportunities to remain in the community would be key to the changes. Mr Chillery highlighted the 6 challenges which were interrelated and various workstreams underway to tackle those. To meet demand, the trust would need to maintain the current 12 discharges per month and then an additional 4. This is then 16 weekly discharges (an additional 4.37 discharges). Mr Chillery advised there was a need for sustained investment, integrated working and significant change, with clear leadership. Mr Chillery reminded the Board a detailed QSIA and EIA would be developed (open action Bpu 24/09/21). The Board recognised the large scale change required and discussed the complexities and risks presented and acknowledged this may create workforce shortages and capability issues. It was important to note OAPs were associated with poorer patient outcomes, and delayed recovery. The Board recognised there may become increased risks within community settings as the organisation moves to caring for people with complex needs closer to home. It was noted the High-Quality Therapeutic Care Taskforce (HQTC) had been established to oversee the work on therapeutic patient care, safety and quality along with timely care. Engagement with colleagues and partners was planned in June to identify and collaboratively develop a consistent model and system of working. Mr Forsyth reinforced the proposed change would not override clinical decision making but rather clinical curiosity and ensuring all aspects were considered, referencing the learning from OAPs. In response to Mr Vallance, Mr Chillery advised some elements of the programme may not succeed. It was unclear what the system appetite was and recognised some cases of disjointed governance amongst partners (NHS trusts, local authorities, Police). **The Board received and noted the Reduction of Inappropriate Out of Area Placements update, acknowledging the ethical, clinical and financial case for reducing OOAP, along with the complexity of change. The Board recognised the work required for three of our 13 directorates, associated senior leadership and executive teams.**	
Bpu 25/05/22	**Integrated Quality Performance Report (IQPR)** Mr Lewis introduced the Integrated Quality Performance Report (IQPR) for April 2025. There had been zero breaches for 'over 24 hour in Section 136', a notable achievement. Improvements had been seen on OOAP. Physical health services continued to perform well across and achievement of the RTT 18 week compliance. From July there would be meaningful health inequalities data reported through the IQPR. Mr Banks drew the Board's attention to the IQPR health inequalities analysis proof of concept and visual design. The IQPR would provide a breakdown of measures against key health	

	inequality elements of age, gender, ethnicity and deprivation. There would be potential to build on data with year on year comparison. Mr Vallance noted the deterioration in Neurodevelopmental Services for people waiting for ADHD assessments when compared with the trajectories. Mr Lewis suggested the Board spend time at the next meeting to understand the complexities in achieving the trajectory. **The Board received and noted the Integrated Quality Performance Report**.	**RC**
Bpu 25/05/23	**Promises and Priorities Scorecard** Mr Lewis presented the paper which highlighted the progress made on the specific promises and the need to focus on delivery in the coming year. Promise 21 relating to hyper local working and integrated neighbourhood teams now had a set of measures to achieve success. Work was underway with strategic leads to make progress in the next six months. Some promises remained actively ongoing and it would be important to celebrate the work that had been achieved in getting close to delivery of those promises. Mr Lewis stated it was important to celebrate and help build on sustaining those achievements. The promises and priorities would be shared at the Annual Members Meeting in July, Mrs McDonough advised an easy read version would be coproduced with PFG. Ms Fountain was pleased to hear about the celebration events and positive achievements. The self-assessment would be presented to CLE in June to discuss what is needed to achieve segment 1, 2, and 3 promises over the balance of the year. **The Board received and noted the Promises / Priorities Scorecard update on the work to date and expectations in 2025/26.**	
Bpu 25/05/24	**Strategic Delivery Risks (SDRs)** Mr Gowland presented the report, reminding the Board of the revised approach taken within the last year to strategic risk management with enhanced reporting and oversight through its committees. Following the positive response from internal audit where significant assurance was received on that new approach, the format had been revised to articulate the risk actions and link to the risk management framework via individual lead executives, committees and in conjunction with the Audit Committee Chair / Director of Corporate Assurance tri-annual reviews. Further refinement and clarity will be achieved in delivering mitigating and impactful action to these risks. The Trust's Strategy remained until 2028 with five SDRs. It was anticipated that the NHS's 10-year plan would be published shortly, this would need to be carefully reflected on, including whether it materially impact on the Trust's Strategy or its SDRs. Therefore, he would consider	**PG**

	and confirm the ongoing SDRs during Q3 and present this to the Board in September. **The Board received and noted the Strategy Delivery Risks report, noting the planned next steps to enhance reporting arrangements and the intended review of SDRs following the publication of the NHS 10 year Plan.**	
Bpu 25/05/25	**Operational Risk Report** Mr Gowland presented the paper which highlighted the current position in relation to the extreme risks. The Board spent time in April at its time out to review risk appetite levels and to determine how it wanted to categorise risks. Mr Gowland drew the Board's attention to the risk management framework and refreshed risk appetite levels. These would strengthen the approach to risk oversight and management, the risk appetite was key to drive that process and improve consistency in risk assessment. The implementation of the new Radar system, from 1 July, would have overview of the risk register across 23 directorates. Mr Gowland confirmed there would be opportunities through the Risk Management Group to review live and tolerated risks against the refreshed risk appetite levels and check they were categorised and being managed correctly. Mr Lewis explained the rationale for there being a low tolerance (as opposed to adverse tolerance) with regards to legal risks. This would allow for judgement and opportunities, perhaps within procurement, where an informed risk may well be beneficial to take. In response to Mr Lewis, Mr Gowland confirmed the disengagement risk identified at the last Board meeting had been considered by the Risk Management Meeting. This was a live open risk with a risk score of 9 (High) with actions underway, referring to the update provided with the the action log (Bpu 25/01/21b). **The Board received and approved the updated Risk Management Framework including the updated risk appetite levels.** **The Board received and noted the Operational Risk Report update, including extreme risks.**	
Bpu 25/05/26	**Fit and Proper Person Test (FPPT) Annual Declaration** Mr Gowland presented the paper and highlighted the process followed to undertake the test and the assurance received from internal audit regarding the process. Mrs Lavery confirmed that, following the receipt and review of self-attestation statements and where applicable, the checks undertaken during recent appointments, she had deemed all members of the Board met the requirements of the fit and proper person test.	

	The Board received and noted the update that confirmed the progress and state of readiness for implementing the requirements of the FPPT. **The Board received and noted the statement from the Chair that, following the receipt of self-attestation statements, she had deemed all members of the Board to be fit and proper.**	
	PAPERS FOR INFORMATION	
Bpu 25/05/27	**Infection, Prevention and Control (IPC) Annual Report** Mrs Lavery informed the Board of the IPC Annual Report presented for information, and noted the work undertaken in 2024 to 2025 that demonstrated the trust was meeting its statutory duties and the required national standards regarding IPC. **The Board received and noted the Infection, Prevention and Control Annual Report for information.**	
Bpu 25/05/28	**Safeguarding Annual Report** Mrs Lavery informed the Board of the Safeguarding Annual Report presented for information, and noted the work undertaken in 2024 to 2025 including the work in response to the limited assurance report from internal audit. **The Board received and noted the Safeguarding Annual Report for information.**	
	SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)	
Bpu 25/05/29	**Learning from Deaths Annual Report** Mrs Lavery informed the Board of the Learning from Deaths Annual Report presented for information, which had previously been presented at Quality Committee level for scrutiny and challenge. **The Board received and noted the additional report for information.**	
Bpu 25/05/30	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/05/31	**Any risks that the Board wishes the Risk Management Group (RMG) to consider** The Board noted the OOA placement risk share would be considered by RMG in July.	
Bpu 25/05/32	**Public Questions** There were no questions raised by members of the public.	
Bpu 25/05/33	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 : JULY 2025 **PAPER C – ACTION LOG**

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/11/19	**Productivity at RDaSH 2025/26** Concerns were raised in respect of the RDaSH geography and the work required with primary care to improve the referral process into CMHTs. Mr Lewis requested a further update on this work within the next 6 months.	IM	**July 2025**: Paper P provides a further update in respect of productivity.	Propose to Close
Bpu 24/05/15a	**Chief Executive's Report** Response to Regulation 28's The Board of Directors to receive in Q4 25/26 an update regarding the implementation of the new Engagement Policy to reflect on how effective it has been.	TL	**July 2025:** Action to be merged with open action below relating to engagement (**Bpu 25/01/21b)**, noting the comments made there.	Propose to close
Bpu 25/05/12	**Report from the Trust People Council (TPC)** Mr Gowland to consider the timeliness of reporting from TPC and Board Committees to the Council of Governors.	PG	**July 2025:** Since June a briefing to Governors entitled 'The day after Committee' has been issued on three occasions following the recent Committee meetings. The briefing is very timely and allows Governor to know about the topics covered and pertinent issues from the meetings. There has been positive feedback from Governors on this change**.**	Propose to Close
Bpu 25/05/13	**Chief Executive's Report** The CLE paper in respect of the joint work with South Yorkshire Housing Association would be shared with the Board of Directors.	TL	**July 2025:** The paper was circulated on 2 June 2025. Consideration would be also given to including the project on a future Board visit programme.	Propose to Close
Bpu 25/05/19	**2024/25 Serious Patient Safety Incidents – Learning update** Mr Forsyth agreed to share the nine key areas of learning with partner organisations.	SF	**July 2025:** The nine key areas of learning have been shared with the Board of Directors and in addition, they have featured in a recent Chief Executive Vlog. References to them were made within the Quality Account and	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
			within the feedback received from (and in the Trust's responses to) partner organisations.	
Bpu 25/03/11	**Report from the Public Health, Patient Involvement & Partnerships Committee** Health inequalities data would be included in the IQPR and presented to the Board on a regular basis.	TL / RB	**July 2025:** As previewed in May 2025, the IQPR now contains extended health inequalities data, in addition to promises 6-12 reporting mentioned in the Promises Report.	Propose to Close
Bpu 25/03/24	**Operational Risk Report – Extreme Risks / High Impact – Low Likelihood Risks** Regarding the newly identified extreme risk (DCGMH 6/23), Mr Lewis requested the Risk Management Group review whether the risk description and score was appropriate due to the medical staffing gap being low (1 vacancy) and whether this could result in patients coming to harm.	SF	**July 2025:** Following successful recruitment efforts, the risk score has decreased from 15 to 12. Under the previous risk management framework, this would have meant the risk was no longer categorised as extreme. Currently, only one vacancy remains in the Doncaster Acute Directorate, with locum support in place to maintain service delivery. However, under the new risk management and appetite frameworks, this risk still sits outside the Trust's appetite, though it remains within the established tolerance limits.	Propose to Close
Bpu 25/03/27	**Promises and Priorities Scorecard** In preparation for the annual members meeting, Mr Lewis agreed to explore how community feedback could be captured and shared with community partners within the event.	TL	**July 2025:** The published report has included feedback from patient groups. The intention from Q3 is for the scorecard to be a standing item within the 'shadow CLE' being established in Q2.	Propose to close
Bpu 25/05/06	**Report from the Quality Committee (QC)** Concerns had formally been raised relating to the failure of receiving medicines management reports on two occasions. An interim update was expected by 13 June.	DS	**July 2025:** A detailed report from October to March (Quarters 3 and 4 2024-2025) were received at the CLE Quality and Safety Group on 8 July and Quality Committee 16 July 2025 and highlighted within the Quality Committee report to Board (Paper D).	Propose to Close
Bpu 25/05/16	**Freedom to Speak Up (FTSU) update**	SF / JH	**July 2025:** The current arrangement for completion of FTSU are set to 30-35 working	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	Mr Lewis noted the improvement in feedback on FTSU concerns, and recommended strengthening timescales to four weeks to give care groups and services ownership as well as manage concerns raised.		days dependent on the severity of the concern. The Guardian is in the process of reviewing these times as part of the implementation (from November 2025) of the new Radar FTSU functionality and from that point the expected completion of FTSU responses **will be reduced to 28 days.**	
Bpu 25/05/22	**Integrated Quality Performance Report (IQPR)** Neurodevelopmental Services for people waiting for ADHD assessments: Mr Lewis suggested the Board spend time at the next meeting to understand the complexities in achieving the trajectory.	RC	**July 2025:** A further commentary and update on this is included within the papers, but the Chief Executive's report suggests a dedicated discussion in September when some remedial work will be more advanced.	Open
Bpu 24/09/21	**Out of Area Placement Risk Share** Mr Mohammed and Mr Lewis to continue negotiations with HNY ICB / North Lincs Place to achieve an equitable OOA placement risk share, in line with the parameters agreed for SY.	~~IM~~ TL / RC	**July 2025:** A detailed QSIA and EIA document will be developed during June, and a material risk entered onto the risk register. It is suggested that this action replaces the former entry and responsibility transfer to the CEO and COO.	Open
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention, by January 2025.	TL	**July 2025:** Implementation has been delayed by other matters, and it is suggested that this remains on the action log with a view to conclusion in **September**.	Open
Bpu 25/01/21b	**Disengagement risk** Mitigation of the identified disengagement risk is dependent upon the revised Engagement and Disengagement Policy.	PG	**July 2025:** The Engagement and Disengagement Policy has been discussed by CLE and most recently shared in July 2025 – with the intention of seeking formal approval in August's meeting. The item will be kept open and considered in the **September** Board.	Open
Bpu 25/05/13	**Chief Executive's Report** To consider an organisational response to the guidance *Leading for all: supporting trans and non-binary healthcare staff* through the appropriate staff	TL / JG	**July 2025:** whilst the minutes record an intent to conclude this work in July, it will take into August to achieve a consulted upon response. Accordingly the item should remain open.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	networks to understand what the changes, if any, mean towards the end of July.			
Bpu 25/05/24	**Strategic Delivery Risks (SDRs)** There would be an intended review of SDRs following the publication of the NHS 10 year Plan, to be presented to the Board in September.	PG	**July 2025:** The 10 year plan has now been published and reference is made to it within Paper X. As the Trust considers the full impact of the Plan there will be consideration given to any required change to the strategic delivery risks – and the conclusion and any proposals will be presented to the Board in **September** 2025, as previously noted.	Open
Bpu 25/05/20	**CQC Readiness: Well-Led** During quarter 4, a formal, externally commissioned, well led review would take place. Mr Lewis requested a subset of leaders should be agreed to oversee this work.	PG	**July 2025:** As recorded, an externally commissioned review will be commissioned in Q3 and delivered in Q4 2025/26.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper D
Date of meeting:	16 July 2025		
Attendees:	Dr Richard Falk (Chair), Dave Vallance, Maria Clark, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery, Dr Jude Graham, Richard Banks, Hannah Hall, and David Vickers.		
Apologies:	No apologies received.		
Matters of concern or key risks to escalate to the Board:	**Mortality Report – April & May 2025**.The committee noted the current position and noted a theme arising for education on substance misuse management for people with comorbidity. This has been a theme in other committees and may be a useful line of enquiry for the Board. There may be need to develop and incorporate substance misuse education into the learning half days to address staff confidence issues.		
Key points of discussion relevant to the Board:	**Patient Safety Escalations** The committee were assured that appropriate systems and processes are in place to ensure the provision of safe care. **Inpatient Safe Staffing Report April and May 2025** The report highlighted there had been no use of agency staff and that the fill rate had been maintained at acceptable levels. The committee were assured that robust systems and processes are in place to report and monitor safe staffing. Recognition of safecare implementation and our MHOST annual review noted. **Quality Safety Impact Assessments (QSIA) Red Indicators** The committee were provided with a QSIA assessment, highlighting the themes and impacts of the savings programme with a target of £8.5 million in savings, and were assured that a structured approach was being taken to assess the impacts and ongoing monitoring on quality and safety. **Promise 16 (personalised care)** The committee were provided with an overview of personalised care and the use of patient reported outcome measures, with four areas of focus being training, data, Care Plans and DIALOG/DIALOG +/ReQOL and GBO, and Promise 16. The committee discussed the importance of training and the organisational cultural change. **Medicines Management Report Quarter 3 and 4, 2024 to 2025** The Committee noted the improved position in respect of medicines management and the challenges with rapid tranquilisation audits. **Always Measures** The committee considered a refined, five key 'Always Measures' (AM) noting them as foundational elements of the Quality and Safety Plan and linked to the strategic objectives. The AMs would be implemented in inpatient areas first, with a wider rollout planned to ensure consistency and avoid duplication. The measures would be be reviewed and adjusted based on feedback and implementation outcomes.		
Positive highlights of note:	**Complaints and Patient Feedback April and May 2025** Update received on the continued success of care opinion with over 1,000 stories heard over 50k times and the importance of using feedback to drive service improvements. An update was provided in respect of our current complaints, and the work to ensure timely responses within 2025-26 **– Q1 themes and learning will be provided to next QC** **Reporting Patient Demographics versus Harm** The committee received the first iteration of the report, acknowledging this is progressing alongside our PSIRF output (SWARM, AAR, MDT).		
Matters for information:	**Integrated Quality Performance Report (April 2025 data)** The committee noted the continued improvement made for MUST assessments, and VTE assessment just below target but consistently maintained these positions the past three months. In June, there had been a decrease in the proportion of patients receiving a falls assessment within 12 hours of admission (the new metric). The challenges with ADHD waiting times were noted with the CEO and COO to finalise the reworked trajectories, but active work is on-going in		

	these services. **Accountable Officer for Controlled Drugs Annual Report 2024/25** Received and noted for information. **Health, Safety and Security Annual Report 2024/25** Received and noted for information. **Infection, Prevention and Control Annual Report 2024/25** Received and noted for information, previously presented to the Board. **Safeguarding Annual Report 2024/25** Received and noted for information, previously presented to the Board.
Decisions made:	
Actions agreed:	**Always Measures Implementation** Review the implementation of Always Measures in HQTC and prepare for wider roll-out across inpatient units by quarter four. **QSIA Process** A retrospective audit of QSIA processes would be undertaken to ensure all cost savings programme items have been appropriately assessed.

Dr Richard Falk, Non-Executive Director (Chair of Quality Committee)
Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	4 June 2025		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers and Dr Richard Falk. In addition: Izaaz Mohammed, Phil Gowland, Jill Savoury, Laura Brookshaw (360 Assurance), Matthew Curtis (360 Assurance), Kay Meats (360 Assurance), Matt Treharne-Clarke (360 Assurance), Stuart Kenny (Deloitte), Carlene Holden.		
Apologies:	No apologies received.		
Matters to escalate:	None.		
Key points of discussion relevant to the Board:	**Counter Fraud, Bribery and Corruption Progress:** The Counter Fraud Functional Standard Return (CFFSR) was in a healthy state, the majority of the components were rated green except for two, the fraud and corruption risk assessment and the training completion. Since the year end the team have met with all risk owners and various training initiatives have been planned which should improve rating to green for these components in 2025/26. **Internal Audit Progress:** • Four audit reports were issued, Financial Ledger Reporting (significant assurance), Waiting List Management (split opinion of significant (data) & limited assurance (standardised process and capture of WL reviews), Fit and Proper Persons Test (revised significant assurance opinion) and Partnership Governance and Risk Management (significant assurance). • The Committee agreed the Internal Audit Plan 2025/26, noting the reduction in days from 242 days last year to 200 days this year. **Annual Report and Accounts 2024/25:** • Good progress and positive team working on the external audit for the deadline of 30 June 2025, there were no significant issues to bring to the Committee's attention. • Audit of the charitable funds and Flourish being carried out by GBAC was essentially completed. • The Committee noted the extraordinary Audit Committee scheduled for the 26 June 2025 to approve the annual report and accounts. **Procurement at RDaSH:** overview of the Trust's current procurement arrangements, current and future plans to improve the function, and a timeline for having an alternate delivery model in place by the end of 2025. The review to include SQW processes/policy to ensure they remain relevant and in line with best practice.		
Positive highlights of note:	**Risk Management Framework:** The Committee noted the positive progress being made to enhance risk management across the organisation, the risk management group was well established with clear reporting lines into the Clinical Leadership Executive (CLE).		
Matters presented for information or noting:	None		
Decisions made:	None		
Actions agreed:	None		

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

Report to the Board of Directors meeting scheduled for 24 July 2025.

OTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	18 June 2025		
Attendees:	Sarah Fulton Tindall (Chair), Maria Clark, Dr Jude Graham, Toby Lewis, Dr Diarmid Sinclair, David Vickers. In attendance: Carlene Holden.		
Apologies:	None		
Matters of concern or key risks to escalate to the Board:	**Annual Mental Health Act (MHA) Equalities Report** The Committee received a refresh of the Annual MHA Equalities Report, with the aim of determining whether the Trust was detaining people under the MHA disproportionately compared to its serving population demographic during 2023/24 and 2024/25, with a focus on ethnicity. An earlier report from the Mental Health Legislation Committee to the Board in 2022 suggested a positive picture for the Trust on data grouped by BME and non-BME based on the percentages of detained individuals in the population. This current analysis, using the same 2020-2021 ONS population data, provides breakdown by granular ethnicity groups and is aligned to the MHA statistic approach, which utilises a per 100,000 population estimate calculation. The latest MHA published statistics indicated that detention rates for the Black community were higher than the White community and whilst this also reflected the national picture, the data shows some over representation in parts of the Trust. Work is underway to better understand the findings. **Seclusion** During April and May there were 19 out of 20 episodes that met the criteria for the patient being seen within 5 hours. An improvement to timely independent reviews was still not being seen during weekends, therefore, a robust action plan was being developed with care groups to improve compliance, this would include job planning.		
Key points of discussion relevant to the Board:	**Trust Hospital Managers' (TAMs) Report Q4 2024-25** TAMs compliance with mandatory training stood at 9 out of 12, the remaining 3 were partially compliant. All TAMs have undertaken their annual reviews due in January 2025. These will be fully compliant once a Trust administrative process has been completed. A number of appeals were upheld, indicating appropriate check and challenge was taking place. **MHA Compliance Report Q1 (April and May) 2025-26** There were 288 detentions, of which 1 was unlawful. Challenges remain with scrutiny of papers. **Consent to Treatment** Consent to treatment on admission averaged out to 92% compliance Trust wide. Consent to treatment at 3 months, showed Rotherham and North Lincolnshire at 100% compliance and Doncaster, 78%. **Section 132 Rights** Having seen some sustained improvement in recent months, Section 132 rights within 24 hours showed a marked reduction, averaging out at 88% across the Trust, with Rotherham showing 79% (52/66), Doncaster 90% (96/106) and North Lincolnshire 97% (40/41).		

	MHA Training and RRI Training Compliance Compliance rates are continuing to improve across all levels. Focusing on MHA Level 3 and RRI training, MHA Level 3 had 170 out of 641 individuals who were out of compliance, with RRI, showing 82 out of 406. A training matrix review was underway to check appropriateness with their respective roles. A new proactive approach to address compliance culture is underway, including individuals being enrolled on courses by the Learning and Development team, along with planned alignment with PDRs. **MHA Performance Report Q1 (April and May) 2025-26** **Blanket Restrictions** The Committee noted 3 new blanket restrictions between April 2024 and May 2025. It also received a presentation, with a focus on an understanding of blanket restrictions within a national and local context. A review was underway regarding the sharing of restrictions across specialism to ensure that where across site restriction was required, this was expected to be complete by the end of August 2025. A review of the governance process was planned, along with an audit to explore whether the process was being followed. The policy itself would also be reviewed. **Culture of Care Patient Feedback** The Committee received a presentation on the national Culture of Care Programme and its application within the Trust. Relevant findings from this feedback would in future form part of the biannual Patient and Carer Feedback report considered by the Committee.
Positive highlights of note:	Only one person out of 52 is now out of compliance for **RRI training for more than 2 years**, which is due to long term sick leave. All 95 **Section 136 assessments** were assessed within 24 hours and only 1 **Section 136 Suite** in North Lincolnshire was closed over the same period for maintenance, showing a sustained reduction across the Trust. There were 6 **MHA Incidents**, of which only 1 was major - a significant reduction on the last report. There were no reported medication incidents.
Matters for information:	The Committee noted the successful closure and transfer of the MHA Approvals Panel service to Winterhead Ltd on 1 April 2025. The Committee acknowledged the forthcoming retirement and distinguished length of service for Helen Moran, MHA Manager, and possible interruption to service, particularly the data led material.
Decisions made:	None
Actions agreed:	None

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Act Committee
Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper G
Date of meeting:	18 June 2025		
Attendees:	Rachael Blake (Chair), Dave Vallance, Pauline Vickers, Carlene Holden, Dr Jude Graham, Ian Spowart, Steve Forsyth. In attendance: Lea Fountain		
Apologies:	Richard Chillery, Richard Rimmington		
Matters of concern or key risks to escalate to the Board:	**The Guardian of Safe Working Hours Report** The new exception reporting reforms are being implemented from September 2025 as a result of the 2024 pay deal, which impacts on the GoSWH role as the expectation forms are reviewed and signed off my HR, with the exception of educational exception reports which are signed off by the PGDME. Unfortunately, the national systems /processes are yet to be developed and embedded via Lead Employers to facilitate these changes. In addition, should there be an increase in exception reports there is an associated financial risk. **Recent spike in racist incidents** was potentially due to the new Radar system and the function that directly asks whether staff feel that the incident included racial and or discriminatory abuse, which provides a more accurate picture. - The committee was reassured of continued overview, and that monitoring would be maintained.		
Key points of discussion relevant to the Board:	**People and Teams Plan** Work was ongoing towards delivering success by 2028, with further communication and socialisation to ensure colleagues understood the vision with the 'think directorate' and the required delivery against all aspects by Directorate rather than group level. The WRES data had deteriorated linked to disciplinary outcomes - a planned review of the process on equal treatment of global majority and white counterparts has commenced **Integrated Quality Performance Report:** **Consultant vacancies** positive recruitment efforts had resulted in three appointments in Doncaster. For all vacancies - impact on turnover and turbulence had positively impacted on a previously highlighted issue, the number fo colleagues leaving within the first 12 months of employment had now positively improved to those leaving within two to three years **MAST training** with compliance was at 94%. **Suspensions** had reduced significantly, with the trust adopting a last-resort approach to suspensions to minimise harm to colleagues whilst safeguarding our colleagues and patients.		
Positive highlights of note:	**Integrated Quality Performance Report** positive progress made on consultant vacancies and sickness absence **People and Teams plan** the good practice noted on self-rostering pilot within the hospice and the trust's flexible working ambition. **Guardian of Safe Working Hours Report** A total of 9 exceptions were reported, this was a significant decrease reported in the preceding two months coinciding with the implementation of hybrid first on-call arrangement across the Trust.		
Matters for information / noting:	None		
Decisions made:	Agreed to refine the committee workplan in conjunction with the people and teams and education and learning plans. Agreed for the survey results to be shared for the committee to identify key themes ranked from 1 to 10 for a focused future discussion.		
Actions agreed:	None		

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

Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper H
Date of meeting:	16 July 2025		
Attendees:	Dave Vallance (Chair), Dr Richard Falk, Maria Clark, Jo McDonough, Toby Lewis, Dr Diarmid Sinclair, Carlene Holden. In addition: Phil Gowland, Steve Forsyth, Nicola Abdy, Richard Chillery.		
Apologies:	Jo Cox, Joy Bullivant.		
Matters of concern or key risks to escalate to the Board:	**Promise 3 – Volunteers** There are currently 286 active volunteers working across the Trust. The Committee received the latest plan to deliver 350 volunteers in place by October 2025, and noted the challenges, including: cultural barriers, uptake / processing and retention of volunteers.		
Key points of discussion relevant to the Board:	**Promise 28 and Research and Innovation Plan** The Committee welcomed a positive progress update – including that the Trust had successfully bid to host the regional Ethnic Minority research Inclusion Network (EMRI). The Committee noted further work was required to enhance research participation year on year and to reflect progress against internal priorities and external targets. **Patient, Carers, Race Equality Framework (PCREF)** The Committee received the self-assessment against the NHS' Patient, Carers, Race Equality Framework. The Trust assessed itself against 3 key areas and work will now commence to move us towards Good in all 3 - noting the further work required to engage patients in the self-assessment. **Partnerships – Internal Audit and new Scorecard** 1. **Internal Audit Report.** The Committee received the audit report on Partnership Governance and risk management. The audit received significant assurance The 3 audit actions were on track to deliver in the agreed timescales. 2. **A Partnership Scorecard** has been developed to ensure that partnerships are strong and supporting the delivery of the strategic objectives and promises. The draft was presented and supported - which had been updated to reflect the recommendation from internal audit as well as national guidance on good governance. **Aspire Partnership** The Committee received its first report from the Alcohol and Drug Service and RDaSH Partnership Board (Aspire) since commencement in October 2024. The report showed strong performance v. most KPIs, finances were on track, as well as the mobilisation of a new modernised service specification. **Health Inequalities Data Report** A suite of data has been developed that sits within the Equity & Inclusion Plan, with some datasets currently going through testing and verification. The Committee received a summary of progress for Promises 6, 7, 8, 11, 12 and 17, noting that work continues on data accuracy in relation to Promise 7 health check and defining metrics for Promise 17, school readiness. **Strategic Delivery Risks Report – SDR1 and SDR3** An update was provided on the 2 Strategic Delivery Risks to the Committee and were informed of the changes to the SDR report.		
Positive highlights of note:	**Promise 28 and Research and Innovation Plan** • Partnership working developed with Clerkenwell Health to enhance clinical trials.		

	• Dr Stephen Kellet from the Rotherham Care Group has become Professor Stephen Kellett with University of Exeter, this is a significant development – and can also attract high calibre Research active staff. • The Trust has been reassessed and met the Gold standard for the Workforce Process Quality Certification which forms part of the Internation Accrediting Organisation for Clinical Research (IAOCR).
Matters presented for information or noting:	**Doncaster Health and Wellbeing Strategy** The Strategy sets out the ambition to be "A compassionate city where collectively everyone is supported to add life to years and years to life". The priorities set out in the Strategy align with the Trust's Strategy and 28 Promises.
Decisions made:	**Promise 27 – Sustainability** The Committee approved the draft Green Plan for 2025-2028 that outlines the strategic approach to reducing the carbon footprint of our services and estates and aligning with the NHS ambition to achieve net zero for all Scope 1 emissions by 2040.
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 24 July 2025.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper I
Date of meeting:	18 June 2025		
Attendees:	Pauline Vickers (Chair), Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Richard Banks, Ian Spowart, Rachael Blake		
Apologies:	Richard Chillery and Richard Rimmington.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Month 12 Finance Report and Month 2 verbal update.** At Month 12 the Trust had achieved a £512k surplus against a planned deficit of £348k (£860k better than plan). An additional internal control total was applied and all care groups and backbone services achieved their spend controls and savings targets, with great effort taken to reach that position. At Month 2, there was a £597k deficit against a planned deficit of £635k (£38k better than plan). The achievement of the out of area placement (OOAP) savings target to take effect from 1 July will be key to deliver the 25/26 financial plan. Whilst the plan assumes a £1m pay award shortfall, it was noted this could be higher once the Trust received confirmation of actual funding. This is expected by the end of August. **Finance Plan 2025-2026 to 2029-2030 – refresh of the medium term plan**. The committee reviewed and noted the next steps to enable the medium term financial plan, including the assumptions used and level of CIP required to deliver an underlying balance by 2026/27 (£7.9m). **Procurement at RDaSH**. An overview of the organisation's procurement function was noted with plans for improvement, with an alternative future procurement model with collaboration with Sheffield Health and Social Care NHS Trust, and Rotherham Council. The new arrangements were hoped to be in place by the end of November 2025.		
Positive highlights of note:	**Data Security and Protection Toolkit Update.** The Committee was assured that the organisation was actively working on the current 2024 to 2025 DSPT workplan and that known risks were actively being monitored with ongoing actions to mitigate. The Committee received the DSPT 360 assurance report and IG compliance report, and supported the final submission of the DSPT by 30 June 2025 with the supporting statements on track to be finalised before this date. **Information Quality Work Programme (IQWP) 2025 to 2026**. The programme detailed a structured and demonstratable process was in place to tackle data quality issues, with remedial actions underway against four indicators to be completed by July 2025.		
Matters presented for information or noting:	None		
Decisions made:	No decisions were made.		
Actions agreed:	To explore benchmarking to support the IQWP and its alignment to the IQPR, and whether there were any areas of best practice and learning.		

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

Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Remuneration Committee	**Agenda Item:**	Paper J
Date of meeting:	29 May 2025		
Attendees:	Kath Lavery (Chair) and Non-Executive Directors: Rachael Blake, Maria Clark, Richard Falk, Kathy Gillatt, Dave Vallance, Pauline Vickers. In attendance: Toby Lewis (Chief executive)		
Apologies:	No apologies received.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	• Revised national arrangements for VSM terms and conditions framework. • The completion of the Chair's appraisal for 2024/2025. • Update on the progress of the Chief Executive's appraisal for 2024/2025. • Arrangements for the appointments of Directors of Finance and Estates and People and Organisational Development. • Executive group performance for 2024/2025.		
Positive highlights of note:	The new framework for VSM colleagues would no longer include claw back arrangements for the Chief Executive's salary. The promised VSM pay review would be submitted to the Remuneration Committee in late August and would include external advice engaged by the Director of People and Organisational Development. The recommended national VSM pay award for 2024/2025 was accepted.		
Matters for information:	Further remuneration committees will be called in July and August.		
Decisions made:	To pay the recommended national VSM pay award.		
Actions agreed:	The Chief Executive would circulate, for agreement to the remuneration committee members, as quickly as possible, recommendations on the salary bands for the Director of Finance and Estates and People and Organisation Development, prior to the posts being advertised. (Action complete)		

Kath Lavery, Chair (Chair of Remuneration Committee)
Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper K
Date of meeting:	23 July 2025		
Attendees:	Kath Lavery, Glyn Butcher (Patient rep), Cheryl Gowland (Interim Chair of Carers Network), James Hatfield (Freedom to Speak Up Guardian), Carlene Holden, Toby Lewis, Tinashe Mahaso (Chair of REACH Network), Simon Mullins (JLNC Staff Side Chair), Jennie Gaul (Staff Governor), Dr Nav Ahluwalia (Senior doctors committee), Victoria Stocks (Staff Governor), Amanda Ambler (Chair of DAWN Network), Atique Arif (Volunteer), Prachi Goulding (Staff Governor), Jessica Williams (Staff Governor), Laura Wiltshire (Co-Chair of Rainbow Network),		
Apologies:	Dave Vallance (Chair of TPC), Jacqui Hallam (Chair of Women's Network), Babur Yusufi (GOSWH), John Whitehall (Unison Steward/JCC Staff Side Chair), Mike Senevirate (Staff Governor) Vicki Mitchell (Co-Chair of Rainbow Network) Emma Wilsher (Staff Governor)		
Matters of concern or key risks to escalate to the Board:	Continued recognition of the scale of change within the NHS and inside the Trust: acknowledgement of sincere efforts to manage that but the need for TPC and the Board to think about how to narrate and prepare people for this in 2025 and 2026.		
Key points of discussion relevant to the Board:	**Voice scorecard**. A graphical representation of the voice scorecard had been produced alongside a descriptive analysis of some of the key points. Further exploration agreed to consider opportunities to facilitate a return to work outside of the current role and outside the trust (in the community) for colleagues on long term sickness, and also the consideration of a 'breathing space' for colleagues who have difficulties in their current role / area of work. **Communication.** The TPC explored areas of focus and challenge within the Trust: reiteration that any member can put forward agenda items and to also share the information and seek feedback with colleagues prior to TPC to shape the discussions. Likely to run October meeting as a development session. **Reasonable adjustments – DAWN Network**. A concern had been raised at the last DAWN network in relation to reasonable adjustments and the facilitation of these adjustments. The concerns related to managerial flexibility to support neurodivergent colleagues with quieter office space and / or remote working alongside flexible working requests. Similar feedback was also shared by the Carers Network. It was agreed that prior to the next TPC meeting, we would explore flexible working options in our acute directorates, neurodiversity and our parameters, and also to work with our managers to understand their perspective on what stands in the way of flexible working, and in some cases kindness (recognising our service responsibilities)		
Positive highlights of note:	The level of engagement and feedback from members was positively received – with many contributing.		
Matters presented for information or noting:	**Remote working.** Presentation shared owing to time **Poverty work.** Presentation shared owing to time		
Decisions made:	Restructure agenda approach next time		
Actions agreed:	Alterations to the Voice scorecard – and actions in relation to stress/sickness		

Kath Lavery, Chair (on behalf of Dave Vallance, Non-Executive Director and Chair of the Trust People Council)
Report to the Board of Directors meeting scheduled for 24 July 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper L
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	24 July 2025

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

The NHS' 10-year plan highlights a focus on neighbourhood health which is relatively consistent with our strategy since 2023. Likewise, the plan focuses on a shift from analogue to digital, which today's Board agenda considers. Importantly, a clear indication is given to move away from block contracts, which is an opportunity and risk for our service portfolio. Perhaps most critically, as the board discussed when it last met, we need, as a Board that the novelty of ideas within the 10-year plan does not become a distraction from our mission to nurture the power in our communities.

The report outlines actions from the last two months and tries to take a view across Q1. It is great news that we have met our first promise (promise 25 – real living wage). Work to deliver promise 19 is progressing well, but we have some very hard and distributed work needed to achieve promise 3 and promise 14 in year – the latter is set out in a detailed report for the Board. Financial delivery risk should be highlighted, given the continued difficulties seeing pay award costs being met – and the likelihood of the Trust losing deficit support funding of £1.8m because of budget overspends at a minority of Trusts and SYICB.

Previous consideration	
Not Applicable	
Recommendations	
The Board of Directors is asked to:	
EXPLORE the patient, people and population issues described	
CONSIDER any matters of concern not covered within the report	
NOTE the release of the Trust's score/rank on the new Oversight Framework	
SUPPORT submission of the Trust's update Green Plan (annexed)	
Alignment to strategic objectives (indicate those that the 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
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
Digital enabling plan	X
People and teams plan	X
Medium term financial plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)				
People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Financial risks	Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risk	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
External and partnership risks	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
SDR 1 and 3
System / Place impact (advise which ICB or place that this matter relates to)
See text, multiple reference to system / place re: financial positions of IC

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: CLE summary June and July 2025 Annex 2: Current register of Trust vacancies June 2025 Annex 3: National publications June/July 2025 Annex 4: Q1 RIDDOR Annex 5: Recommended revised Green plan (promise 27) Annex 6: NHS Plan and neighbourhood briefings from ICB colleagues

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

July 2025

1.1 Over the last month, we have seen publication both the Ten-Year NHS Plan, and the first iteration of quarterly oversight scores for provider Trusts. Whilst the former understandably generates significant discussion and is considered below and in more detail in my private report, it is significant that **the tone of national policy increasingly emphases the responsibility of Boards**, and the autonomy and accountability of provider Trusts.

1.2 We were pleased that our core scores, using the 12 measures that apply to community and mental health Trusts, would have produced a 2/5 rating (the second best feasible). Our lower scoring areas were sickness rates, 2-hour community crisis response times and long (60d+) length of stay. We are seeking to understand the denominators used for some of the calculations, as we get used to the new system: 7 of 12 indicators are based on monthly data, with the majority of the balance being annualised and retrospective. **Our receipt of £2.4m of deficit support funding acts as an override, leading to us being rated as a 3: placed 34th of 61 peer Trusts.**

1.3 The ten-year plan creates potential opportunities as well as distractions with its "three-shifts" ambitions. We understand an implementation plan will be due in the autumn nationally. The focus on neighbourhood health, and on integrators and provider contracting, needs to be carefully managed, with a palpable risk emerging that neighbourhood becomes no more than the new name for place, rather than a more hyper local space of relevance of people we serve. The delay into autumn in changes to ICBs retains some organisational memory but, of course, could exacerbate this old wine/new bottles risk. **Our focus, I believe, needs to be in two areas**: (1) developing our relationships within primary care and general practice and (2) working to co-produce meaningful *outcomes* from neighbourhood working, such that form can be designed to function.

1.4 The Care Quality Commission has confirmed that it no longer holds ratings at Trust level, rendering moot our legacy requires improvement rating as an organisation. However, within the Ten-Year Plan, there is an implication of restoring a revised assessment in time. We would expect, before the Board next meets, that we will see **publication of the outcome of our acute/PICU ward** visits – which we expect to reinforce the Board's analysis, requiring improved consistency of care, and a greater therapeutic activity base within our wards.

1.5 The NHS has long aimed to be first national system to achieve net zero (2040), including net zero for directly controlled items from 2036. **Refreshed green plans** are needed and appended to my report is the proposed final submission. The five priorities we have set are tangible but very ambitious. With the abolition this spring of HMG grant-based funding for energy-related schemes, our focus is fully on a public/private partnership to create replacements for gas-based sourcing, and the

Board will consider our intentions in the August timeout, which explores our site and estate plans in more detail.

Our patients

2.1 The **Leng review into the use of PAs** across the NHS has been recently published, with important recommendations for change, which DHSC has adopted in full. I can confirm that our uptake of PAs in recent years has been very modest, with only one postholder in the last 18 months, who has since left the organisation. This colleague worked under close consultant supervision, and we have no concerns about unboundaried involvement in diagnosis. The assistant role is one that we do support looking forward, as we work to ensure that we provide all suitable support to senior clinicians in best use of their scarce and valuable time.

2.2 Our preparedness work for **the upcoming resident doctors' strike** is well-advanced. We do not expect to stand down any service delivery, and rate cards and other items, subject to agreement with trade union partners, are in place. Notwithstanding the national dispute, we continue to work closely with trainees, and a survey is with them currently exploring recent changes to our HR functions, and how any risks arising from that might best be mitigated. We know that difficulties associated with the ward changes in January created some ill-feeling, and we continue to work with the postgraduate deanery to ensure that our learning environment is conducive and communication is meaningful and proportionate.

2.3 Monitoring work suggests we are sustaining the recent improvement in complaint and PALs turnaround times, and indeed response times within Care Opinion. It is too early to take a view on the 50-day maximum for Patient Safety Incident Investigations (PSII) that we confirmed in approving **our revised PSIRF policy in May**. The priority audit in Q2 will explore whether we are accurately applying the various options for investigation within PSIRF, and whether choices are similar across different directorates. This analysis needs to considered alongside a review of how RADAR is being used, and we would hope to be able to explore that with data in the October timeout, which will be about four months after adoption – at the time of writing the backlog of unresolved Ulysees incidents is now 41, but clearly it will be important that no similar backlog develops within RADAR. This will become a core data-item within delivery reviews from September 2025.

2.4 Other papers, before the Board, explore the approach being taken to trying to deliver improved productivity. This work needs to become better aligned to our routine management processes, as we look to pay attention to volumes of care being delivered by teams. The **ostensive 19% shift in care volumes year on year** is truly encouraging, and we want to integrate those figures with waiting numbers and waiting time data. It will be important to discuss how we get a prototype in place for that alignment over the course of Q3, recognising that a move to volume related funding, even in shadow form, is possible for 2026/27.

2.5 The test-bed ward for some of the changes from our High Quality Therapeutic Care taskforce has gone live. Sandpiper in Rotherham will help us to refine the ways of working timetable that was co-developed in June. **The new patient visiting times**

changes will start from September 1st, organisation wide. Crucially, we have to have in place the right care planning model, not only in our wards, but elsewhere: the work to test that approach will start imminently – and from October we will be delivering on our pledge to ensure that on every ward, every day, there is at least one meaningful therapeutic activity.

2.6 There is encouraging progress in tackling **out of area placements**, which is a substantial quality and financial risk. For South Yorkshire, we are seeing figures fall, and out of hours, out of area placements, have been substantially reduced over the period of the last six weeks. Recognising that work at Great Oaks will mean temporary outplacement, the Board has been briefed in our private meeting in June on use of the Magna facility near Sleaford for the period until construction completion in March 2026.

2.7 Waiting times at the Trust are discussed in a specific paper before the Board today, as we countdown to April 2026 and our promise 14 deadline. **Neurodiversity waits** are reduced but not at the scale we had sought, either for children and young people or adults. Jude Graham is working with the clinical teams to address remaining practice blockages to moving to a more 'clinic' booked sessional model of care. This work, alongside work across the South Yorkshire ICB that I am co-leading, will be brought back to the Board in September – recognising the substantial investment made in 2024, and since by the Trust, to reduce these waits. We would hope by early autumn to have the new facility in Bentley available for use, recognising that space is one, albeit not the only, issue faced by teams as we work to offer the same commitment for ADHD diagnosis, and autism support, as we have to other conditions. The first report from the national taskforce on this issue provides clarity for Boards on work that must be done to address, finally, the significant consequences of delay in the NHS meeting needs in this area.

Our people

3.1 We know that **recognition and acknowledgement at work** remains a critical issue for NHS staff, perhaps more so at a time when wider public and political esteem is more challenged than before. Of course, projects like Care Opinion, help to bring direct balance to that. In 2024, we changed our rewards system, both to make it more diverse and more localised. Nominations close for our traditional once a year awards scheme on August 8th (ceremony November). Prior to that, the first Shining Stars winners will be announced by the chair – drawn from those who have been recognised inside our six Groups. The Community Fun Day in July saw more recognition for length of service, meaning that all between April 2022 and March 2025 have now had the opportunity to receive acknowledgement under the new scheme that the Clinical Leadership Executive adopted. The next ceremony is in March 2026, covering this public sector financial year.

3.2 The focus on **fully staffed** remains as a Trust, noting that the two large new teams mean our vacancy figure has sizeably risen. Initial analysis of those being hired suggests that the demography of our recruits is changing and becoming more diverse. This is encouraging, but we need to do the work to compare it to our local population in Q3. At the same time, promise 9 means we need to launch a variety of

targeted employment schemes over the course of 2025 – and we will update the Board in November on our delivery of those commitments.

3.3 In 2024/25, we adopted a **seven-point action plan in response to part of Promise 25** (on anti-racism and wider discrimination). This will be audited again in 2025/26, but we are now in a position where some of the elements of that plan are nearing full delivery: complaints of staff/staff racism are subject to investigation led by someone from a global majority background, and the process of changing interview panel composition will be ready for the start of 2026. The rollout of training for senior leaders is taking place. Later in the year, we will aim to undertake a targeted survey of employees to gain a more in-depth understanding of experience – notwithstanding the data we will receive in March 2026 from the October 2025 WRES data.

3.4 During June, our latest round of **open staff meetings**, complimented sessions held online since April, to explore the 'NHS reset'. The diversity of themes was striking, but there is clear appetite to extend our Learning Half Day offer – as well as a need to do more to help line managers to communicate and explore complex change efforts in a way that is relatable, but timely, at local level. We have extensive plans to ensure that written communication is more targeted at directorate and professional level, but this cannot substitute for dialogue and conversation. Jo McDonough is leading work to consider how best we support local team meetings to take place and to be equipped to improve explanation, not only of what is going on trustwide, but why.

3.5 As the Board knows, we are working diligently to introduce, or reset, **job planning** into a variety of professions within the Trust. The pressing need to complete this work for medical staff is evident on the back of HQTC and promise 14 analysis, but also in responding to colleagues' desire to have meaningful SPA time. As a Trust, we need that time to be biased towards education, leadership and research but should, of course, explore commitments beyond the Trust on occasion. We hope that this year's exercise will create a baseline, making future annual updates more straightforward. The timing of audited review of the outcome and fidelity of plans to practice is yet to be finalised.

Our population and partners

4.1 This month sees the launch of our membership offer, and later in Q2 we will go live with **the shadow Clinical Leadership Executive**. That grouping will provide peer support to those involved as patients in our decision-making meetings already, but it also needs to create a space of influence for voluntary and community sector groups. This does not overlook the lean-in commitment, nor time needed, to support our visibility and presence in community spaces, perhaps especially at a time of commissioning restraint and renewed austerity.

4.2 Our papers today see the first formal issue of **our health inequalities** IQPR material. This long list or 'red flag' analysis aims to identify potential discrepancies in access or care. We know already that we detain formally a higher proportion of our black and minority ethnic population, albeit analysis of presenting data by ethnicity is being re-analysed. The Public Health, Patient Involvement and Partnerships Committee has

had sight of work to create dataflows in support of promises 6 to 12. Over coming weeks, the move to make sure such data is visible by directorate will be really important to moving to better delivery in H2 25/26.

4.3 Alongside the formal annual members meeting (AMM) for 2024/5, we have hosted **our first dedicated Children and Young People's AMM**: this is a next step after the expansion of our membership, and with an eye to the 'takeover' of the Council of Governors planned for later in 2025/6. The issues of travel, technology, waits, support, and justice raised in the AMM are ones to consider – and explore whether we are doing enough to be confident of change. We are seeing encouraging progress with our 'age-transitions' work, perhaps notably in expanding Talking Therapies access to 16 and above ('the voting age') – and we will review how ambitious we need to be in light of feedback from young people, as well as adult carers.

4.4 Whilst we have seen some collaboration 'knock backs' over recent weeks, notably with the standing down of work to create a joint-venture in mental health commissioning in Humber and North Yorkshire, it is positive to see the North Lincolnshire Joint Committee (for commissioning) starting work – just as we now have **approval across South Yorkshire for the all-age Eating Disorders collaborative**, which has already seen go-live to level up community eating disorder services for adults across the four places! The next step is to develop, if we can, an inpatient unit for South Yorkshire residents.

4.5 We have worked with local GPs to co-design the system to **publish our waiting times on the Trust website, monthly from the end of July**. Hopefully this transparency will help us moving forward and reduce pressure within primary care to explain delays or placement within the wider secondary care system. This is one of the five commitments we made in January 2025 for 2025/26 to improve our interface working with primary care partners.

Toby Lewis, Chief Executive
17th July 2025

Annex 1

Clinical leadership executive – June and July 2025

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

June	July
Policy management	Segment 3 priorities among our promises
Learning and education deep dive	Promise 14 – responding to urgent referrals
Engagement and disengagement policy – revised	High quality therapeutic care – next steps including the test bed site
HQTC – outcome of June event	Appraisal proposals for 26/27
CQC readiness next steps	Promise 2 plan
Sickness absence update	Progress update on transitional care

In terms of decisions made, we have confirmed the go-live data for new visiting hours for our wards (01/09). We kicked off work to move to good from November for remaining areas of CQC self-assessment that are short of that measure. And we noted that the council of governors has a new focus on transitional care.

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

Over the next two meetings (August/September) we will consider in particular:

- Final version of the engagement policy (also discussed in CEO private report)
- Apprenticeship levy workplan
- Delivery plans in relation to segment 3 promises
- Communication in relation to plan B work (also discussed in private papers)
- Implementation of the outcome of HQTC test bed site
- Neighbourhood working and NHS ten-year plan
- Work to introduce mandated changes into the Trust

Toby Lewis, Chief Executive
18 July 2025

Annex 2 **Current vacancy summary at 7th July 2025**

Org L4	FTE Budgeted	FTE Actual	FTE Variance	RECRUITMENT	Awaiting Authorisation	Advert	Shortlisting	Interview	offered	Start Date	Total
376 CCG Management	28.00	26.43	-1.57		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 CCG Mental Health	329.27	314.03	-15.24		11.20	6.80	2.00	1.20	5.80	6.80	33.80
376 CCG Physical Health	296.31	281.76	-14.55		1.00	0.00	0.00	0.00	2.30	2.00	5.30
376 DMHLD Acute Services	230.61	202.52	-28.09		1.00	0.60	1.00	1.00	5.00	10.20	18.80
376 DMHLD Community Services	337.50	325.23	-12.27		3.00	2.68	1.00	1.00	0.60	4.00	12.28
376 DMHLD Learning Disabilities & Forensics	189.55	182.77	-6.78		0.00	1.60	0.80	0.00	0.00	2.00	4.40
376 DMHLD Management	10.20	9.80	-0.40		0.00	1.00	0.00	0.00	0.00	0.00	1.00
376 NLCG NHS Talking Therapies	182.67	184.65	1.98		3.00	1.00	0.00	0.00	2.00	1.00	7.00
376 NLCG Acute Care Services	134.21	117.67	-16.54		1.80	5.00	1.00	2.80	1.00	5.40	17.00
376 NLCG Community Care Services	140.21	110.35	-29.86		0.00	0.95	0.00	3.64	3.40	3.00	10.99
376 NLCG Management	25.01	25.14	0.13		1.00	1.00	0.00	0.00	2.00	0.00	4.00
376 DPHG Community & Long Term Conditions	405.84	395.32	-10.52		0.80	2.00	0.00	1.50	3.60	3.80	11.70
376 DPHG Rehabilitation	323.22	307.88	-15.34		3.00	3.00	1.00	3.00	6.52	1.61	18.13
376 DPHG Management	10.40	9.85	-0.55		0.00	0.40	0.00	0.00	0.00	0.00	0.40
376DPHG Neurodiversity	42.66	40.99	-1.67		0.00	0.00	0.00	0.00	1.00	2.00	3.00
376 RCG Acute Services	247.58	220.47	-27.11		0.00	11.20	3.97	12.28	0.00	0.70	28.15
376 RCG Community Services	236.49	225.99	-10.50		0.00	2.20	1.00	1.80	1.00	0.00	6.00
376 RCG Management	16.16	15.06	-1.10		1.00	0.00	0.00	0.00	0.00	0.00	1.00
376 Corporate Assurance	29.09	26.56	-2.53		0.05	3.00	0.00	0.00	0.00	0.00	3.05
376 Estates	42.18	42.17	-0.01		0.00	1.00	0.00	1.00	0.00	0.00	2.00
376 Finance & Procurement	42.99	40.52	-2.47		0.00	0.00	0.00	0.00	0.00	1.00	1.00
376 Health Informatics	74.46	73.96	-0.50		0.60	2.00	1.00	0.00	1.00	0.00	4.60
376 Medical, Pharmacy & Research	48.28	55.39	7.11		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Nursing & Facilities	167.20	160.77	-6.43		0.50	0.24	0.64	0.00	0.00	0.70	2.08
376 Operations	51.08	48.20	-2.88		0.00	0.00	0.00	1.00	0.00	0.00	1.00
376 People & Organisational Development	90.25	85.50	-4.75		0.43	2.00	0.00	0.00	1.00	0.00	3.43
376 Strategic Development	20.25	19.56	-0.69		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Psychological Professionals and Therapies	12.50	11.00	-1.50		0.00	1.00	0.00	0.00	0.00	0.00	1.00
Total	**3,764.17**	**3,559.55**	**-204.62**		**28.38**	**48.67**	**13.41**	**30.22**	**36.22**	**44.21**	**201.11**

Annex 3: National publications/guidance summary – June 2025/July 2025

Fit for the Future: 10 Year Health Plan for England
(NHS England, published 03/07/2025)

https://assets.publishing.service.gov.uk/media/68760ad755c4bd0544dcae33/fit-for-the-future-10-year-health-plan-for-england.pdf

NHS Oversight Framework 2025/26
(NHS England, published 26/06/2025)

https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

Workforce Disability Equality Standard: 2024 data analysis report for NHS trusts
(NHS England, published 25/06/2025)

https://www.england.nhs.uk/publication/workforce-disability-equality-standard-2024-data-analysis-report-for-nhs-trusts/

Workforce Race Equality Standard: 2024 data analysis report for NHS trusts
(NHS England, published 25/06/2025)

https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2024-data-analysis-report-for-nhs-trusts/

Health inequalities and equality legal duties: A reference document for NHS commissioners and providers
(NHS England, published 09/07/2025)

Integrated care boards, NHS trusts and foundation trusts and other NHS organisations should use this document to inform action to meet their legal duties on health inequalities and equalities. This reference document replaces 'Guidance for NHS commissioners on equality and health inequalities legal duties' (2015). Any future updates will be clearly marked and communicated as appropriate.

https://www.england.nhs.uk/long-read/health-inequalities-equality-legal-duties/

Letter: Further action to reduce NHS spending on temporary agency staffing
(NHS England, published 02/06/2025)

https://www.england.nhs.uk/long-read/letter-further-action-reduce-nhs-spending-temporary-agency-staffing/

Letter: Agenda for Change non-pay deal recommendations – NHS job evaluation
(NHS England, published 03/06/2025)

https://www.england.nhs.uk/long-read/letter-agenda-for-change-non-pay-deal-recommendations-nhs-job-evaluation/

Mental Health: delivering the three shifts
(NHS Providers, published 05/06/2025)
This briefing sets out analysis and key actions to deliver values-driven, patient-centred, and staff-enabled mental health care.

https://nhsproviders.org/resources/mental-health-delivering-the-three-shifts

Commissioner guidance for adult community mental health rehabilitation services
(NHS England, published 09/06/2025)

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

Very senior managers pay award for 2025/26
(NHS England, published 18/06/2025)

https://www.england.nhs.uk/long-read/very-senior-managers-pay-award-for-2025-26/

Report of the independent ADHD Taskforce
(NHS England, published 20/06/2025)

Part 1 of the Taskforce's report is now available. Work continues on a final report later in 2025, and to align recommendations with other work across Government.

https://www.england.nhs.uk/wp-content/uploads/2025/06/PRN02031-interim-report-of-the-independent-adhd-taskforce-part-1.pdf

Artificial intelligence use in NHS communications
(NHS Confederation, published 23/06/2025)

https://www.nhsconfed.org/publications/artificial-intelligence-use-nhs-communications

Quality impact assessment – framework and tool
(NHS England, published 24/06/2025)

This framework and accompanying tool set out good practice principles and guidance for undertaking quality impact assessments (QIAs) as part of the decision-making process for planning, approving and implementing changes to or commissioning new health and care services.

https://www.england.nhs.uk/publication/quality-impact-assessment-framework-tool/

Flu and COVID-19 Seasonal Vaccination Programme: autumn/ winter 2025/26
(NHS England, published 26/06/2025)

https://www.england.nhs.uk/long-read/flu-and-covid-19-seasonal-vaccination-programme-autumn-winter-2025-26/

Review of patient safety across the health and care landscape
(NHS Providers, published 07/07/2025)
This briefing sets out NHS Providers' views on the report and a summary of key findings.

https://nhsproviders.org/resources/review-of-patient-safety-across-the-health-and-care-landscape

Digital transformation and the productivity and efficiency challenge
(NHS Providers, published 08/07/2025)
This report explores how to harness the potential productivity gains associate with digital.

https://nhsproviders.org/resources/digital-transformation-and-the-productivity-and-efficiency-challenge

First 1000 days of life: a renewed focus – evidence to the health and social care committee inquiry
(NHS Confederation, published 10/07/2025)

The NHS Confederation's submission to the Health and Social Care Committee's inquiry on the first 1000 days of life

https://www.nhsconfed.org/publications/first-1000-days-life-renewed-focus-evidence-health-and-social-care-committee-inquiry

NHS Social Value Playbook
(NHS England, published 14/07/2025)

https://www.england.nhs.uk/long-read/nhs-social-value-playbook/

Annex 4 **RIDDOR - Quarter 1 2025**

RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These regulations require employers, the self-employed and those in control of premises to report specified workplace incidents to the Health and Safety Executive (HSE). In quarter 1 (1st April to 30th June 2025) there were 5 RIDDOR reportable incidents resulting in injury, 3 in April and 2 in May.

Incident date	Cause	Location	RIDDOR reason
03/04/2025	An employee slipped on a wet floor in the hub area and suffered a knee injury.	Brodsworth Ward (Doncaster Acute Directorate)	Over 7-day absence
22/04/2025	A Community Healthcare Assistant suffered shoulder pain and a trapped nerve after applying compression bandages to a bariatric patient's legs.	Patient's home (Community Long-Term Conditions)	Over 7-day absence
30/04/2025	A Community Partner (volunteer) suffered a hip fracture after falling up steps at an offsite Trust event.	AES Seal New York Stadium	Member of the public taken to hospital
06/05/2025	A patient hit an employee in the face causing severe bruising and psychological harm.	Mulberry House (N Lincolnshire Acute Directorate)	Over 7-day absence
11/05/2025	A patient was pushed by an employee. The following day they were transferred to an external facility (planned transfer) where they complained of leg pain.	Brodsworth Ward (Doncaster Acute Directorate)	Member of the public taken to hospital

The fall incident on Brodsworth Ward was caused by a wet floor that had recently been mopped but was reported as having no signage. When interviewed, domestic staff reported that signage had been installed but may have been obscured. The Domestic Manager is providing refresher training to employees and monitoring performance during supervision. Additional signage reminding employees about procedures has been installed in sluice areas.

An incident in the 136 suite in North Lincolnshire involved a number of employees being assaulted by a patient. At staff changeover, the patient struck an employee in the face, the alarm was sounded and employees responding were also assaulted. The incident involving a volunteer would have been more appropriately reported by the venue rather than the Trust as the injury occurred on their premises. However, a 'belt and braces' approach was used to ensure that a report was made. There are no reported faults with the stairs and the volunteer has no known mobility issues, although it is reported that they found it difficult to lift their leg high enough to climb the step.

Annex 5

NHS RDaSH Green Plan 2025/28

(Draft version 3)

Foreword

- To be drafted via CEO

Executive Summary

> ***"Indeed, often health and climate are mutually reinforcing goals"***
>
> Rt Hon Lord Darzi

The RDaSH Green Plan 2025–2028 outlines our strategic approach to significantly reducing the carbon footprint of our services and estates, aligning with the NHS ambition to achieve Net Zero for all Scope 1 emissions by 2040. This plan highlights key priorities, progress monitoring, and targets for the next three years, supporting Promise 27 of our Clinical and Organisational Strategy to deliver sustainable, climate-adaptive healthcare. It also emphasises how we will work with partners ensuring collaborative working, embracing joint funding opportunities and maximising opportunities for economies of scale.

Since our previous Green Plan, progress has been limited with some emissions categories, such as business mileage and food waste, showing increases of 15% and 36% respectively. Addressing these trends is a central focus in this plan.

Our governance framework ensures clear leadership and accountability for tracking progress. Notable achievements from the last plan include establishing a Green Champions Network, completing a Heat Decarbonisation Plan, commissioning electric vehicle charge points, and enhancing biodiversity through tree planting.

For 2025–2028, we concentrate on five evidence-based priorities to drive emission reductions:

1. **Estates Decarbonisation** – Targeting a 500-tonne annual reduction in gas emissions through building rationalisation and capital projects, despite funding challenges.
2. **Business Mileage** – Aiming to cut emissions by 200 tonnes annually by optimizing route planning, increasing electric vehicle use, expanding charging infrastructure, and promoting sustainable travel schemes.

3. **Digital Transformation** – Leveraging digital tools to reduce paper use by 20%, expand virtual care pathways, and procure low-carbon IT hardware with net zero supplier requirements.
4. **Food Waste Reduction** – Reducing waste from 137 to 30 tonnes annually via smarter inventory management, portion control, sustainable menus, and food redistribution partnerships.
5. **Climate Adaptation** – Preparing all services for climate impacts through benchmarking, adaptation planning, staff education, and supplier engagement.

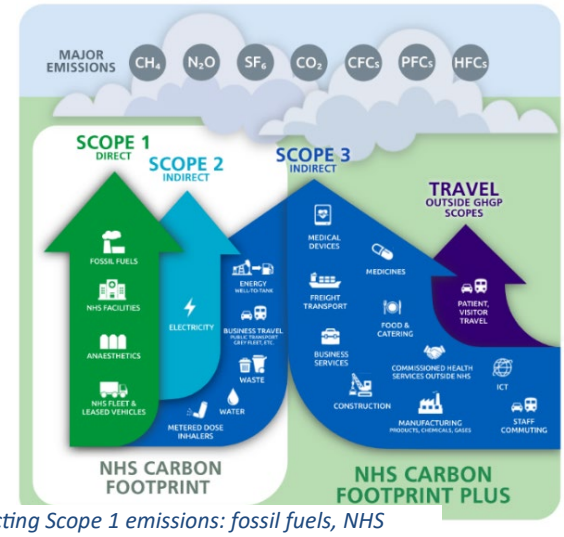
Through these focused actions, RDaSH commits to reducing its environmental impact, enhancing resilience to climate change, and improving outcomes for local communities.

What is the 'RDaSH Green Plan'?

Our RDaSH Green Plan for 2025/28 identifies the key areas of focus over the next 3 years, with a view to reaching the wider NHS ambitions of achieving Net Zero for all Scope 1 emissions by 2040. In this plan we set out:

- what our priorities will be;
- how we will monitor progress;
- the current status of each priority area;
- where RDaSH would be like to be by 2028.

The Green Plan also supports us with delivering on Promise 27 of our Clinical and Organisational Strategy:



A graphic depicting Scope 1 emissions: fossil fuels, NHS facilities, anaesthetics and NHS fleet & leased vehicles.

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

The success measure for our Promise is that local communities and environments will benefit from a reduction in CO2 produced by the trust and our services will adapt to the challenges of climate change. More information about this can be found here:

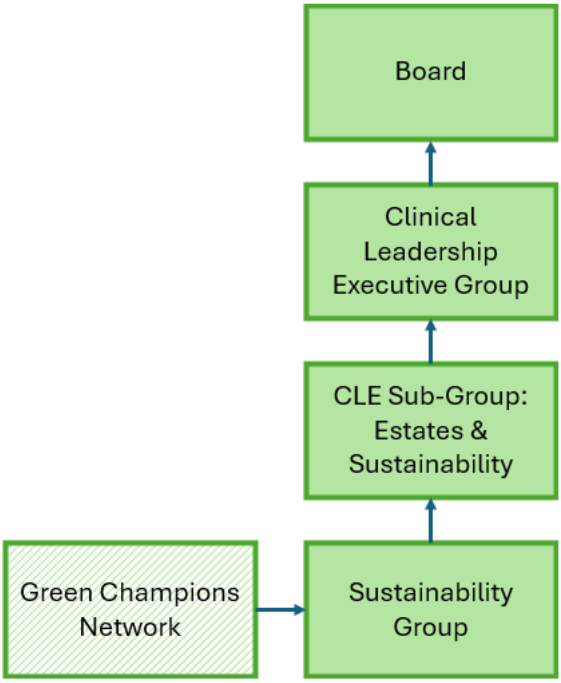
https://www.rdash.nhs.uk/documents/clinical-and-organisational-strategy-2023-to-2028/

Since the publication of our previous Green Plan, progress has been slow in most areas. We are disappointed to report that some of categories of emissions have increased. For example, our business mileage is currently heading on an upward trajectory: in 2023/24, we used 727 carbon tonnes versus in 2024/25 where we used 836 carbon tonnes. This is an increase of 15%. Food waste is also currently heading on an upward trajectory: in 2023/24, we used 101 tonnes versus in 2024/25 where we used 137 tonnes. This is an increase of 36%. Both categories feature as priorities in this Green Plan as we attempt to address the worsening picture and begin to make progress in the right direction.

What is our governance structure for monitoring progress?

The RDaSH governance structure for our Green Plan ensures successful implementation of our targets, with clear leadership, accountability and monitoring of the outlined actions. This structure ensures that we are able to effectively track progress and engage stakeholders at all levels.

A visual representation of the RDaSH governance structure for the Green Plan and Promise 27 can be seen below:



What did we achieve in our last Green Plan?

The previous RDaSH Green Plan had a much broader scope and led us on a journey of understanding the sustainability needs of our communities, assessing our estate, and expanding our relationships with partners to include the green agenda. Here are some of our achievements:

- Held a Climate Adaptation Simulation Day
- Established a 'Green Champions' Network
- Worked collaboratively with partners to understand the areas more at risk of climate change
- Identified areas within our communities which are at risk of flooding
- Finalised our Heat Decarbonisation Plan
- Commissioned 21 additional charge points for electrical vehicles

- Planted almost 1,000 trees
- Took biodiversity action on the Tickhill Road Site, planting for wildlife and pollinators.

Green Champions Network logo

What do we want to achieve this time?

In the RDaSH Green Plan for 2025 – 2028, we will focus on **5 priorities** to significantly reduce our emissions. These priorities are all evidence-based to ensure we are targeting areas which are most likely to have the biggest impact on reducing our emissions. For each priority, there are several **key actions** which we will undertake to achieve the goal; however, this list is not exhaustive.

Our current annual emissions are 3,562 carbon tonnes. By the end of 2028, we aim to reduce this by 2,000 carbon tonnes per year in line with Promise 27 in the RDaSH Clinical and Organisation Strategy.

Priority 1: Estates Decarbonisation

Objective: Reduce annual gas emissions by 500 carbon tonnes via estates decarbonisation.

Reliance on gas to power our buildings uses 1,896 carbon tonnes per year, which is approximately 53% of our total tonnage. Reducing our need for fossil fuels like gas provides an opportunity to make a significant reduction on our emissions. The removal of PSDS funding from the national budget in June 2025 has made estates decarbonisation more difficult; however, we are confident that progress can be made in this area by optimising estates rationalisation solutions.

Plan:

Action	Measurement	Delivery
We will use our Estates Plan (which includes the rationalisation of buildings) to make informed decisions about how we use our buildings.	Unnecessary buildings will be decommissioned, as per the RDaSH Estates Plan. We expect building rationalisation to save approximately **500** carbon tonnes annually.	2028
We will use our Heat Decarbonisation Plan to create technical specifications for tangible capital projects in the name of a reduction in emissions.	Multiple technical specifications for identified projects will be prepared to RIBA Stage 4.	2026

Action	Measurement	Delivery
We will make advanced preparations to be in a position to apply for grants and funding to decarbonise our estate.	Multiple technical specifications for identified projects will be prepared to RIBA Stage 2.	2026
We will incorporate actions from the Heat Decarbonisation Plan into our Capital Programme from 2026/27 onwards.	Actions to appear in Capital Plan from 2026/2027.	2026

Priority 2: Business Mileage

Objective: Reduce annual emissions created via business mileage by 200 carbon tonnes.

The Covid-19 pandemic changed the way we worked for a few years; staff were encouraged to move to online options for appointments and meetings to help keep our communities safe during an uncertain period. These adaptations allowed us to make unintentional progress towards a reduction in business mileage; however, as we transition back to more in-person contact, we are seeing a steady rise in our mileage emissions which are now similar to the figures which were recorded before the pandemic 6 years ago. There is an urgent need to regain the progress we made during the pandemic, without impacting on service delivery.

Plan:

Action	Measurement	Delivery
We will implement and optimise route planning software across all our community services to ensure our colleagues reach all our patients using the fewest possible miles.	Software to be implemented and consistently used across the organisation. We expect this to save approximately **120** carbon tonnes annually.	2027
We will commit to purchasing and leasing electric vehicles only within the organisation and we will invest in more pool cars which are solely electric.	Electric vehicles only, with fuel vehicles being phased out as contracts expire. We expect this to save approximately **50** carbon tonnes annually.	2026
We will promote the salary sacrifice scheme to all community colleagues, to provide them with more affordable access to electric vehicles and support them with greener travel.	**100%** more staff enrolling onto the salary sacrifice scheme for electric vehicles only. We expect this to save approximately **30** carbon tonnes annually.	2028

Action	Measurement	Delivery
We will expand the number of charging points at all appropriate RDaSH sites to ensure colleagues feel incentivised to use electric vehicles.	**20** more charging points to be installed at RDaSH sites.	2027

Priority 3: Digital

Objective: Maximise the benefits of digital transformation to reduce annual emissions.

Digital sustainability provides an opportunity to enhance operational efficiency, as well as support with broader environmental goals.

Plan:

Action	Measurement	Delivery
We will reduce the use of paper, where clinically appropriate.	We will see a reduction in paper use of **20%.** This will take our paper usage from 6 million sheets per year, to 4.8 million.	2027
We will provide more virtual pathways where clinically appropriate.	More virtual pathways.	2026
We will commit to using circular and low-carbon approaches to IT hardware management, which may include longer device lifetimes, leasing models and buying refurbished or remanufactured equipment.		2028
We will continue to engage digital suppliers by applying net zero supplier requirement in all digital procurement, to ensure that sustainable technology and digital services are procured.	All digital suppliers to include net zero requirement.	2025

Priority 4: Food Waste

Objective: Reduce annual food waste from 137 tonnes to 30 tonnes.

Reducing food waste at RDaSH provides a good opportunity to improving sustainability, cut costs and promote better health outcomes. By implementing smarter inventory management, improving portion control, simplifying supply chains and using food waste tracking systems, we can minimise excess food production while ensuring patients, visitors and staff receive the nutrition they need. Collaborating with food suppliers and local charities to redistribute surplus food can also significantly reduce waste and benefit the wider community.

Plan:

Action	Measurement	Delivery
We will use data from food waste tracking to understand where the majority of our food waste is coming from.	Good evidence of quality data which pin-points areas to focus on.	2025
We will target the areas with the most food waste and work to ensure significant improvements are made. This will include 3 key areas: 1. Better portion control; 2. More sustainable menu options; 3. Redistributing surplus food.	Less food waste from in-patient and staff food areas. We expect these initiatives to save approximately **107** tonnes of food annually.	2026
We will work to improve our food offerings for patients and visitors across our organisation, but particularly at Woodlands in Rotherham and the Hospice in Doncaster. This will include improved choice, as well as more sustainable choice.	Higher satisfaction ratings towards menus.	2028

Priority 5: Climate Adaptation

Objective: Prepare all RDaSH services for the impact of climate change, as per current forecasting data.

Building on the RDaSH Climate Adaptation Day which was held in Rotherham in February 2025, we will continue to address the growing challenges posed by climate change. With rising temperatures, extreme weather events (i.e. flooding) and shifting disease patterns, RDaSH must adapt and plan for forecasted challenges to safeguard both patients and staff in the future. This includes weather-proofing our buildings, adopting sustainable ways of working and preparing for increased demand.

A picture of colleagues at the RDaSH Climate Adaptation Day. From left to right: Kavitha Sethumadhavan, Steph Pinnell, Toby Lewis, Jo McDonough, Neil Cartwright and Louise Preston.

Plan:

Action	Measurement	Delivery
We will carry out a benchmarking exercise against the national Climate Adaptation Framework to understand any gaps.	Evidence of benchmarking exercises by directorate.	2026
Based on the outcomes of the benchmarking exercise, we will adopt Climate Adaptation plans.	Climate Adaptation plans to be created by directorate.	2026
We will recycle the simulation activities from the RDaSH Climate Adaptation Day and use them to offer Climate Adaptation learning events on the Learning Half Days. This will ensure all staff have the opportunity to learn about adaptation and what it means for their service area.	**50%** of the workforce to have engage in Climate Adaptation awareness training.	2028
We will continue to engage digital suppliers by applying net zero supplier requirement in all digital procurement, to ensure that sustainable technology and digital services are procured.	Evidence of understanding about what our partners are doing in relation to Climate Adaptation, with areas of similarity identified.	2025

Conclusion

The RDaSH Green Plan 2025–2028 represents a clear and committed pathway toward reducing our environmental impact and preparing our services for the challenges of a changing climate. While we acknowledge the setbacks experienced since our last plan, this renewed focus on five key priorities demonstrates our determination to make measurable progress over the next three years. By decarbonising our estates, reducing business mileage, embracing digital innovation, minimising food waste, and strengthening climate adaptation, we will contribute meaningfully to the NHS's Net Zero ambitions and support healthier, more sustainable communities.

Success will depend on strong accountability, collaborative effort, and continuous engagement across all levels of the organisation. Together, we can meet our environmental responsibilities and create a resilient future for our patients, staff, and the wider community.

Annex 6 - 10Y Plan / neighbourhood briefings from ICB colleagues

Chief Executive public board report RDaSH
Board of Directors

NHS
South Yorkshire
Integrated Care Board

National 10 Year Health Plan

System Leaders Executive – 15th July

National 10 Year Health Plan

NHS South Yorkshire Integrated Care Board

- Aims to respond to the Darzi Report and reimagine the NHS through three shifts
  - Hospital to community
  - Analogue to digital
  - Sickness to prevention

- Sets out the following to enable the shifts
  - New NHS operating model
  - Increased transparency
  - New workforce model aligned to future
  - Reshaped innovation strategy
  - A different approach to NHS finances

National 10 Year Health Plan

The Three Shifts			
	1. Hospital to Community Neighbourhood Health Service	The case for change & need to reimagine the NHS – 3 Shifts	NHS Workforce fit for the future
	2. Analogue to Digital NHS App	A new NHS Operating Model	Powering transformation, innovation to drive reform
	3. Sickness to Prevention	Transparency of quality of care	Productivity and a new financial foundation

Three Shifts	The plan includes…
1. Hospital to Community Neighbourhood Health Service	• Greater investment out of hospital • Creation of Neighbourhood Health Services • Improve access eg primary care and dentistry • Delivery of more urgent and emergency care in the community • Expansion of same day emergency care • Increase mental health emergency care
2. Analogue to Digital NHS App	• Give patients control over their data and single patient record • Transform the NHS App into a tool for patient access, empowerment and care planning. • Optimise use of AI scribes and automation to reduce admin • Promote digital first access, options for those with complex needs
3. Sickness to Prevention	• A focus on modifiable risk factors – smoking, obesity, alcohol • Child health – Healthy Starts, expanding free school means • More mental health support teams in schools • Increase HPV vaccination uptake • Joining up support across work, health & skills to aid employment

From Hospital to Community – Developing Neighbourhood Health Services

NHS South Yorkshire Integrated Care Board

Neighbourhood health service

- Creation of Neighbourhood Health Services that embody prevention.

- The plan says that care should happen
  - as locally as it can,
  - digitally by default,
  - in a patient's home if possible,
  - in a neighbourhood health centre when needed,
  - in a hospital if necessary

To make this possible the plan will

- Invest more out of hospital (in next 3-4 yrs)
- Train more GPs & reduce OP reliance
- Increase role of community pharmacy
- Bring in new contracts for neighbourhood health providers
- Establish a neighbourhood health centre in every community (6 days / 12 hours)
- Deliver more urgent care in the community
- Improve access to dentistry
- Improve the NHS App
- Expand same day emergency care
- Increase mental health emergency care

1. Hospital to Community

From Analogue to Digital

NHS South Yorkshire Integrated Care Board

The plan will

- Give patients real control over their data and single patient record
- Transform the NHS App into a tool for patient access, empowerment and care planning.
- Optimise use of AI scribes and automation to reduce admin
- Promote digital first access – with options for those with complex needs

The aim is for the NHS App to

- Provide advice for non urgent care
- Enable people to choose their provider
- Book directly into tests
- Manage their medicines
- Manage long term conditions
- Manage children's healthcare
- Enable people to leave feedback
- Use continuous monitoring

2. Analogue to Digital

From Sickness to Prevention

NHS South Yorkshire Integrated Care Board

The plan will

- Deliver on our world-leading Tobacco and Vapes Bill
- Launch a moonshot to end the obesity epidemic – restrict junk food / energy drinks
- Focus on child health, restore the value of Healthy Start and expand free school meals
- Expand access to weight loss medication
- Citizen engagement
- Tackle harmful alcohol labelling
- Encourage more people to move more
- Refresh ambition on air quality
- Join up support across work, health and skills to support people to find/stay in work
- Expand mental health support teams in schools
- Increase uptake of HPV vaccinations
- Roll out lung cancer screening for those with a history of smoking
- Create a new genomics population health service

National 10 Year Health Plan

- Large waiting lists
- Poor access
- Increasing inequalities
- Low public satisfaction
- Low workforce moral
- Urgent need for change

The case for change & need to reimagine the NHS – 3 Shifts

NHS Workforce fit for the future

- Give leaders more freedom
- Focus on local recruitment
- Develop models of practice
- Optimise skill mix
- Reduce sickness rates
- Optimise use of AI

- NHSE/DHSC to consolidate
- ICBs Strategic Commissioners
- System of earned autonomy
- Reinvent NHS FTs
- ICBs / SHAs coterminous
- Patient choice charter

A new NHS Operating Model

Powering transformation, innovation to drive reform

- Focus on AI, data, genomics, robotics and wearables
- Health Data Research Service
- Enhance NHS App
- Wearables standard - 2035
- Multi year funding to enable transformation

- Provider quality league tables
- Accountability-underperform
- NHS App for patient choice
- Patient Reported Outcomes
- Focus on maternity/neonates
- Reform complaints
- Modernise inspection

Transparency of quality of care

Productivity and a new financial foundation

- 2% annual productivity gain
- Restore financial discipline
- End short term finance fixes
- Move to five year £ plans
- Deconstruct block contracts
- Test year of care - outcomes
- Better align funding to need

What does it mean for South Yorkshire ?

NHS South Yorkshire Integrated Care Board

Strategic direction

- The three shifts align strongly with the direction in our South Yorkshire Integrated Care Strategy and our Bold Ambitions.

New Operating Model

- It reaffirms the ICB role as a strategic commissioner and indicates a new Commissioning Framework incoming
- It sets out plans for ICBs to be coterminous with strategic health authorities / MCAs
- It reinvents Foundation Trust
- Indicates potential for IHO development

Partnerships

- There is potential for us to look at how we can develop our Place Partnerships into Integrated Health Organisations.
- Partnership working with SYMCA, LAs, VCSE will continue to be important – beyond the ICP we will continue in a different way
- Working through cross system Provider Collaboratives & Alliances will be enable delivery at scale, eg using economies of scale to address backlogs
- The plan sets out the need to embrace technology and build new partnerships with innovators

Considering the 10 Year Health Plan and our Response

South Yorkshire Integrated Care Board

3 July

10 Year Health Plan Published

15 July

System Leaders Executive

Initial Considerations

22 July

Integrated Care Partnership

Development Session

6 August

ICB Board Development Session

Workshop

19 August

System Leaders Executive

Development Session

3 September

ICB Board Meeting in Public

ICB Response

NB – Potential National delivery plan in the autumn

Timeline

- **What are the South Yorkshire Leaders initial reflections on the National 10 Year Health Plan?**
  - What do leaders really welcome in the plan?
  - What do leaders think is missing and/or worries them about the plan?
- **What would be helpful for us to do as partners to prepare for responding and implementing the plan?**
  - *Noting – potentially expect National Delivery Plan in the autumn*
  - *Proposal to use August System Leaders Development Session*

Initial Reflections

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Older People's Quality Indicators paper	**Agenda Item**	Paper M
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	24 July 2025

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

In April 2025 the Trust Board took the decision to close an older adult ward and to repurpose another existing ward from a purely organic older adult ward to a mixed functional/organic older adult ward. At that time, it was agreed that, in addition to operational indicators related to the Rotherham ward merger, we would agree and track a series of older adult QIs – revisiting in 2026 whether a blended model was delivered good-enough care.

Building on the agreed paper, extensive engagement has taken place to develop a set of indicators that now span both community and inpatient care. This assessment will take place at Trust and place level. The expectation for these agreed metrics will be to allow comparison over time for Older Adult services but also to allow for comparison to working age services to ensure that there is parity between the two. Data will be shared at Board level in November 2025, March 2026 and July 2026, with a view to a formal review of progress in September 2026. This is slightly longer than the timescale outlined when the Board met in March to permit time for implementation of change and some shared learning.

Previous consideration

March 2025 Board paper and decision relates

Recommendation

The Trust Board is asked to:

AGREE the quality indicators and the intention to compare the indicators against other relevant providers (noting the intent to also make comparison to working age services)

Alignment to strategic objectives (indicate those that the 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

Alignment to the plans: (indicate those that this paper supports)	
Finance plan	x
Quality and safety plan	x
Equity and inclusion plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X

Financial risks	Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
External and partnership risks	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
None
System / Place impact (advise which ICB or place that this matter relates to)
None

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
Older People's Care Quality Indicators

1. Measuring Mental Health Quality Indicators in Older Adults: Why It Matters

1.1 Understanding and improving the quality of mental health care for older adults is more critical now than ever.

1.2 In April 2025 the Trust Board took the decision to close of one of our dedicated older people's wards. We have now moved to a mixed-diagnosis model across all older adult mental health inpatient services within the Trust.

1.3 This shift from the more traditional functional (e.g. depression, anxiety) and organic (e.g. dementia) ward split to a combined model represents a significant service change. It must be noted that this model is a minority position with roughly 80-90% of Trusts utilising a model which retains the organic and functional split. RDaSH has previously successfully implemented this model in other localities such as Doncaster and North Lincolnshire.

1.4 Our different inpatient areas have different designs and also staffing makeups and so whilst we are able to draw on some of the lessons from implementing the model elsewhere it is likely there will be bespoke challenges in local implementation as well as themes that cross cut across the Trust.

1.5 In September 2024 the Trust was issued a Regulation 28 notice by His Majesty's Coroner due to the concerns about a lack of crisis team provision for people over the age of 65. It was apparent that the three different geographies of the Trust had taken different approaches to this historically with North Lincolnshire providing equitable access to over 65s but this was not the case in either Doncaster or Rotherham.

1.6 New arrangements for over 65s requiring crisis team input came into effect in December 2024.

2. Why We Need Older People's Mental Health Quality Indicators

2.1 Implementing and tracking meaningful mental health quality indicators for older adults serves several important purposes:

2.1.1 Monitor the Impact of Service Changes Over Time: With the move to a mixed-diagnosis ward model, we need to understand how this impacts patient outcomes, safety, satisfaction, and equity of access. Metrics will help us evaluate whether the new model delivers on its promise or reveals unintended consequences.

2.1.2 Compare with working age Services: By benchmarking older people's mental health services against those for working age adults, we can identify disparities in care, treatment intensity, staffing, and outcomes. This allows us to assess whether there is true parity of esteem

2.1.3 Drive Data-Informed Service Development: Good data enables good decisions. By collecting, analysing, and acting on quality metrics, we can ensure that services for older people are not only reactive but also proactive

in anticipating needs, allocating resources, and designing care pathways that work.

2.2 The proposed quality indicators can be broadly split into two main categories. Firstly, inpatient indicators and secondly community indicators.

3 Inpatient Indicators

3.1 Accessibility:

Awaiting admission > 24 hours: Number of Older Adult patients confirmed as requiring admission waiting longer than 24 hours to be admitted
Bed Occupancy: Older Adult Bed Base bed occupancy percentage
Out of area: Number of inappropriate out of area placements for Older Adult patients
Clinically ready for discharge: Number of patients that are clinically ready for discharge

3.2 Effectiveness:

Length of stay: Average duration of admissions per ward
Readmission rate: Percentage of patients admitted to a ward shortly after discharge (within 30 days)
Clinical outcomes: PROMs and other clinical tools
Discharge destination: Number of patients being discharged to their usual place of living

3.3 Safety:

Incident reports: Frequency of events such as falls, self-harm, suicide attempts, incidents of violence and aggression and mortalities
Medication incidents: Rates of prescribing errors and administration errors
Restrictive practice: Number of incidents of rapid tranquilisation, segregation and seclusion
72 hour follow-up: Percentage of patients having follow up within 72 hours of discharge
Safe Staffing Levels: Number of shifts without safe staffing levels
Staff sickness: Rolling average of staff sickness
Staff turnover: Rolling average over 12 months
MAST Compliance: Number of staff who are not fully compliant with MAST training

3.4 Patient experience:

Complaints: Number of complaints
Feedback: Number of care opinion and themes from feedback about Older Adult inpatient services

3.5 Other measures:

CQC self-rating: Self rating over CQC inspection domains

4 Outpatient Indicators

4.1 Accessibility:

<4 hours wait for emergency referrals: Number of Older Adult patients not seen within 4 hours of an emergency referral
<48 hours wait for urgent referrals: Number of Older Adult patients not seen within 48 hours of an urgent referral
4 week wait for routine referrals: Number of Older Adult patients not seen within 4 weeks of a routine referral
Crisis referrals: Number of Older Adult patients taken onto Crisis Team caseload
DNA rate: Percentage of appointments where the patient did not attend
Dementia diagnosis rate: Percentage of patients in a locality with a recorded diagnosis of dementia compared to expected prevalence
Talking therapies: Number of Older Adults accessing NHS talking therapies

4.2 Effectiveness:

Care plan completion: Percentage of patients with a personalised care plan completed
Hospital admission rate: Percentage of patients admitted to a mental health ward whilst under an Older Adults Team
SMI Checks: Percentage of patients with SMI that have had an annual health check completed
Clinical outcomes: PROMs and other clinical tools

4.3 Safety:

Incident reports: Frequency of events such as falls, self-harm, suicide attempts, incidents of violence and aggression and mortalities
Medication incidents: Rates of prescribing errors and administration errors
Staff to patient ratio: Number of patients per member of staff for Older Adult teams that hold caseloads
Staff sickness: Rolling average of staff sickness
Staff turnover: Rolling average over 12 months
MAST Compliance: Number of staff who are not fully compliant with MAST training

4.5 Patient experience:

Complaints: Number of complaints
Feedback: Number of care opinion and themes from feedback about Older Adult inpatient services

4.6 Other measures:

CQC self-rating: Self rating over CQC inspection domains

5 Conclusion

The Trust board is asked to agree the quality indicators and the intention to compare the indicators over timer periods but also to compare against working age services.

Dr Diarmid Sinclair
Medical Director
18 July 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 24: Education at RDaSH	**Agenda Item**	Paper N
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Dr Judith Graham, Director for Psychological Professionals & Therapies		
Meeting	Board of Directors	**Date**	24 July 2025

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

The paper highlights the progress made in terms of education and educational processes aligned with the Trust's Education and Learning Plan approved by the Board of Directors one year ago. It is clear that traction is being achieved in moving educational matters into the mainstream of the Trust, and September will see the first use of the scorecard in a Care Group Delivery Review.

It was common ground in 2024 that historic processes for apportioning money and staffing within education could not be evidenced to reflect either best practice elsewhere, or fairness in line with our values. This process work has also resulted in the development of educational dashboards for each of the clinical care group to inform delivery reviews. Of course, education is also a priority for corporate directorates. The enhanced processes and data analysis has therefore enabled purposeful training allocation, aligned with promise 9 (concerning apprenticeship allocation for people who are less senior banded and for people with diverse characteristics), and promise 24 (associated with multiprofessional enhanced educational spend). The Board's plan for 2025/26 holds to the commitment that training is the only "ringfenced" budget that will grow year by year over the lifetime of the strategy.

The Board may wish to use the material provided to consider where we need to be in July 2026. That date being, subject to the chair's discretion, the likely next 'education' board meeting. It may be that it is helpful to devote much of February's People and OD committee to a 'half time' assessment of progress.

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

At the Education and Learning sub-CLE meeting.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

EXPLORE the changes made in terms of processes, forward planning and budget management

CONSIDER any matters of concern not covered within the report

NOTE the progress made in terms of Promise 9 and 24

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	x
Education and learning plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Patient care risk	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X

	Patient experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	220 / 199
Performance risks	Capacity and demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	201
External and partnership risks	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	MAST standards as set by NHSE and assessed by CQC

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR1, SDR2, SDR3, SDR5							
System / Place impact (advise which ICB or place that this matter relates to)							
Not applicable							
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 – MAST Breakdown per Directorate
Annex 2 – Apprentice Spend Breakdown
Annex 3 – Care Group Educational Dashboard

Education at RDASH – Update Paper

Board of Directors – July 2025

Situation

Education and Learning are both important aspects to our Trust provision. They are also concepts that transcend all 23 directorates in the Trust.

This paper has two purposes, to explore our progression against strategic promises 9 & 24 promises and to look forward in terms of actions over the next year to improve further in this area. This paper should be read in conjunction with the Board of Directors – Learning Paper.

Background

For the purpose of this paper, it is firstly important to understand what is meant by 'education', which is summarised as –

- Education is one component of the broad concept of learning.
- Education is typically where knowledge, skills and experience are gained via taught courses, experiential programmes or other qualification-based activity.
- Education is provided as a part of our workforce obligation and to support continuing professional development.
- Education is also provided to enable people to enter employment or advance their career.

Within our Trust Strategy we have 2 Promises specifically focussed on Education. These are Promise 9 and 24 –

> *Promise (9) Consistently exceed our apprentice levy requirements from 2025 and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.*
>
> *Promise (24) Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan*

In the work we conducted in 2023 to devise the Trust 'Learning and Education' plan, the following 12 issues were identified in particular relation to the education promises: -

1. Education spends have previously been 'ad hoc' and provided on a 'first come, first serve' perspective.
2. Education spends were not linked with a workforce plan
3. There was no multi-professional oversight or educational spends
4. Educational investments were disproportionately allocated
5. There was underused spend linked with apprenticeships
6. Lack of cohesive plan for placement increase and recruitment based on return on investment
7. There was no investment in partner agencies regarding educational spend
8. No previous monitoring or tracking was in place in terms of protected characteristics and educational spend.
9. Medical education spend has been separate from all other education spend and has been rerouted into staff costs.
10. Directorates have had no way of tracking their spend or learners.
11. Colleagues have raised concerns that they do not have the time to complete their MAST and other learning.
12. MAST (Mandatory and Statutory Training) has not reached the Trust stretch target level of 90%>

The following section will provide a summary in terms of actions taken against these 12 areas to meet the promises made within our Trust Strategy.

Assessment

Issue (1) Education spends have previously been 'ad hoc' and provided on a 'first come, first serve' perspective.

Action Agreed and Taken – In order to gain a solution to this issue internal conversations have been conducted in Q2 24/25 and other Trusts were contacted in terms of their processes and policies. The action agreed was to schedule a planning cycle in Q3 each year for the training spend in the following year. The rationale for this is to enable time to consider all requests, consider requests that are duplicated in different directorates (and plan for economies of scale), consider where there may be learning that can be staff group specific and multi-disciplinary and lastly identify where there may be cost pressures or other budgets require consideration. In addition, changes were made to the study application and sign off processes to ensure relevant data was captured to track achievements against strategic promises.

The process was commenced in Q3 24/25 and a learning session conducted in Q4 in order to plan for the 25/26 year and improve methodology. The reflection was that the process produced a more transparent and equitable allocation, and it enabled an overview of all requirements and requests, which revealed that some requests could be internally completed via subject matter experts as part of the half day learn session.

The issues raised in the reflection is that there was still ad hoc income sent via the education arm of NHSE with short timescale access to certain courses; that clinical staff were considered, but administrative staff needed more profile moving forward, and that medical budgets still remained complex which will be expanded upon in section 9.

The forward planning process is now embedded and scheduled into the education and training team activity in order to support directorates. It was requested that the date for this be placed in the corporate calendar for 25/26, however the request was too late for the calendar being issued and therefore it will be placed in the 26/27 calendar.

Finally, although the bulk of training is covered by the annual planning structure, we have also built in an 'exception request' process for training funding required between planning rounds associated with service need and change. This is via the out-briefs provided from each care group, monthly to the Learning and Education group.

Outcome – actions complete – issue resolved.

Issue (2) Education spends were not linked with a workforce plan

Action Agreed and Taken – The Education and Learning Plan has been developed in conjunction with the People and Teams (P&T). The two Executive directors responsible for the plans have met regularly to ensure alignment and actions. This has then enabled the training requests to be referenced against the P&T Plan by the education team and considered in the context of wider plans that have strategic training requirements (i.e. the digital plan and the quality and safety plan). In addition, both Directors are members of the People and Organisational Development Committee thus ensuring a common understanding across the areas.

Outcome – action complete – issue closed.

Issue (3) There was no multi-professional oversight or educational spends

Action Agreed and Taken – the establishment of the education and learning sub-CLE group, and membership considerations have enabled multiprofessional oversight of education requests and spend. This includes the annual planning requests as well as any exception requests that come in between planning rounds associated with service need and change.

The CLE Group Attendance League table paper supplied by the CEO in November 2024 shows the attendance at each of the learning and education meetings. An up-to-date 'Attendance League table' is currently being produced for all sub CLE meetings and CLE but this doesn't significantly alter the previously reported position. Most professionals have attended consistently; the medical attendance has been the most variable. Given the appointment of the CMO he will support the attendance of medical representatives to ensure all staff groups are considered timely at the meeting.

Where there have been apologies from a specific profession or directorate representative, subject matter experts have been invited for the items concerning multi-professional training. This has worked well.

Outcome – action complete – closed.

Issue (4) Educational investments were disproportionately allocated

Action Agreed and Taken – The actions taken with this are linked with Issue 1 in terms of the forward planning round and the allocation of both apprentice and non-apprenticeship educational funding – Ensuring the E&L group had sight of all requests and the proportion of requests per area for parity.

Outcome – action complete, process now in place – closed.

Issue (5) There was underused spend linked with apprenticeships

Action Agreed and Taken – Apprenticeship spend was assessed and targeted aligned with Promise 9. As an organisation we also decided to switch to apprenticeships being a part of all recruitment for Band 2 and 3 workers in the Trust as part of our Apprenticeship First approach, previously reported to Board – the aim being to act as an educational springboard for colleagues at this level. Although this has meant that we have achieved a good level of spend, we have not achieved total spend given the financial value of courses at this level are much lower than the higher-level courses (our spend breakdown and comparators are detailed in Annex 2). Whilst this is disappointing, we have moved from our position in previous years of not supporting any level 2 qualifications to supporting equity across the workplace and embracing the lower-level qualifications rather than advantaging or more senior/higher paid colleagues. We have also gifted some of our apprenticeship levy in 2024/25 from our historical underspend to support local partners who do not have direct access to their own levy due to the size of their organisations.

The E&L group have explored the reasons for this, and these are the main points raised –

- There has not been as much requirement for new Band 2's and 3's apprentice courses as anticipated as we are experiencing colleagues entering these roles with a higher level of qualifications.
- With the financial changes, some of the posts estimated for replacement have been changed or removed as part of the cost savings programmes, contributing to underutilisation.
- The issues linked with functional skills requirements have been problematic in terms of application.

Outcome – We have not achieved total spend in terms of our apprenticeship, therefore there is still work to do in this area. The work is informed by our previous years learning. This issue will therefore have a continued focus and carry forward actions are included in the recommendations section.

Issue (6) Lack of cohesive plan for placement increase and recruitment based on return on investment

Action Agreed and Taken – Work has been conducted to develop training dashboards. These include placement numbers and specialisms. This has been required and helpful, because previously separate professional groups were seen, but the workplace landscape was not looked at in terms of multiprofessional placements, and also the increasing placements we have seen in terms of work experience, T level placement and also some of our volunteer and peer placements. Issue 10 below describes the dashboards and governance in more detail.

In terms of recruitment based on return on investment, this pertains to recruiting the people we have provided placements for especially in the penultimate and final year of their professional training. The work conducted in this area concerns working with expanding the portfolio or educational institutions we work with and take placements from; working with educational institutes to develop more placements in terms of these final years

(which tend to be managerial placements and specialist placement). In addition, we have also expanded work we complete in terms of guest lecturing for local universities as well as supporting student recruitment panels and graduation events. This is all aimed at anchoring into our local systems, investing in our local learners and promoting our organisation as a workplace of choice.

As we progress work will be conducted with the grounded research team, and as part of the Research and Innovation plan in terms of additional roles that support the joint working with educational institutions – specifically the development of professorial roles. We have one Professorial role that was awarded in July 2025 to Dr Stephen Kellett who works in our Grounded Research Team and Rotherham Adult Inpatient Care Group. This is with Exeter University, with whom we work in regard to a number of our Talking Therapies undergraduate training programs.

Outcome – complete, processes now in place.

Issue (7) There was no investment in partner agencies regarding educational spend

Action Agreed and Taken – We do have a limited educational spend, however we are aware of how fortunate we are in comparison to some of the agencies and partners we work with, especially our VCSE partners. We also recognise that as we progress forward, aligned with the new NHS 10-year health plan, launched in July 2025 we increasingly need to focus upon the education of the system rather than just its individual parts.

Work that has been conducted by the Learning and Education Group has focussed upon enabling learning spaces to broaden and become more inclusive; actively seeking opportunities for cross organisational (place and neighbourhood learning) and funding specific places for partners on courses.

Examples include –

- LDO places funded for VCSE partners.
- Half Day Learn Sessions coproduced with GP and place based physical health partners.
- The enablement of our volunteers and lived experience partners to access ESR and certificated and online learning via this platform.

Outcome – complete, forward plan work concern apprenticeship spend with partners.

Issue (8) No previous monitoring or tracking was in place in terms of protected characteristics and educational spend.

Action Agreed and Taken – When we consider achievement against promise 9 specifically, the requirement is that we need the comparative data and spend from both apprenticeship and CPD spend. This was not available or collected prior to the launch of the education and learning group and plan in 2024. Work has been completed to enable a retrospective analysis (and therefore establish a baseline from 24/25). And an adjusted study application process that enables monitoring of progress in terms of purposefully privileging those who have been underrepresented/excluded in previous educational investment. The tables below summarise the change, which is specifically related to promise 9 achievement –

Ethnicity	23/24	24/25		Ethnicity Summary
White British	139 (90%)	140 (85%)		The CPD allocation for 2024/25 shows that 9% has been allocated to global majority colleagues, when compared to the position in 2023/24 this demonstrates a slight improvement of 2% however there is still work to do to increase equity of access. The most notable improvement is that the allocation to Black/Black British colleagues has increased by 5%. The Trust ethnicity profile shows that 89.8% of our colleagues identify as White/White Other, with 9.5% of colleagues identifying as global majority and with 0.7% choosing not to declaring their ethnicity.
White Other	3 (2%)	7 (4%)		
Asian or Asian British Indian	5 (3%)	3 (2%)		
Black/Black British	3 (2%)	12 (7%)		
Chinese	1 (1%)	0 (0%)		
Not stated	2 (1%)	2 (1%)		

Gender	23/24	24/25		Gender Summary

Male	7 (5%)	18 (11%)		There has been an increase of 11%, in the number of male colleagues accessing CPD funding in 2024/25. The Trust gender profile consists of 84% female and 16% male, therefore, there remains an underrepresentation of male colleagues accessing CPD funding.
Female	146 (95%)	147 (89%)		

Sexual Orientation	23/24	24/25		Sexual Orientation Summary
Heterosexual/Straight	132 (86%)	142 (87%)		There has been minimal movement in the data from 2023/24 with no significant areas of improvement/deterioration to note. At trust level, 83% of colleagues identify as heterosexual and so at 87%, the number of heterosexual colleagues accessing CPD monies is 4% higher than our workforce profile meaning that there is underrepresentation across all other categories of sexual orientation. It is recognised that 564 of our colleagues (18%) have chosen not to declare their sexual orientation.
Not stated (colleague asked but declined to provide a response)	13 (9%)	17 (10%		
Bi-sexual	4 (3%)	3 (2%)		
Gay/Lesbian	3 (2%)	3 (2%)		
Undecided	1 (1%)	0 (0%)		

Disability	23/24	24/25		Disability Summary
Yes	23 (15%)	24 (15%)		There has been no movement in the % of disabled colleagues accessing CPD, with the % remaining static at 15%. The Trust profile identifies that 402 (10%) of our colleagues identify themselves as disabled, however it should be noted that 602 (15%) of colleagues choose not to declare their disability status or have not recorded it.
No	119 (78%)	122 (74%)		
Not stated	11 (7%)	19 (11%)		

Age Range	23/24	24/25		Age Summary
21-25	5 (3%)	12 (7%)		There have been some marginal movements in the age of our colleagues accessing CPD monies. Most notably, colleagues aged 21 to 25 accessing CPD monies has increased from 5 (3%) in 2023/24 to 12 (7%) in 2024/25. This is reflective of the workforce demographic changing with younger colleagues commencing employment with the Trust.
26-30	20 (13%)	16 (10%)		
31-35	27 (18%)	33 (20%)		
36-40	32 (21%)	32 (19%)		
41-45	24 (16%)	15 (9%)		
46-50	17 (11%)	22 13%)		
51-55	17 (11%)	17 (10%)		
56-60	6 (4%)	12 (7%)		
61-65	5 (3%)	6 (4%)		

It is appreciated that the data collected focusses upon the 'underrepresented communities' component of Promise 9, and not the refugees, citizens with learning disabilities and care leavers. This data is therefore considered as well as the information in terms of targeted investment and donation of apprenticeship levy.

Issue (9) Medical education spend has been separate from all other education spend and has been rerouted into staff costs.

Action Agreed and Taken – A number of meetings have taken place between the Directors for Medical Education, Director for People and OD and the CEO in terms of education processes and budget. There has also been a process established in terms of being core members at the education and learning group. The attendance however has been variable by medical colleagues which has effected the pace of this work.

Outcome – The actions in terms of this area will be carried forward. There are 2 specific actions that will be completed in 25/26 which are (1) CMO to review medical education budget and investment into posts supporting education and training and provide a review (2) medical education request will not continue to be

separate from other staff and therefore in the planning cycle medical education requests will also be brought through the educational forward planning round in Q3.

Issue (10) Directorates have had no way of tracking their spend or learners.

Action Agreed and Taken – Work has been focussed in the Learning and Education Group regarding the development of dashboards that enable care groups to have a better awareness of their spend, placements and MAST. These dashboards have been clinically, and care group designed with support from the learning and development team. An example dashboard is provided in Appendix 3 to show what each directorate can view and is supplied with monthly. In addition to this information, a biannual breakdown of allocation by protected characteristic in terms of educational spend is also supplied by the learning and development team.

Outcome – Action complete. L&D team now to provide dashboards each month to care groups for their internal directorate oversight, delivery reviews and forward planning. Moving forward the automation of the dashboards will be considered alongside the implementation of the new workforce solution and the reporting functionality the new system will (or wont) provide.

Issue (11) Colleagues have raised concerns that they do not have the time to complete their MAST and other learning.

Action Agreed and Taken – Focussed work has been completed concerning the pilot and full Trust launch of half day LEARN monthly sessions. LEARN stands for – Learning, Education And Research Networking. Each stage of this work has been completed using a PDSA cycle. The work is summarised in the 'Learning Paper' to the Board of Directors, which should be read alongside of this.

Outcome – Action to enable time complete – carry forward work is planned in terms of the participation in these LEARN half days by our RDaSH inpatient and community 24-hour shift workers and also our administration workers. This work is detailed in the BoD Learning Paper for July 2025.

Issue (12) MAST (Mandatory and Statutory Training) has not reached the Trust stretch target level of 90%>

Action Agreed and Taken – In creating the half day LEARN sessions each month (as described above), the issue of 'having time for learning' has been removed. Although there is a range of activities that may be completed inside of LEARN sessions colleagues have been requested to concentrate upon achieving 100% MAST compliance as a priority. A positive improvement has been seen since the commencement of Trustwide LEARN sessions, this is demonstrated in the figure on the following page (page 6), with a steady increase in compliance seen since the across Trust Launch of half day LEARN sessions in September 2024 – overseen by the education and learning group.

Whilst we have seen an overall increase, in reflecting on the progress against this issue, we do note that the change represents a larger shift for some colleagues than others, and also that some directorates still have some issues in terms of compliance rates. For transparency, a full Directorate breakdown is presented in Annex 1 of this document.

Outcome – action complete, process now in place – monitoring process via line management - issue closed.

*It should however be noted that as the next stage of being able to manage against this new process, a policy change is being made in terms of the Trust 'People's Policies'. This concerns mandating engagement in LEARN sessions, to enable time for MAST and other activities. And also, a shift from % compliance, to a matrix which demonstrates Compliance/ Non-Compliance. This policy change is currently being completed (excluding our 24-hour workers – considering issue 11 above), and our staff side representatives are also being consulted about this change and implications for job planning and staff performance management.

Directorate	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
CCG Management	91.23%	91.07%	89.70%	92.73%	94.26%	95.79%	96.32%	96.56%	93.12%	95.26%	97.08%	97.39%	97.71%	96.76%	96.94%	95.83%	95.83%	98.15%	98.86%
CCG Mental Health	89.42%	89.28%	90.66%	90.09%	90.08%	91.16%	90.55%	90.98%	90.70%	90.36%	91.12%	91.71%	92.22%	92.39%	92.63%	93.80%	93.80%	94.68%	95.15%
CCG Physical Health	91.10%	90.71%	93.36%	92.28%	91.70%	92.94%	93.41%	93.65%	93.87%	94.47%	95.16%	95.32%	95.41%	95.84%	95.27%	95.92%	95.92%	97.10%	96.71%
Corporate Assurance	84.01%	83.67%	90.37%	88.86%	88.12%	87.83%	90.73%	90.31%	85.42%	86.34%	91.98%	94.08%	94.84%	95.59%	96.70%	96.88%	96.88%	96.20%	95.48%
DMHLD Acute Services	86.61%	86.51%	88.67%	89.05%	87.68%	88.19%	88.54%	88.69%	89.43%	89.41%	88.79%	90.26%	90.22%	90.52%	90.30%	92.08%	92.08%	92.84%	92.62%
DMHLD Community Services	87.67%	87.12%	89.18%	88.31%	88.80%	89.40%	89.64%	90.42%	89.39%	89.82%	90.51%	90.70%	91.80%	91.93%	90.72%	91.71%	91.71%	93.05%	93.64%
DMHLD Learning Disabilities & Forensics	91.39%	91.11%	93.30%	92.77%	91.58%	92.33%	91.81%	92.09%	92.01%	92.49%	91.93%	92.16%	92.61%	93.66%	92.57%	94.27%	94.27%	95.11%	94.63%
DMHLD Management	83.94%	83.12%	89.79%	90.50%	92.97%	89.49%	92.18%	92.27%	98.21%	97.76%	98.51%	100.00%	100.00%	95.77%	94.48%	95.86%	95.86%	98.76%	99.38%
Estates	82.43%	82.03%	83.77%	82.01%	76.92%	81.89%	82.14%	83.39%	79.58%	82.43%	84.28%	85.10%	83.96%	85.96%	85.84%	85.33%	85.33%	85.05%	83.70%
Finance & Procurement	85.99%	85.51%	92.54%	92.25%	93.26%	90.26%	92.38%	88.41%	82.10%	84.67%	82.88%	89.83%	91.72%	95.98%	94.67%	97.41%	97.41%	96.29%	95.94%
Health Informatics	90.56%	90.04%	94.26%	93.34%	93.64%	92.23%	92.42%	93.21%	88.23%	93.51%	95.00%	96.02%	96.18%	97.47%	97.69%	98.07%	98.07%	98.42%	98.18%
Medical, Pharmacy & Research	90.56%	90.31%	93.98%	94.62%	94.89%	94.95%	95.03%	94.19%	92.38%	93.82%	94.32%	93.77%	95.66%	96.00%	95.99%	97.37%	97.37%	97.10%	97.27%
NLCG Acute Care Services	90.35%	90.55%	91.30%	91.66%	90.80%	91.82%	93.08%	93.26%	92.19%	91.34%	91.67%	90.30%	90.43%	90.33%	90.81%	92.17%	92.17%	93.42%	93.40%
NLCG Community Care Services	92.89%	92.03%	92.66%	90.98%	92.20%	92.44%	92.48%	92.13%	90.77%	89.67%	91.53%	92.70%	93.07%	93.78%	91.96%	94.51%	94.51%	94.50%	94.79%
NLCG NHS Talking Therapies	87.06%	86.84%	89.61%	88.72%	91.08%	91.37%	91.21%	91.30%	91.33%	89.81%	90.24%	92.16%	93.04%	93.70%	93.75%	93.36%	93.36%	94.49%	94.16%
North Lincs Care Group Management	87.21%	87.24%	89.80%	89.40%	87.92%	88.01%	84.72%	86.18%	82.12%	83.84%	87.55%	87.57%	87.80%	89.29%	91.67%	91.63%	91.63%	95.36%	94.72%
Nursing & Facilities	78.23%	77.41%	81.05%	82.11%	82.07%	82.47%	82.17%	82.15%	77.57%	80.48%	83.05%	84.16%	85.68%	86.66%	87.19%	89.00%	89.00%	93.40%	94.26%
Operations	86.92%	87.15%	92.31%	93.08%	93.67%	94.42%	93.38%	93.92%	91.85%	91.96%	90.76%	91.11%	90.86%	92.09%	92.62%	93.89%	93.89%	96.40%	97.37%
PHND Community & Long Term Conditions	90.56%	90.46%	93.03%	93.22%	93.37%	94.01%	94.59%	94.44%	94.53%	93.65%	94.88%	95.50%	95.59%	95.48%	95.23%	96.11%	96.11%	97.32%	97.46%
PHND Management	91.87%	91.33%	94.00%	94.00%	95.07%	95.50%	92.31%	93.44%	88.71%	90.00%	88.60%	91.30%	92.39%	92.50%	91.04%	97.99%	97.99%	98.99%	97.99%
PHND Neurodiversity	91.38%	91.05%	93.72%	95.58%	90.73%	93.10%	91.72%	91.58%	90.26%	88.76%	90.46%	89.36%	91.11%	90.50%	91.67%	91.84%	91.84%	91.92%	90.72%
PHND Rehabilitation	88.84%	88.49%	90.55%	91.27%	91.54%	92.32%	91.81%	91.79%	91.68%	91.24%	91.76%	92.34%	91.81%	92.84%	92.93%	93.49%	93.49%	94.53%	94.80%
People & Organisational Development	90.67%	90.70%	95.99%	94.73%	95.32%	95.79%	95.95%	95.76%	93.25%	95.54%	96.67%	97.15%	97.71%	98.21%	97.27%	98.11%	98.11%	98.54%	97.27%
Psychological Professionals and Therapies	93.77%	93.44%	91.28%	94.20%	95.69%	95.00%	95.09%	95.11%	95.11%	94.64%	93.11%	88.02%	89.97%	93.31%	92.31%	94.19%	94.19%	94.44%	95.22%
RCG Acute Services	85.12%	84.79%	88.26%	89.42%	88.46%	87.87%	88.99%	88.90%	89.11%	86.53%	86.47%	87.09%	87.62%	86.03%	86.43%	87.63%	87.63%	89.80%	90.53%
RCG Community Services	88.61%	88.29%	90.42%	89.69%	90.44%	91.13%	90.80%	91.39%	91.12%	91.87%	92.67%	92.88%	92.41%	91.72%	91.71%	93.10%	93.10%	94.62%	94.86%
RCG Management	85.35%	84.38%	92.78%	95.53%	95.47%	95.75%	96.66%	95.92%	93.77%	93.85%	95.90%	94.35%	97.08%	96.93%	90.93%	93.16%	93.16%	94.03%	94.89%
Strategic Development	79.41%	81.38%	88.44%	86.89%	83.57%	83.29%	83.29%	82.75%	80.70%	80.12%	86.42%	92.02%	93.87%	94.17%	96.07%	96.91%	96.91%	97.06%	97.92%
Trust Compliance	**88.47%**	**88.18%**	**90.64%**	**90.48%**	**90.42%**	**91.02%**	**91.13%**	**91.29%**	**90.60%**	**91.01%**	**91.34%**	**91.94%**	**92.29%**	**92.53%**	**92.31%**	**93.36%**	**93.36%**	**94.61%**	**94.74%**

Recommendation(s) and Forward Plan

Significant work has been completed by the Education and Learning Group over the past 12 months aligned with the strategic delivery plan and associated 2 promises. Of the 12 issues raised as problematic, 9 issues have been discussed, actions commenced and closed.

The remaining 3 issues have had actions taken against them (as described in the above section), however there are 25/26 actions required, which will be overseen in the Education and Learning Group work plan, which feeds also through the Board People and Organisational Development Committee.

This is a summary of the high-level actions against the remaining 3 issues:-

- Issue - There was underused spend linked with apprenticeships

The Learning and Development team have conducted a scoping exercise to gather insight into predicted numbers for 2025/26. The projections have been used to create a financial summary table below. Our current costs are those which have been already committed from our existing apprenticeships, and the estimated costs are those which have been estimated from predictions linked with the Q3 planning round and training needs analysis.

Assuming all the predicted apprenticeships happen at the times we have estimated, without losing existing apprentices we would spend £636,908, leaving an underspend of £113,175, as demonstrated in the table below:-

April 2025 to March 2026			
Date	**Your current costs**	**Estimated costs**	**Monthly Cost**
Apr-25	£63,472	£4,800	£68,272
May-25	£34,539	£5,844	£40,383
Jun-25	£50,539	£6,788	£57,327
Jul-25	£30,305	£7,733	£38,038
Aug-25	£28,484	£8,677	£37,161
Sep-25	£36,783	£10,155	£46,938
Oct-25	£29,307	£15,300	£44,607
Nov-25	£29,411	£26,981	£56,392
Dec-25	£25,611	£28,226	£53,837
Jan-26	£43,544	£29,670	£73,214
Feb-26	£27,459	£32,715	£60,174
Mar-26	£26,406	£34,159	£60,565
Total			£636,908
Budget			£750,617
Underspend (anticipated underspend from 2025/26)			£113.709

Forward Plan – There are two national changes that will support our apprentice spend moving forward (1) the change in the national apprentice requirements related to functional skills announced in June 2025 and (2) the shorter apprenticeships (8months rather than 12 months) due to launch in August 2025 - will allow learners to qualify faster while maintaining quality.

In addition to these changes, and whilst still focussed on achieving our strategic promise 9, a paper has been served in the education and learning meeting focussed on spend in terms of – Band 2 and 3 workers: community investment and clinical upskilling utilising this projected underspend. Detailed information can be found in the meeting papers should readers require this.

Finally, in relation to Promise 9 – although we can see a positive shift in terms of our spend in terms of some of our protected characteristics. The collection of data and therefore monitoring of investment in 3 main other groups listed in the promise (refugees, citizens with learning disabilities, care leavers) is not something that is collected via ESR. Therefore we will need to consider both the investment and monitoring.

** Please note that - RDaSH have the option to support local place-based transfers to a maximum of 50% of our funds which equates to £375,308. It is recommended that a transfer plan is developed for 2025/26. A meeting has been organised with the Senior Project Manager in the NHS South Yorkshire Integrated Care Board (ICB) and interested Voluntary, Community and Social Enterprise (VCSE) partners to discuss suitable apprenticeship programmes, and providers, as well as gain levy transfer.

RDaSH have not made any transfers of levy funds in 2024/25. The total amount of levy transfer for South Yorkshire ICB for 2024/25 is forecasted at £947,865. All trusts except for Doncaster and Bassetlaw Teaching Hospitals and RDaSH have made transfers in 2024/25. Sheffield Health & Social Care have transferred to date £158,042 which is 32% of their total spend for 2024/25. TRF have pledged £76,753 to date which is 10% of their total spend for 2024/25 and Sheffield Teaching Hospital pledged £519,556 which is 11% of their total spend for 2024/25. Barnsley is currently the lowest transferring trust with only £15,324 pledged which is 2% of their total spend for 2024/25. We are the lowest at 0% transfer. This approach would further support the Trust mission – nurturing the power in our communities if we focus on VCSE transfers.

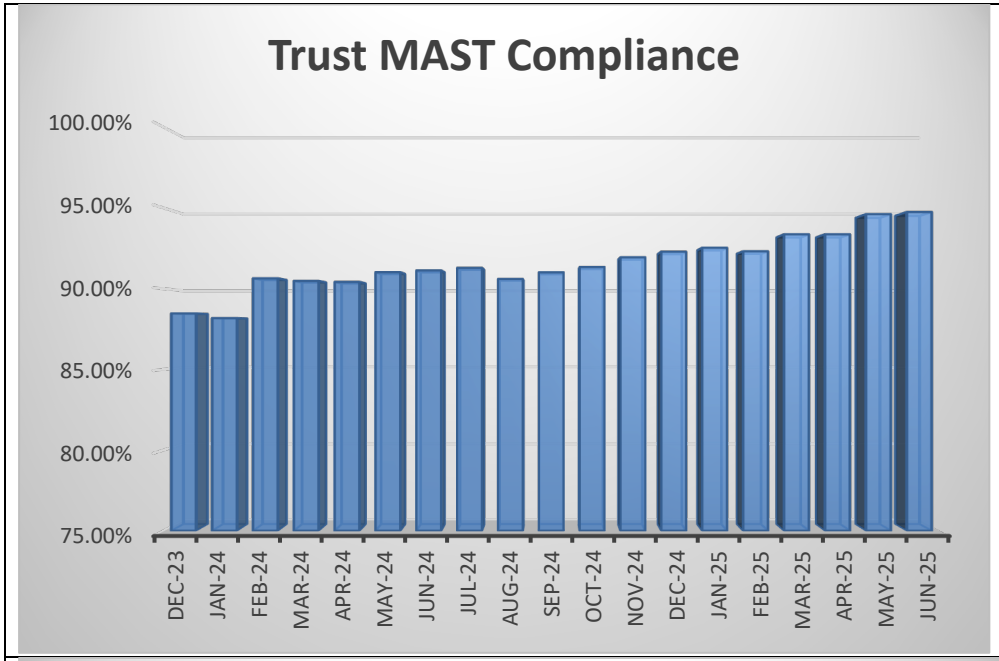
- <u>Issue - Medical education spend has been separate from all other education spend and has been rerouted into staff costs.</u>

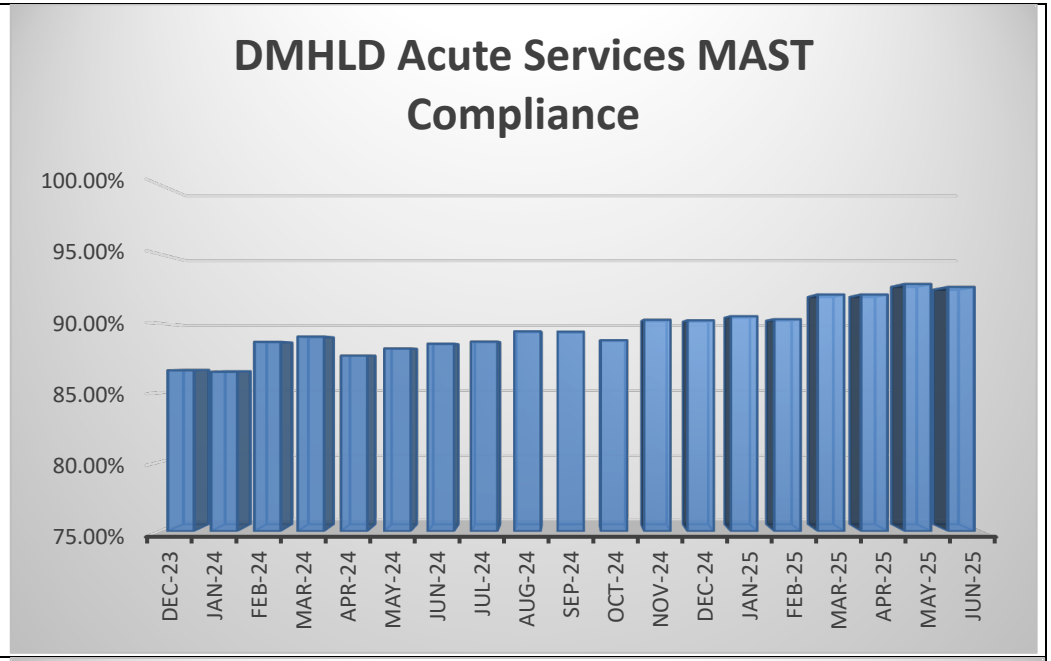
  The actions in terms of this area will be carried forward. There are 2 specific actions that will be completed in 25/26 which are (1) CMO to review medical education budget and investment into posts supporting education and training and provide a review (2) medical education request will not continue to be separate from other staff and therefore in the planning cycle medical education requests will also be brought through the educational forward planning round in Q3.

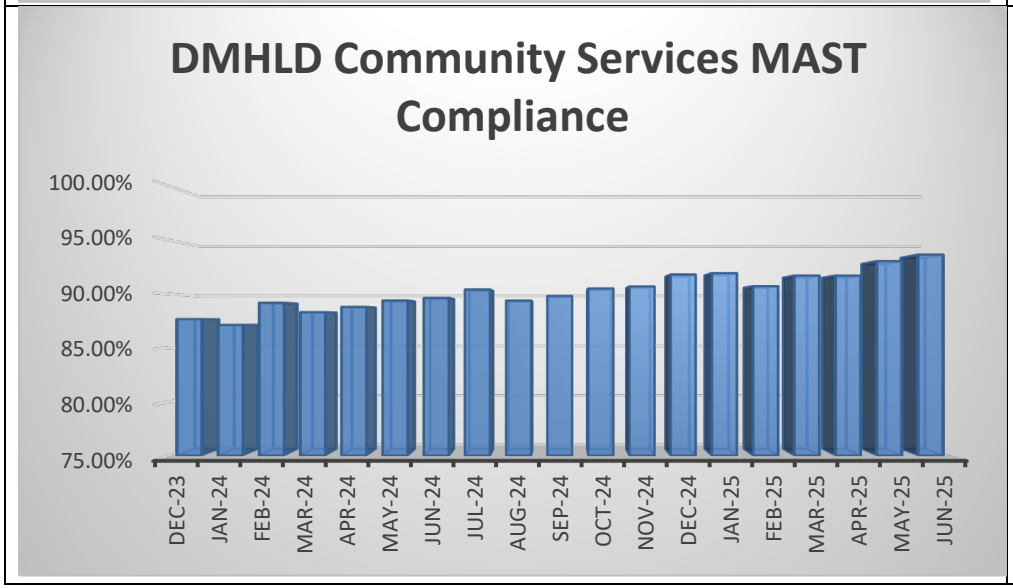
- <u>Issue - Colleagues have raised concerns that they do not have the time to complete their MAST and other learning.</u>

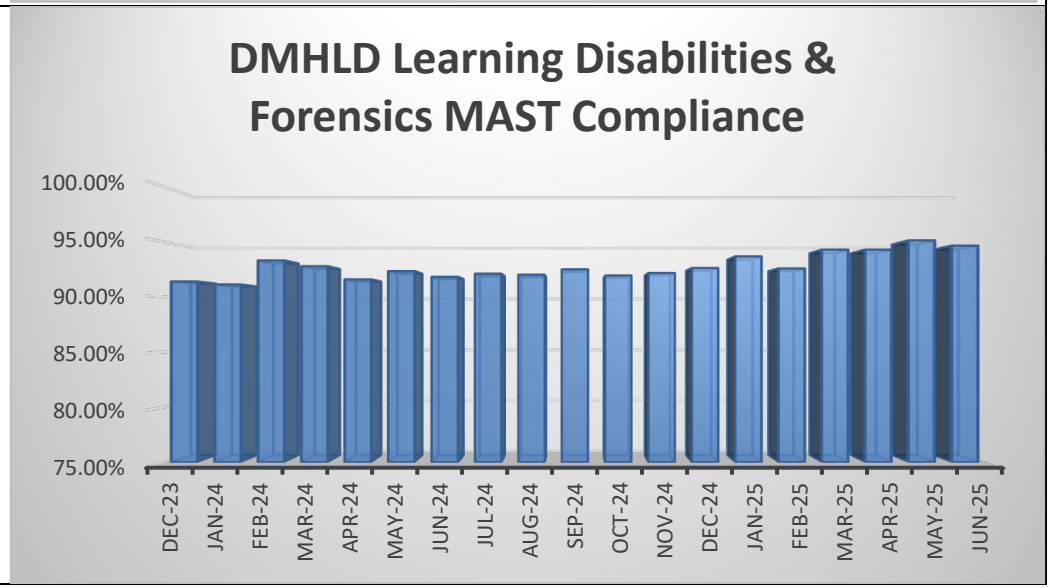
  The PDSA cycle plan related to Inpatient and 24-hour community workers is detailed in the separate ‘learning paper’ that is served alongside of this paper in the Board of Directors in July 2025.

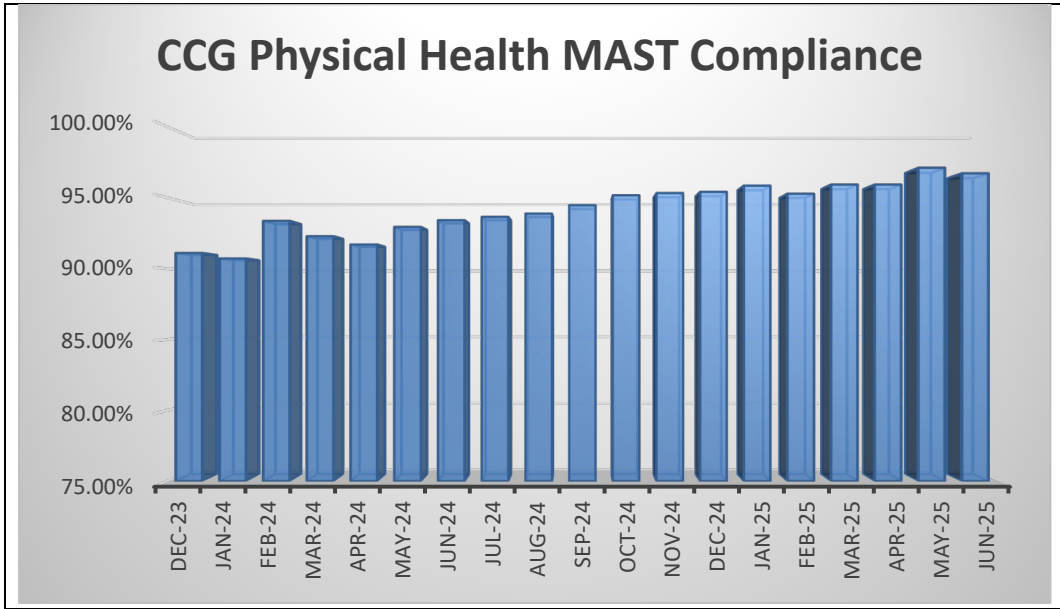
Annex 1 – MAST Breakdown per Directorate







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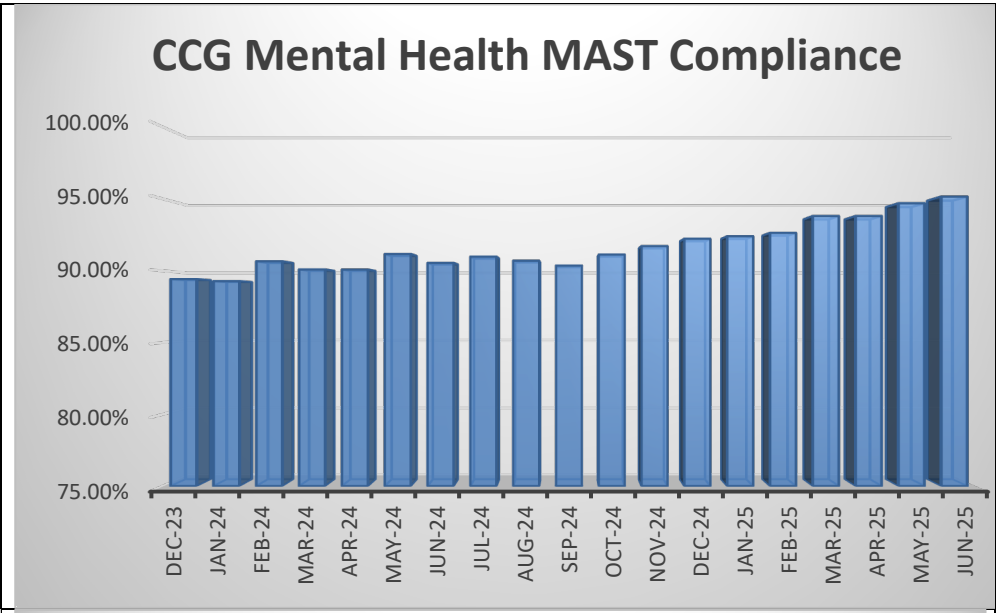
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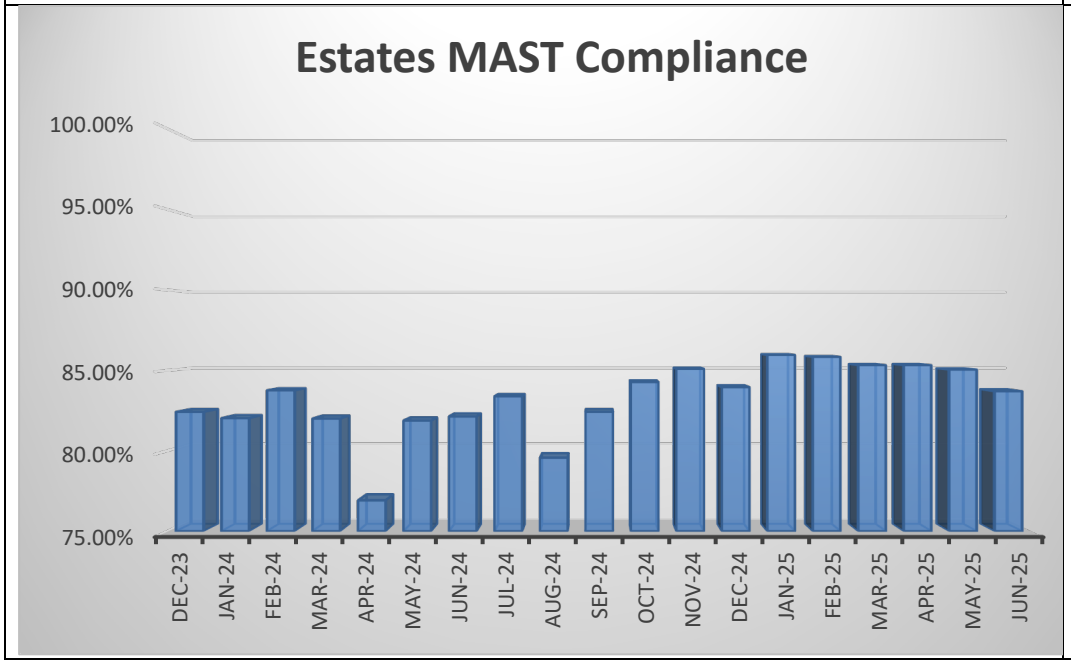
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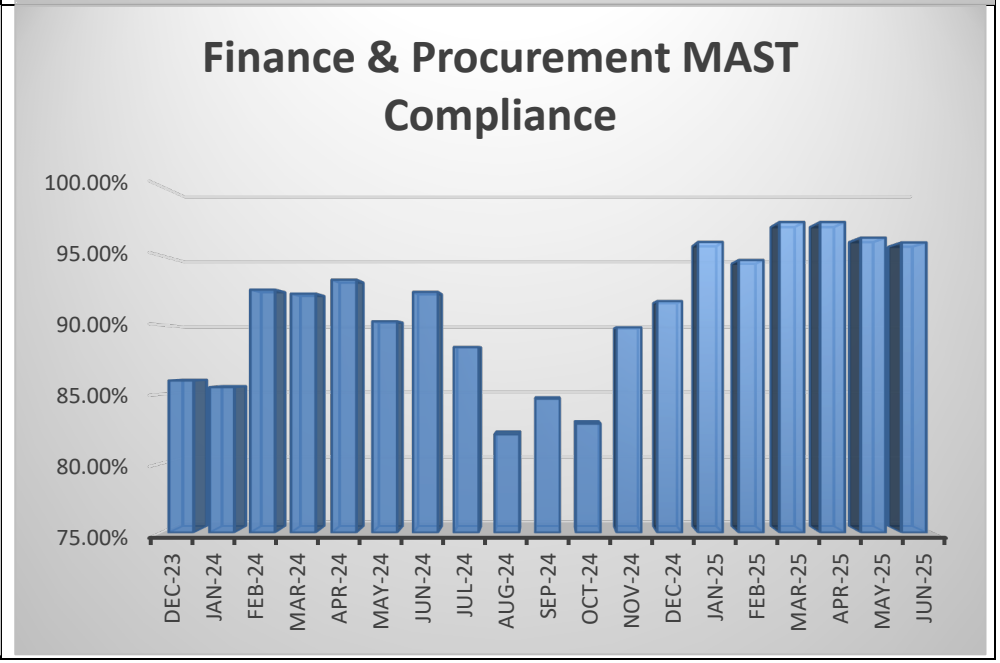
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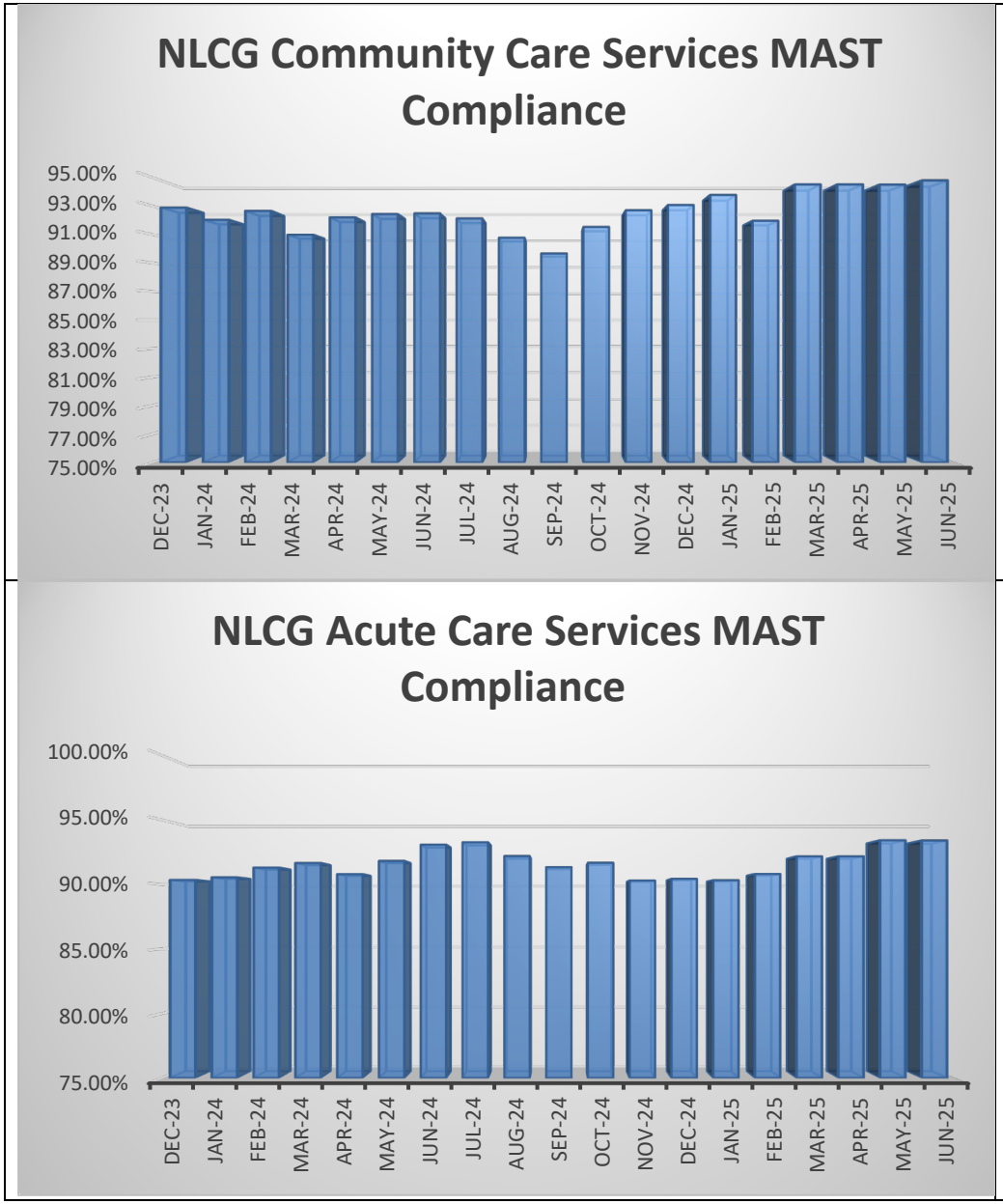
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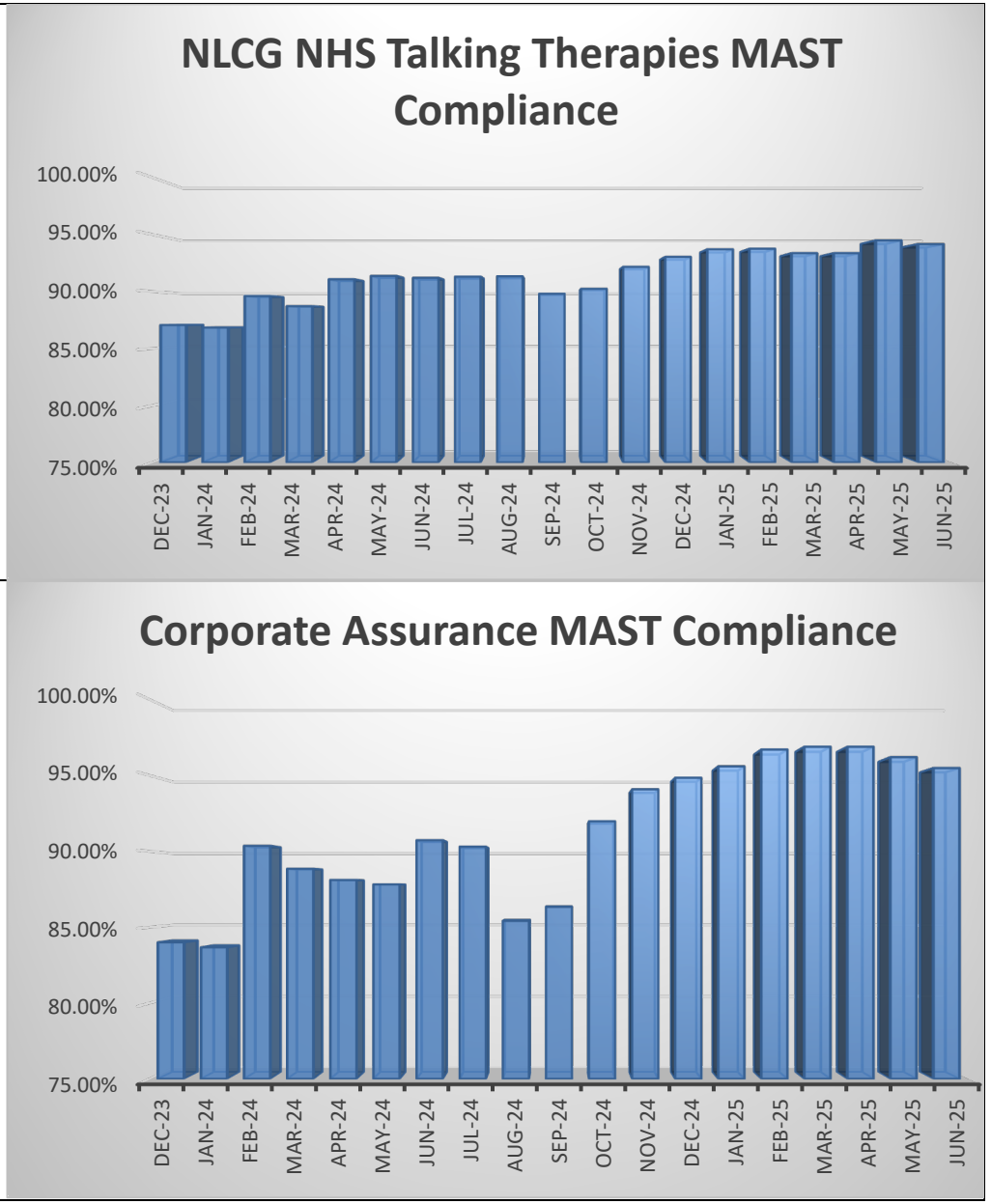
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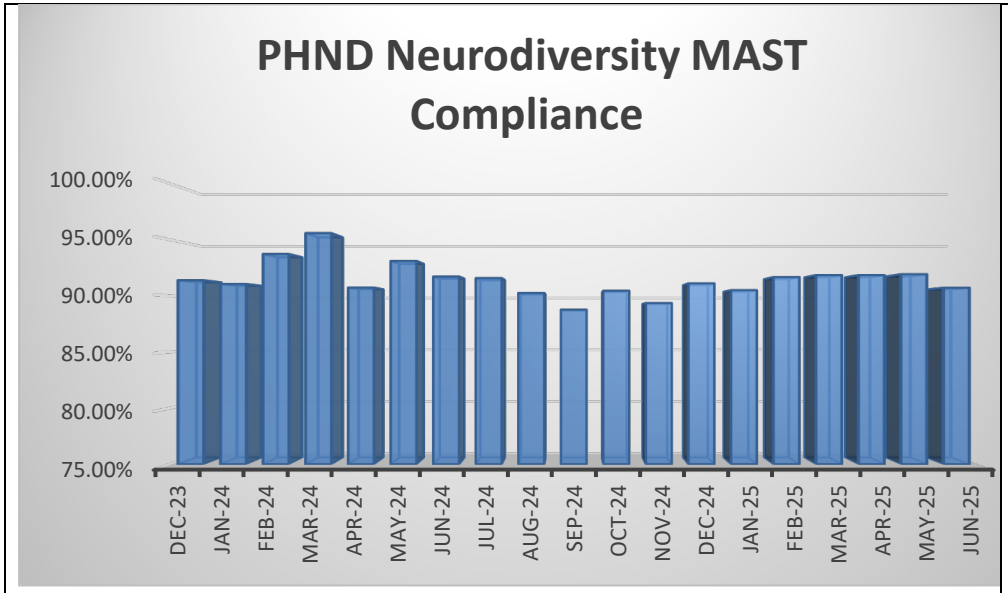
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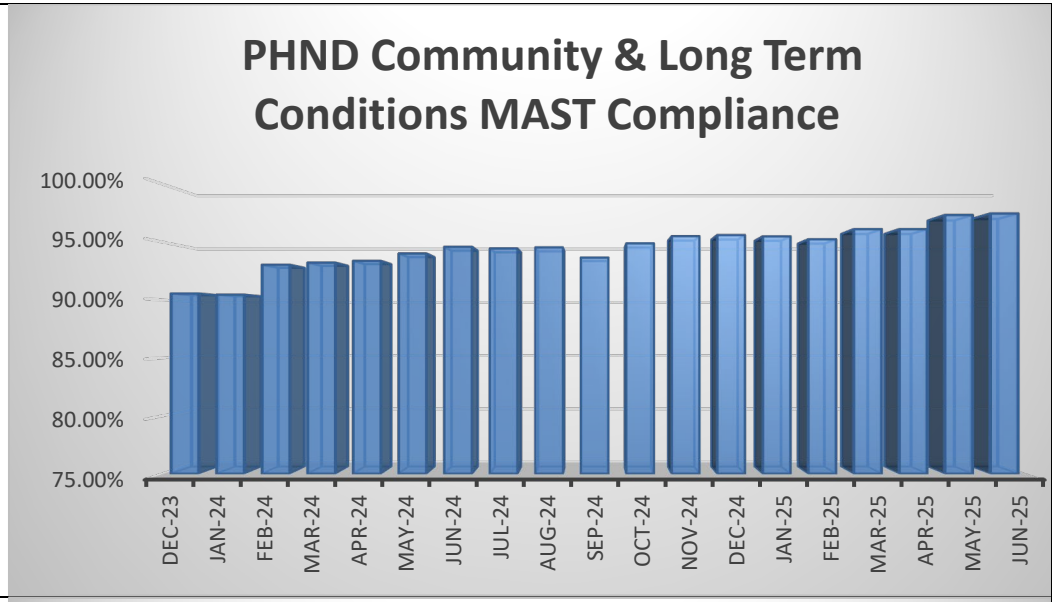
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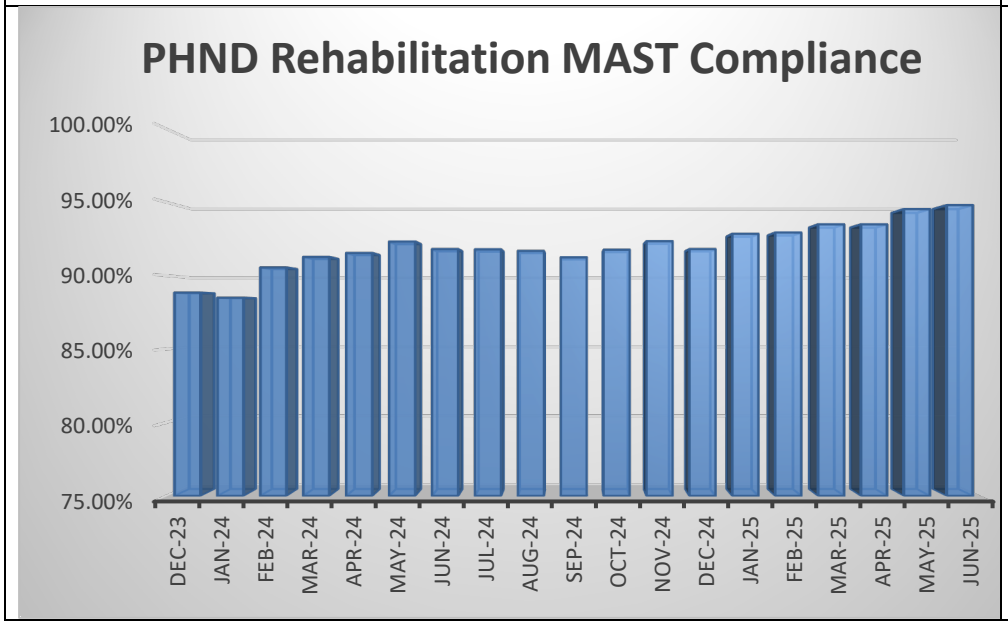
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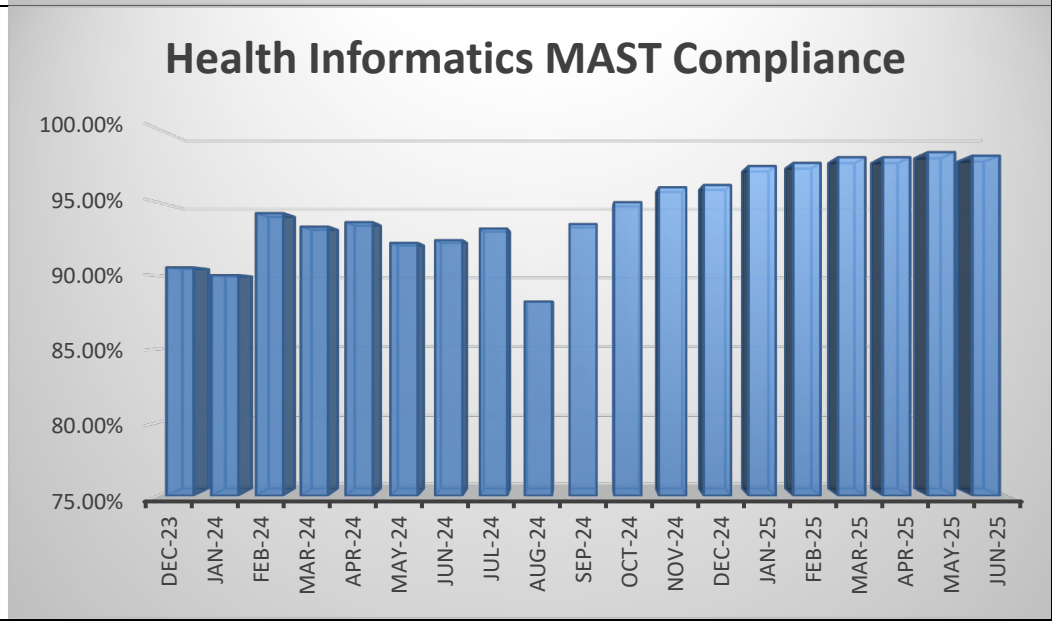
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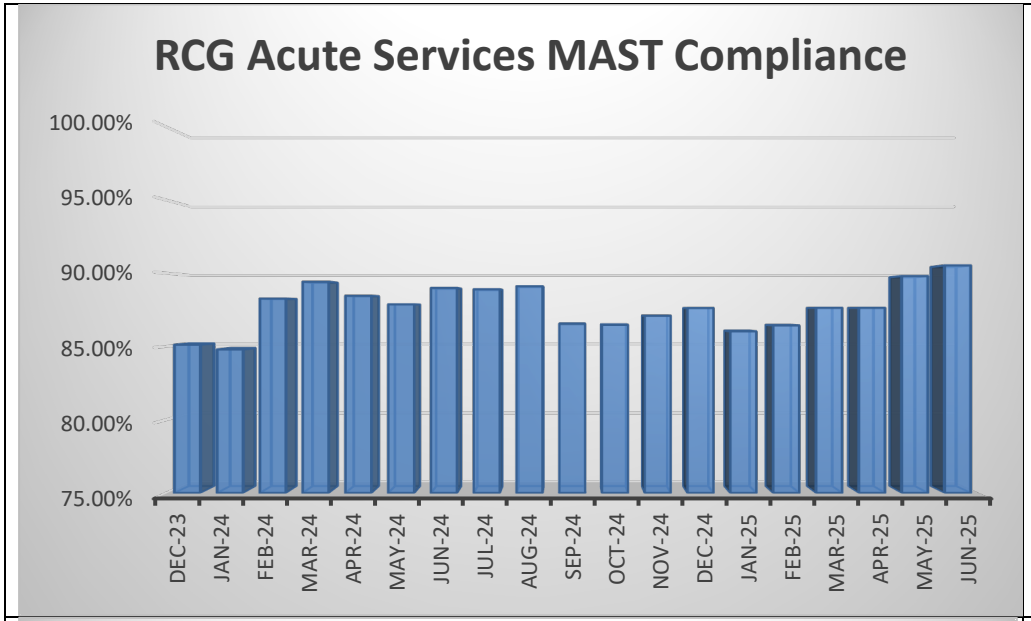
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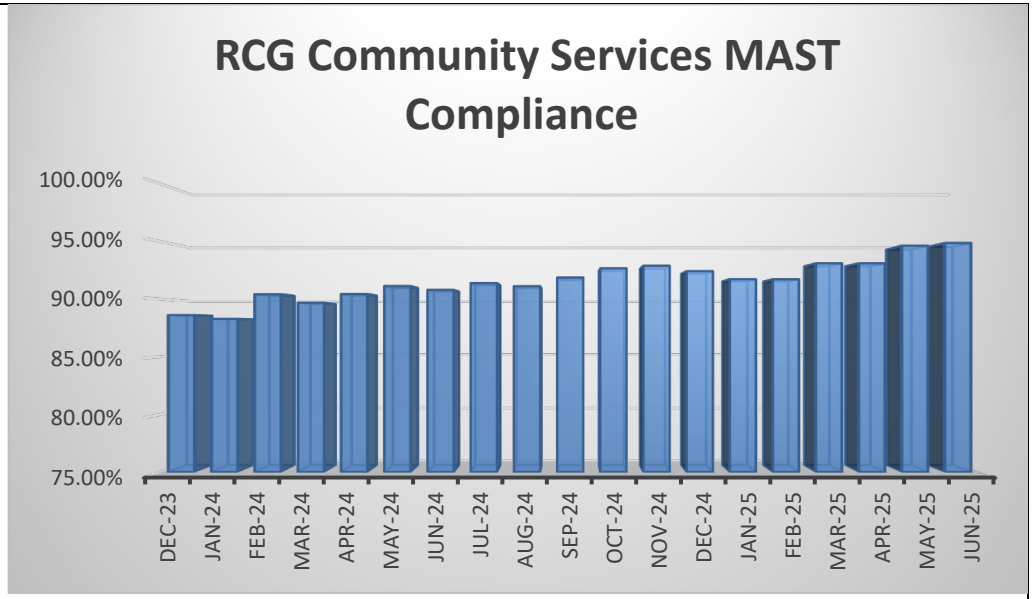
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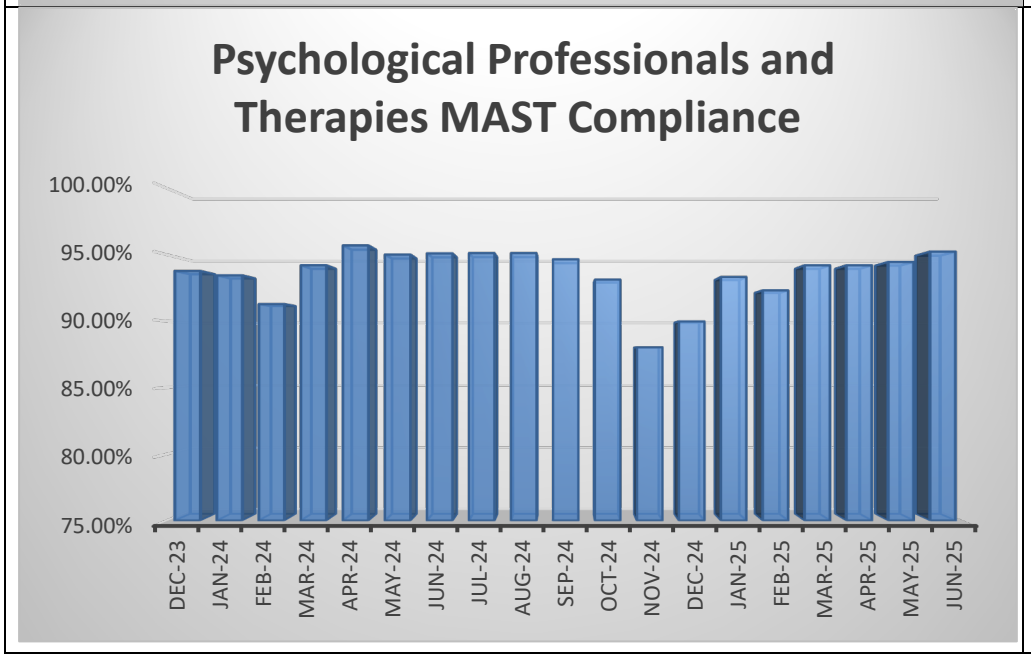
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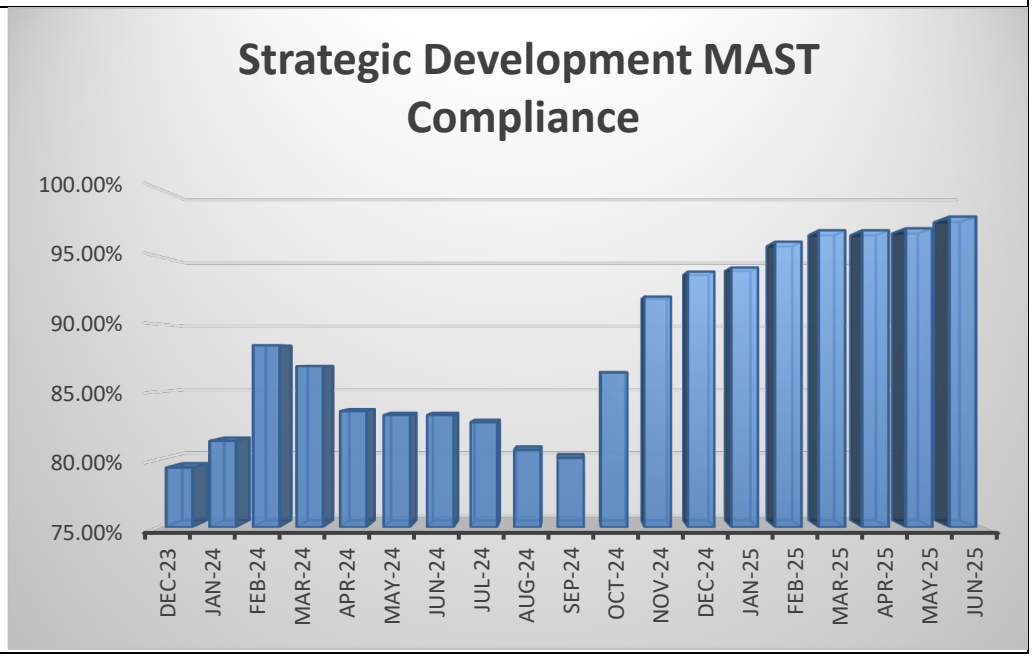
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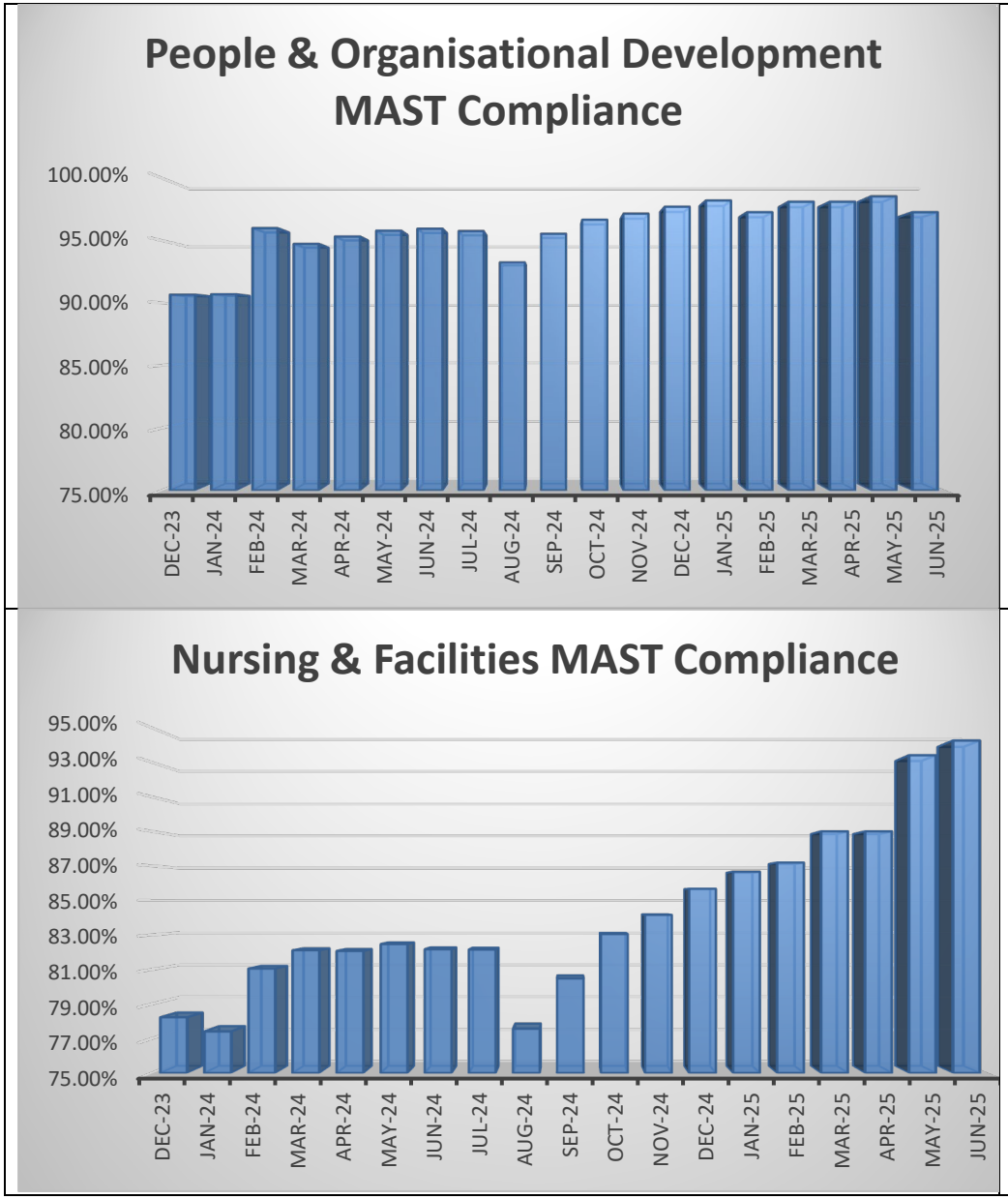
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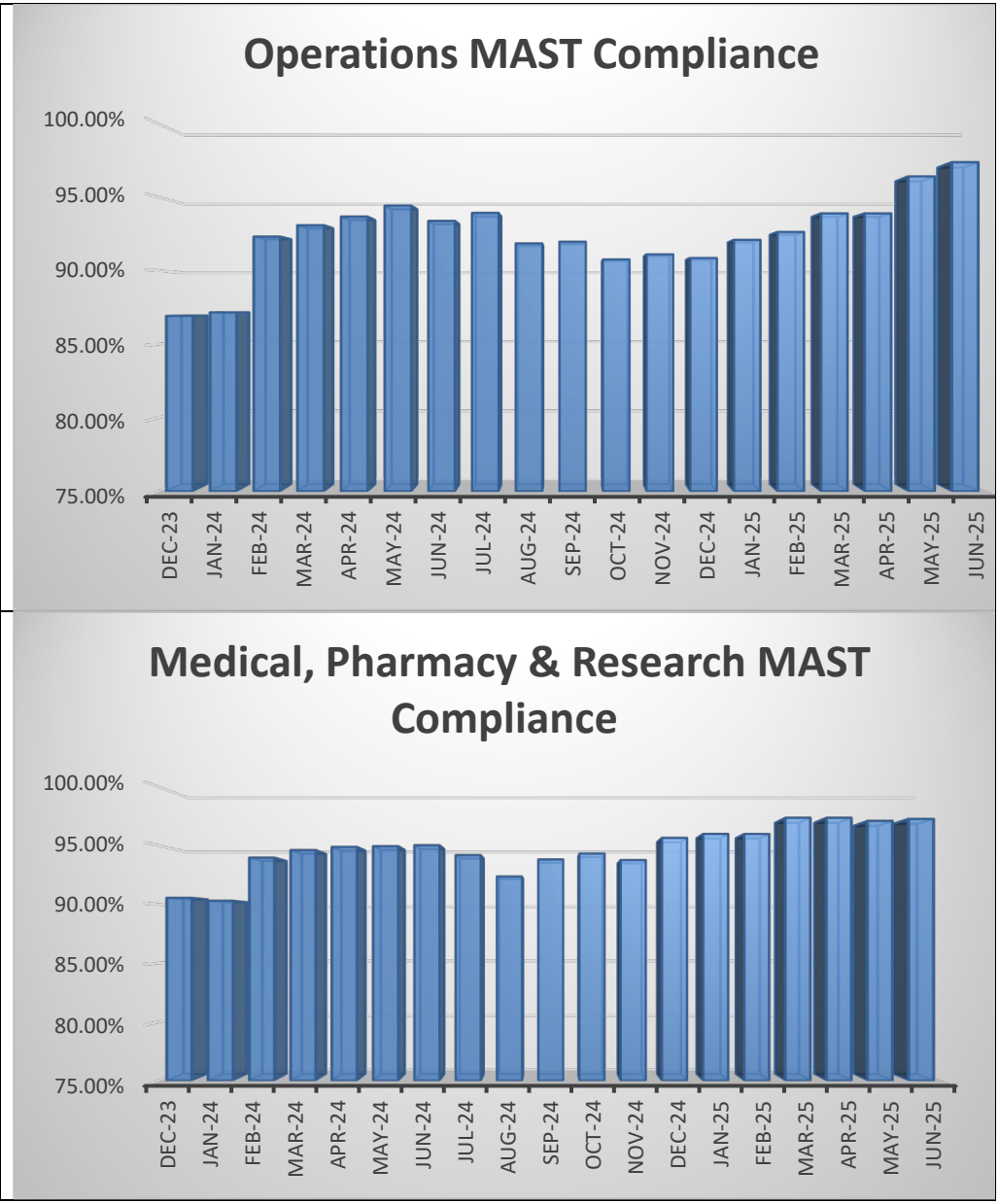
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Annex 2 – Apprentice Spend

RDaSH achieved a 70% spend on our levy entitlement for 2024/25, which is above the national 55.5%[1] average spend. RDaSH are currently on a par with other trusts within the South Yorkshire ICB, such as Sheffield Health and Social Care, Sheffield Teaching Hospitals, Doncaster and Bassetlaw Teaching Hospitals. Rotherham Trust is slightly lower with a planned spend of 65% and the highest within the ICB is Barnsley who are reporting an estimated spend of 84%. However, ultimately, we are aiming high and have committed to fully spending our levy, moreover RDaSH aspire to be exemplar in this space, therefore aim to look at ways we can further increase our levy spend to make up the 30% underspend in 2025/26.

The below gives an overview of the current financial position in relation to the Apprenticeship Levy.

Current Funds in Levy	Levy budget for 2024/25	Actual Spend Q1 – Q3	Projected spend Q4	Planned total spend	Levy underspend
£1,480,676	£750,617	£418,478	£105,332	£523,810	£226,273

The levy budget is determined by our pay bill. Our reduced vacancies and annual national pay award and our move to the real living wage will directly influence and increases the levy budget we receive as an organisation.

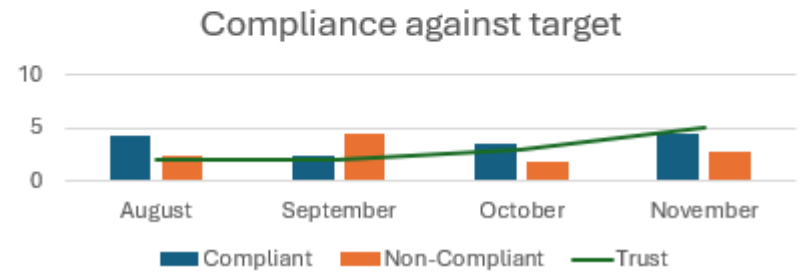
The trust wide levy budget for 2025/26 is expected to be at least £750,617 in accordance with the 2024/25 levy budget. However, it should be noted that the ongoing Band 2/Band 3 Healthcare Support Worker exercise will further increase the levy allocation given that our pay bill will increase because of staff moving from Band 2 to Band 3. We currently have 260 Band 2 Clinical Nursing Support Workers across the Trust who are likely to become Band 3.

[1] https://www.cityandguilds.com/news/february-2023/only-four-per-cent-of-employers-are-spending-their-full-apprenticeship-levy-funding

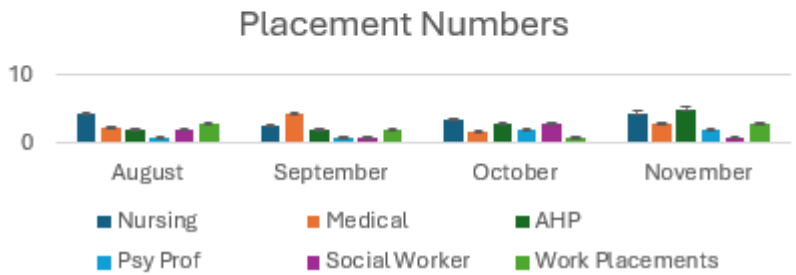
Annex 3 – Education and placement dashboard

Directorate Learning and Placement Dashboard

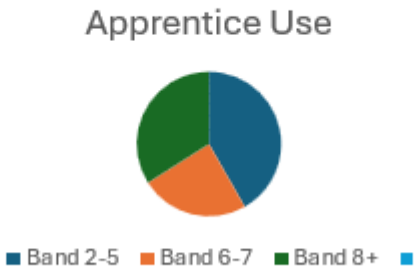
MAST



Placements



Apprenticeship Levy



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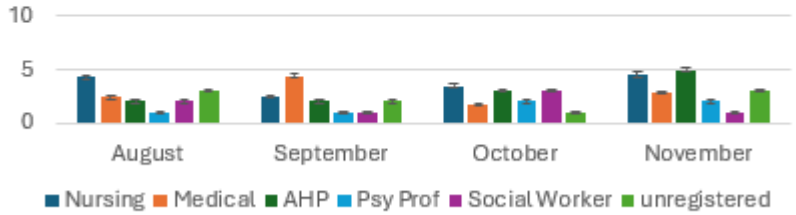


ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Learning Update	**Agenda Item**	Paper O
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Dr Judith Graham (Director for Psychological Professionals & Therapies)		
Meeting	Board of Directors	**Date**	24 July 2025

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

The paper summarises work completed in relation to the Learning and Education Plan. It highlights the strong areas of learning in the Trust and the areas for development, whilst also highlighting key work conducted in terms of creating the culture that appreciates the importance of learning and also prioritises time to learn through the ½ day LEARN sessions now embedded in the Trust calendar and directorate work.

The Board's attention to drawn to some of the issues that have been raised in terms of progressing work in the learning space, and to plans to progress enhanced vehicles for learning over the rest of 25/26, linking in closely with the work being completed in other strategic plans, namely – Quality and Safety, People and Teams and Research and Innovation.

The Board may wish to spend most time on the mechanisms suggested in terms of seeking evidence that the change in learning model is firstly supporting a more open and reflexive culture, and secondly, and most importantly aiming at prevention of actions that may precipitate the repeat of risks and incidents. This follows from discussions in May and March about the same idea. We should not overlook the seismic change needed in some corporate teams to be able to identify and "package" learning if we are to deliver on our ambitions.

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

Summarised in papers presented through the Education and Learning sub-CLE Group. Presented at the June 2025 Clinical Leadership Executive

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

EXPLORE the methods and actions for learning reflected upon and planned for

CONSIDER any matters of concern that are not covered in the paper**.**

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	x
Education and learning plan	x
Quality and Safety Plan	x
Equality and Inclusion Plan	x
Research and Innovation Plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	172 / 020
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks	Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	x

Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	311 / 002
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	x
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	319 / 015
	Patient experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	373
Performance risks	Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	x

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

SDR1, SDR2, SDR3, SDR5

Not applicable

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 – Peer Review Feedback
Annex 2 – Learning Styles
Annex 3 - Primary care learning sessions planned for 2025/26

Learning Paper – Plan Update

Board of Directors – July 2025

Situation and Background

Within our Trust Strategy we have a specific focus upon continuous learning, learning with our partners and patients and learning to improve. One or our key sub strategy delivery plans is the Education and Learning Plan which was the first plan finalised and was launched in summer 2024. This paper provides an update concerning work conducted in the field of learning and the forward plan in terms of coordinated learning.

This paper should be considered in conjunction with the Education Paper also served at the July 2025 Board Meeting. Why this is the case is that at RDaSH we have stated that we believe that 'learning' is:-

- A broad concept which encompasses a number of different methods and approaches (one of which is education).
- We also believe that 'learning' is an active and continuous process, rather than just a process that has to be time boundaried.
- We believe that our learning is structured around '4 Pillars of Learning':- (1) Learning to know, (2) Learning to do, (3) Learning to live together, (4) Learning to be – this is model that can be used on an individual and systemic learning basis.
- We believe that 'learning' is applicable to all roles in RDaSH and enables safety.
- We feel that 'learning' can be gained from examining things that go right and also things that go wrong.
- And lastly we believe that learning partnerships also enable across system growth (i.e. safeguarding partnerships)

The subject of learning is also aligned with the CQC 'Learning Culture' description and links to the following quality statement:- '*We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices'*.

What this statement means for us at RDaSH is that –

- Safety is a top priority that involves everyone, including staff as well as people using the service. There is a culture of safety and learning. This is based on openness, transparency and learning from events that have either put people and staff at risk of harm, or that have caused them harm.
- Risks are not overlooked or ignored. They are dealt with willingly as an opportunity to put things right, learn and improve.
- People and staff are encouraged and supported to raise concerns, they feel confident that they will be treated with compassion and understanding, and won't be blamed, or treated negatively if they do so.
- Raising concerns helps to proactively identify and manage risks before safety events happen.
- Incidents and complaints are appropriately investigated and reported.
- Lessons are learned from safety incidents or complaints, resulting in changes that improve care for others.

The 'I statements' that relate to patients, carers and staff in terms of a 'learning culture' reflecting what people have said matters to them are: -

- I feel safe and am supported to understand and manage any risks.
- I can get information and advice about my health, care and support and how I can be as well as possible - physically, mentally and emotionally.

With these principles in mind, it must be acknowledged that the 'learning' approach and topics discussed in this area also link with the Trust 'Quality and Safety Plan' and 'People and Teams' plan, as well as linking to concepts such as 'duty of candour' and safeguarding, and Trust Strategic Promises related to patient engagement and empowerment.

Assessment

Within our Education and Learning meeting we have focussed upon the aligned strategic promises (9 & 24) and reviewing and developing our education processes (this is detailed in the Board of Directors paper that should be read in conjunction with this paper). The focus on education is interlinked with learning, however our focus upon learning has been broader than education. Therefore, this section will focus on (a) 'what we have learned so far, reflecting upon the previous years' work, and (b) how we move forward to better triangulate learning in the organisation. The last section of the paper will focus upon the forward plan and next steps in our RDaSH learning journey.

Section (a) What we have LEARN'ed so far

*LEARN = **L**earning **E**ducation **A**nd **R**esearch **N**etworking

We have been clear from the launch of the Education and Learning Plan that the first issue we have is the need to create the time and space to learn and embed this into the fabric of the organisation. We therefore commenced our learning journey, focussing on the launch of the LEARN half days.

Since the launch of the RDaSH LEARN half days in Q1 24/25 we have taken the approach of progressing using PDSA cycles to constantly improve. We have had two PDSA cycles so far, and we are just entering our third cycle. The cycles are:

- PDSA Cycle 1 - North Lincolnshire and Talking Therapies Pilot – Q1&2 24/25
- PDSA Cycle 2 – Whole Trust roll out – Q3/4 24/25

Within the whole Trust roll out we have focussed in Q1 in exploring feedback about how the LEARN sessions have progressed, been embedded and also where there have been positive progression and also where there have been problems. We have collected this data through the 'Learning and Education' sub-CLE meetings, through mid-point discussions (at Christmas 2024), through peer reviews (see Annex 1) and also through monthly 'half day LEARN coordination' meetings/ drop-ins facilitated by our Chief Allied Health Professional, open to all Directorates (Care Group and Backbone).

In brief the Trustwide findings have been:

Positives
- All staff grateful for protected time to learn - 2,262 recorded portal sessions - Positive outcomes - Range of sessions generally caters for range of staff - Ability to record self-directed study - Administrative time for care groups has reduced
Areas for Development
- Steadily decreasing number of portal recorded sessions - No current 'request' system for learning - Lack of notice for courses and programmes - Queries about available time if engaged in other study. - Underserves non-autonomous non-9-5 workers - Band 2-3 staff often felt they were searching for topics to book onto for the sake of filling the time - Clinical priorities and upcoming pressure, such as achieving the work 4 week waiting time. - Negative impact on 24/7 services and the unintended consequence regarding increased Single Point of Access (SPA) calls during the learning half day, this was also a similar position for the crisis team, home treatment, depot clinics and those services commissioned for a certain number of days. - The group acknowledged that inpatient nurses have the most disadvantage due to increased pressure on meeting safe staffing numbers, whilst navigating the learning half days. - Disconnect regarding the MAST training scheduled and the issuing of the corporate calendar – agreed that the late issue of the corporate calendar needed to be addressed for next year. - POD Directorate – challenges with the OD and L&D team having the protected time to utilise their own learning half day, as opposed to delivering training. - Staff networks some feedback on these not being learning but support for staff – moving them to half day learning does not feel in the spirit. - Managers didn't feel they had sight or grip on how staff were utilising their learning half day.

What this means for us at RDaSH: The LEARN sessions have had a positive effect for many, however there are specific challenges in terms of the 24-hour services we provide in terms of both access and

utilisation of the time. There are proposed ways in which these services may use an adapted model to benefit, but in a way that suits the needs of the service as well as the workers. There is also a specific need for coordination, recording and policy. The actions generated from the learning from this PDSA cycle, approved at the June 2025 Clinical Leadership Executive meeting are:

1. **Develop and communicate a clear process for booking and recording half day LEARN sessions.**

   Current context –
   - Staff portal is a repurposed booking system and not a bespoke solution. It has been provided at no cost / development time.
   - Staff are expected to book onto a session when they are completing self-directed study. Clear that very few do – however they also cannot at 1 minute past the time of the session due to the nature of a booking system.
   - Participants do not complete evaluations on the booking system, similarly 'tutors' do not always complete attendees.

   Solution –
   - People and OD team to work with IBM about a functionality for recording LEARN activity in ESR. In this way it could be batch uploaded or individually entered, and also audited to form part of the batch data that people can self-service.
   - Time frame for development to be set within August 2025 Education and Learning Meeting.

2. **Develop a central co-ordination function for LEARN activity outside of team meetings and MAST.**

   Current context –
   - Care Groups and Directorates tend to arrange their own programme of activity. This is positive for some targeted specialist learning, however, causes duplication when requesting things such as Schwartz Rounds and certain MAST training which could be provided as an across organisational resource.
   - Some things that are available across Trust are listed on the Trust app but not all.
   - Some staff are stating that they are finding there is 'nothing to do' (i.e. comments from B2 and B3 staff above)

   Solution –
   - Investment bid agreed for a therapeutic learning coordinator, to support half day 'LEARN' and also Trust wide learning (covered in part B of this paper).
   - This post is out for recruitment and is expected to commence from August 2025.
   - This post holder will work with all directorates to progress a more robust and targeted programme of activity, which does not interfere with Team meetings and other localised work, but enables across Trust activity to be requested, sourced (internally and externally) and archived.
   - The post holder will also ensure different methods of communication to suit different learner needs including – using the app; providing information for newsletters in directorates; providing information and data for VLOGS and also providing a managed inbox for requests and suggestions.

3. **Resolve questions around 'other study' and LEARN time**

   Solution –
   - Investment bid agreed for a therapeutic learning coordinator, to support half day 'LEARN' and also Trust wide learning (covered in the 2nd section of this paper).
   - This post is out for recruitment and is expected to commence from August 2025.
   - An 'easy access' guides to be produced by the Learning and Education Teams.

4. **Policy changes and Appraisals/PDR**

   Current context –

- LEARN is currently in progress but not in RDaSH policy or process. This gives rise to a lack of framework to support people with.
- LEARN is not currently also a part of PDR or Appraisal processes.

Solution –

- People and OD team to adjust learning, appraisal and PDR policies to include LEARN session expectations and audit processes.
- People and OD teams to provide a management briefing in terms of what this means in terms of staff support, PDR data and performance monitoring.
- People and OD Team to work with staff side in terms of changes to policy at this stage.
- This policy change will be completed by Sept 2025, with briefings in Q3 25/26 and full launch in Q4 25/26.

*Please note that this change will only apply to non-24-hour services at this time as it is accepted there will need to be a further PDSA cycle in these services to effectively enable LEARN activity.

5. Earlier Corporate Calendar is requested to be issued 4 months earlier to enable booking

Current context –

- The corporate calendar is appreciated as a complex document. Appreciating the core delay was due mostly to external parties, the delay has hindered our Q4 and Q1 25/26 learning.

Solution –

- CEO agreed that the corporate assurance team produce the corporate calendar

6. Decision about whether Staff Networks remain a part of LEARN

Proposed solution –

- Staff Network Chairs and Sponsors to discuss the focus of the networks and whether they are purely there for 'support' or activity, and in so whether there is a place for networks in the LEARN sessions.

7. Explore the actual impact on SPA (Single Point of Access) and complaints in terms of the LEARN introduction.

Current context –

- LEARN is enabled by a 'Christmas Day Service' this results in SPA communicating this as well as a corporate communication via communications.
- Physical Health and Neuro Care Group who manage SPA have reported through the Learning and Education meeting, that there has been an increase in volume of activity when the LEARN half days are on.
- The patient experience and complaints team have reported that there has been an increase in complaints related to learn half day activity.

Solution –

- Activity report requested from SPA service manager comparing activity in LEARN with 'standard day' – through the duration of the full Trust roll out. These are the results:

Date ↓ Day→	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Average per week
Sept 24	588	601	571	546	522	276	260	480
Oct 24	689	710	658	639	630	316	273	559
Nov 24	708	661	578	603	569	308	289	538
Dec 24	641	571	615	576	596	315	315	518
Jan 25	686	650	596	594	586	320	312	535
Feb 25	668	614	614	560	534	336	284	515
Mar 25	636	595	630	621	530	321	287	517
April 25	709	663	637	568	365	294	293	504
May 25	648	624	645	600	546	265	284	516
Average per day	664	632	616	589	542			

*Half day learn sessions are varied in terms of day but are highlighted in yellow on the chart.
**The rationale for showing the data in this way is that we can see that the workload is increased despite of the day that is varied

The above figure demonstrates that there is some variance in terms of the work pressure in SPA when the half day learn sessions are conducted, despite of the days of week they are being conducted: 5/9 have resulted in calls higher than the day average, and 9/9 have resulted in calls higher than the week average (however there is a caveat that when taking an average call for a week – the Saturday and Sunday call average is significantly lower and so reduces the average across week – if the Saturday and Sunday figures are removed only 3/9 have an average that is higher). This workload pressure requires continued monitoring during the next phase of the learning roll out.

- The patient experience and complaints team have reported that there has been an increase in complaints related to learn half day activity.

This has been explored by the CNO. The CNO reported that there has been no reported increased incidents on the half day LEARN sessions, and that the issue raised in the reflective Education and Learn session was in error.

8. Pilot and adjusted model of LEARN in 24-hour services over Q2&3 25/26 (community and inpatient)

Pilot Proposal

- The development of a resource bank will enable people in teams to access items discussed 'in LEARN' when they are in 24-hour services. This will be enabled by the Therapeutic Learning Coordinator.
- The suggestion of spreading the LEARN hours over a more annualised rather than specific 'half day format' is requested. Care groups will be asked to plan the 'team meeting' and internal 'clinical specialist' sessions within their services (i.e. hospice sessions planned by the matron, manager and nurse consultant).
- Backbone services to provide certain sessions 'out of hours' for the pilot period (i.e. trolley dash, Schwartz Rounds and certain face-to-face MAST training).
- Digital learning sessions and MAST is available to people who work in evenings and weekends.
- Out of Hours – drop-in feedback sessions to be facilitated by the therapeutic learning facilitator to explore pilot experience and gain feedback on what is helpful and what can be improved.

9. Discuss the issues raised about capacity to balance - supporting the delivery of care and strategic objectives as this was expressed as feeling 'overwhelming' at times and a feature of LEARN discussions.

Solution –

- The LEARN activity is not the only issue that is being discussed as a capacity strain. Therefore, it is requested that these is a discussion about capacity and pace incorporating LEARN reflection.

Section (b) - The triangulation and sharing of learning in the organisation

Now we have created the space to LEARN – as described in section (a), our focus is upon enabling a more robust approach to triangulated learning that is communicated in a way that is accessible and used and informs preventative action.

In the Education and Learning meeting we have considered several specific data points which help us to be a learning organisation. These specific points (not an exclusive list) –

- People/HR investigation outcomes
- PSIRF process outcomes
- FTSU data and outcomes
- Risk Register items
- Complaints, compliments and Care Opinion.
- Safeguarding

What we have reflected upon is that we have positive processes for learning in terms of each specific item, and within a care group or directorate. However, what we are not advanced in is learning across the different data points and also across specialism and directorate. Therefore this needs to be our focus when looking forward into 25/26.

So what next?

The Education and Learning Group (with additional subject matter experts invited) met and discussed the mechanisms for sharing rich learning across the organisation and how improvements could be made in this regard.

The discussion raised the following themes –

- Learning 'in team' and 'in directorate' seems positive

- Learning across Trust, and across specialism (i.e. acute inpatient) is less structured with gaps.

- The ability to learn is affected by different aspects, most specifically the delay in investigatory time and published output (i.e. the delayed SJR process we have seen over the past 18 months; the complaints and PSII investigation delays we have seen over the past 12 months, and the delay in some HR/Workforce investigations).
  *please note, this is not to say that urgent learning that happens in the 'hot debrief' at the time of the incident does not take place, as it does and is shared Trustwide.

- Now that some of the processes have been significantly shortened to enable output from investigatory processes to be communicated in a timelier manner, more responsive learning should be enabled.

- Finally, the last issue notes was that information systems have not been in place to support triangulated learning. The progression of the move to a different incident reporting mechanism has noted this fact in the procurement process, and now RADAR is being launched the clinical system should help with reporting.

In addition to this, what was reflected in the Clinical Leadership Executive (CLE) meeting in June 2025 is the above points tend to be focussed upon where there are deficits, which shows us were we culturally feel we 'should' be learning. A challenge has been that correspondingly we have a large number of positive areas of practice and we need to make sure we also spread and embed the positive practice as part of our next stage learning journey.

The 'triangulation of learning' pilot –

At CLE in June 2025, it has been agreed to progress a set of communications which pull together the different aspects of learning in a way that can be digested by all. These aspects would include the list at the top of section (b) as well as the positive practice learning from our research, our pilots and our awards. This set of communication would be a 2 monthly sharing that would take the following form –

- Learning points from: - People/HR investigation outcomes, PSIRF process outcomes, FTSU data and outcomes, Risk Register item, Complaints, compliments and Care Opinion and Safeguarding bimonthly.
- A VLOG to be produced summarising these points and 'what this means' for different specialisms
- A newsletter to be produced and circulated,
- An Outbrief to be produced and circulated.
- An audit to be defined to explore whether the triangulated learning has resulted in prevention

The rationale behind considering different communication styles is based on both feedback from staff and also considering different learning styles and preferences – as summerised in Annex 2.

Summary and Recommendations

The above paper provides a brief overview of the 'learning activities' completed in the past year and should be considered alongside of the education paper served at the Board of Directors in July 2025, as the two papers link together in terms of the whole organisational approach to learning and also the learning and education plan.

In terms of the forward plan over the next year we will -

- Embed the half day LEARN sessions into our policy, our job plans and our performance management processes. Accepting that this will exclude the inpatient and 24-hour service staff who require a different set of processes.

- We will progress the 9 recommendations in terms of LEARN half days, including the 24 hour service pilot.

- We will progress the coordinated trustwide learning from Q3. Alongside of this approach we will progress a multi-modal audit process (aligned with our PSIRF processes) to explore whether learning has been embedded and resulted in prevention. Activities associated with this will be –

    - Random dip sample
    - Targeted via peer reviews (advance selection of learning brief points in each review)
    - Set a metric for reduction after each review and then use RADAR System report (i.e. number of mental health act errors, depot medication errors)

- Consider the impact of the NHS 10-year plan launched in July 2025, and the focus upon multi-organisational learning and place/neighbourhood learning. We have completed some focussed activities related to this in terms of our 'joined up learning sessions with GPs and Primary care' and also have specific sessions planned in for 25/26 – Annex 3 demonstrates examples of this.

Annex 1 – Peer Review Summary regarding LEARN half days.

Learning half day feedback from quality reviews – reviews undertaken 3/3/24 – 20/3/25

Ward	Date of review	Feedback
Hawthorne	12/9/24	Staff had not been able to participate in the learning half day yet; more work needs to be done as a Trust on how wards can be supported but it was acknowledged this is a new process and still developing. Learning needs to be shared from North Lincs on how they undertook the pilot.
Kingfisher	19/9/24	Access to the learning half day for the ward is also a challenge as they are already working on minimum/Christmas staffing, so are not able to release staff.
Windermere	3/10/24	Access to the learning half day for the ward is also a challenge as they are already working on minimum/Christmas staffing, so are not able to release staff.
Skelbrooke	17/10/24	Not been able to take advantage, process needs more work.
Osprey	7/11/24	They had tried to use the previous learning half day for staff to catch up on mandatory and statutory training. Can't do 3 hours continuous on the ward, unless they could double staff. Staff had issues getting on internet to do e-learning.
Danescourt	11/12/24	Staff were not participating in the Learning Half Days. There was one laptop for use between all staff and staff advised that WiFi connectivity was poor.
Magnolia	29/1/25	Some staff have participated. Therapists engaged and like the protected time, including team building. Value the protected time.
St John's IPU	20/2/25	Some staff have participated in the Learning Half Days but the timings of them do not lend to the Hospice being able to take full advantage of them. For example, staff said that mornings were difficult to accommodate staff being away from the ward and a more bespoke approach to being able to run learning half days would be better.
North Lincs CRHT	25/2/25	Not all staff had participated in the Learning Half Days.
Hazel	12/3/25	The staff reported that they had not been able to participate in the learning half days as it was not possible to roster extra staff on to free up staff to undertake training. It was felt to be a good idea but in practice, was not working.
Sandpiper OOH	18/1/25	Many of the staff spoken to were not aware of the trust learning half days or the schedule
Cusworth OOH	9/2/25	All of the staff spoken to said that they were not aware of the learning half days, even when this was described to them, so had not participated.

Annex 2 – Learning Styles

1- The Visual Learner

Someone who learns by vision will have greater understanding and memory retention of things they see. For example, a visual learner would gain more from reading a hard copy of a book, than listening to an audio version. Also, images and graphs will make a big impact on these learners. Therefore, focus on visual aids that make the topic more inviting for the learner.

2- The Auditory Learner

Someone who learns by audible stimulus will have a greater understanding and memory retention of things they hear. This works opposite to the visual learner, as auditory learners would gain more from an audiobook than a paperback.

3- The Read/Write Learner

This learner would remember notes from a book much better after reading it several times over or re-writing the notes out. A read/write learner could study for a test simply by repeatedly reading and re-writing notes from a textbook. Therefore, the more times the learner reads and re-writes, the greater the memory retention and understanding.

4- The Kinesthetic Learner

Someone who learns kinesthetically must do, practice, and experience. This learner would like to be given the opportunity to actively try to learn something in order to gain a base understanding. Rather than listening to any extensive explanation before trying something. For example, a practical science experiment would give a kinesthetic learner the utmost opportunity to gain knowledge.

Annex 3 – Primary care learning sessions planned for 2025/26

Date	Time	Service
Thursday, 21 August	12 noon to 1 pm	Children's Neurodevelopment Pathway (All localities)
Wednesday, 10 September	1 – 2 pm	Talking Therapies (All localities)
Monday, 13 October	1 – 2 pm	TBC
Wednesday, 26 November	1 – 2 pm	Learning Disability and Forensic Service (All localities)
Tuesday, 16 December	12 noon to 1 pm	Epilepsy Service (Doncaster)
Wednesday, 28 January	12 noon to 1 pm	Wheelchair Service (Doncaster)
Thursday, 19 February	12 noon to 1 pm	CAMHS (Getting Advice) – (All localities)
Tuesday, 17 March	12 noon to 1 pm	Zone 5-19 (School Nursing, Sexual Health and Substance Misuse – Children and Young People)

Example LEARN Sessions involving Primary Care and GP partners in Physical Health Care: - this is an example of over 100 attendees at a Diabetes half day learn session in Doncaster in Q4 24/25

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Productivity at RDaSH	**Agenda Item**	Paper P
Sponsoring Executive	Izaaz Mohammed, Director of Finance and Estates		
Report Author	Will Holroyd, Senior Programme Manager		
Meeting	Board of Directors	**Date**	24 July 2025

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

The board received a paper in November 2024 titled “Thinking about productivity at RDaSH” and this was initiated by a paper titled "Productivity: Where to start?” presented in May 2024. These identified an arguable lack of national coherence on productivity in mental health and community settings and introduced the findings from Akeso which identified a potential productivity gain in the services reviewed of £3.8m, the majority associated with older adult services. Since then, a £4.8m target for productivity improvements was included in the 2025/26 financial plan, linked to a 4% increase in productivity from a 23/24 activity baseline. Additionally, the 10-year plan asks providers to deliver 2% year on year annual productivity improvements. We are following up with peers inside the ICB how consistently these non-cash releasing metrics are being tracked.

For these reasons we have developed a framework that will unify all the related work under a single definition and this paper introduces this framework and starts to outline the delivery chain for improving productivity within the organisation. Our proposed definition of productivity doesn’t just focus on inputs vs output. We will also include a measurement of the effectiveness which will include patient feedback and outcomes, as well as staff motivation & satisfaction information. The ambition to achieve promise 14 (4 week wait) is the primary driver that will deliver the productivity improvements this financial year, and data analysed at month 2 shows that we are delivering to plan at this early stage in the year. Productivity pilots will continue the early progress seen in the achievement of productivity gains and will aim to inform the future work required to meet the national 2% annual improvement outlined in the 10-year plan.

In exploring the digital enabling plan, we need to be confident of congruence.

Previous consideration

This topic was discussed at May 2024 and November 2024 BODs

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors are asked to:

NOTE that the ambition to achieve promise 14 (4 week wait) is the primary driver that will deliver the productivity improvements in this financial year.

ACKNOWLEDGE the progress made in creating a method for embedding the productivity improvement requirements into the existing delivery work of the trust.

CONSIDER any material aspects of productivity not included in this paper.

Alignment to strategic objectives (indicate those that the paper supports)

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

Alignment to the plans: (indicate those that this paper supports)	
Estates plan	x
Digital plan	x
People and teams plan	x
Finance plan	x
Quality and safety plan	x
Equity and inclusion plan	x
Education and learning plan	x
Research and innovation plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

Financial	Financial Planning, CIP & Sustainability	**Low Tolerance**	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	076 / 194/ 143/ 280/ 011

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

Not applicable

System / Place impact (advise which ICB or place that this matter relates to)

SY ICB – system financial sustainability

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

Productivity at RDaSH

1.1 The board received a paper in November 2024 titled "Thinking about productivity at RDaSH" building on the earlier *"Productivity: Where to start?"* discussion from May 2024. These papers highlighted the lack of national coherence on defining and measuring productivity in mental health and community settings, and shared findings from Akeso which identified a potential £3.8m productivity gain across some services in RDaSH. The previous papers established the importance of linking productivity work to existing projects already planned or underway, minimising the likelihood of this work being seen as a new initiative that our teams need to add to their to-do lists, and increasing the chances of success.

1.2 The 2025/26 financial plan includes a requirement to deliver a 4% productivity gain above the 2023/24 baseline; this translates in a productivity gain of £4.8m. The 10-Year Health Plan for England calls for a 2% year-on-year improvement in productivity over the next three years to help return the NHS to pre-pandemic levels. In response, we have developed a framework that brings all productivity related work under a single definition. This paper introduces that framework and outlines the delivery chain for improving productivity within the organisation.

The RDaSH Productivity Framework

2.1 In the purest sense productivity is the relationship between the volume of inputs and outputs in any process; activity divided by the cost of delivering that activity. The higher the productivity value from that calculation the more productive a process is. In healthcare this is more complex to calculate. Just because a process (or treatment pathway) can increase the number of patients it treats it does not mean that it is more productive, as there is no consideration made for outcome of that treatment. If a low-quality outcome is delivered by that process it may lead to the need for additional treatment or re-processing which is unproductive.

2.2 By increasing productivity within a healthcare setting we are releasing time to care by managing time well, focusing clinical expertise on those who most need specialist help, and looking after more patients within existing resources.

2.3 When considering productivity in healthcare, productivity is the relationship between the effectiveness of outcomes and what is put into delivering care to patients.

Economics Definition

$$Productivity = \frac{Volume\ of\ Activity}{Cost}$$

Healthcare Definition

$$Productivity = \frac{\begin{pmatrix} Volume\ of \\ Activity \end{pmatrix} \times (Effectivness)}{Cost}$$

2.4 The measurement of effectiveness should include patient feedback & outcomes, as well as staff motivation & satisfaction information.

$$Productivity = \frac{\begin{pmatrix} Volume\ of \\ Activity \end{pmatrix} \times \begin{pmatrix} Clinical\ Outcome \\ Patient\ Feedback \\ Staff\ Feedback \end{pmatrix}}{Cost}$$

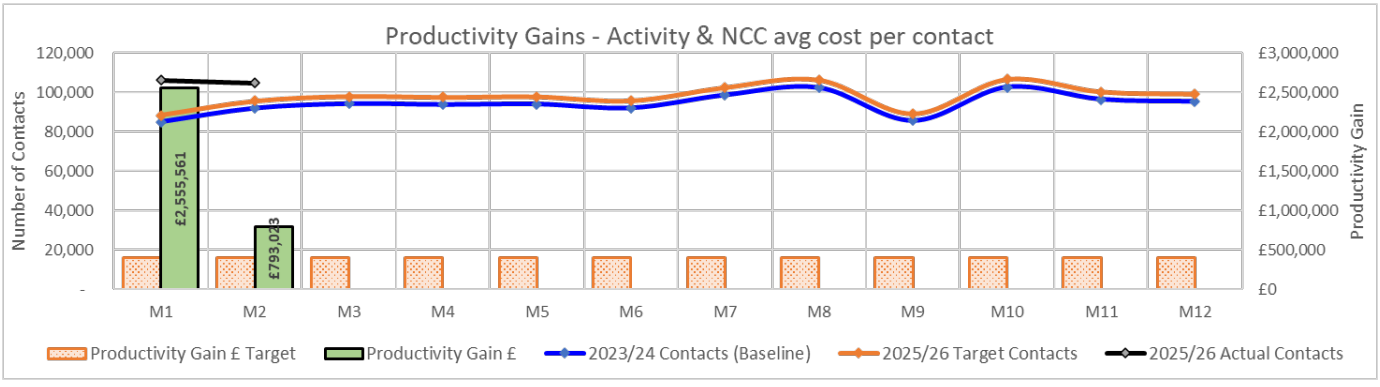
2.5 Having a clear and organisationally understood definition will ensure that any effort to measure or improve productivity is guided by this definition. Reframing productivity to focus on creating and sustaining high quality care will allow for deeper engagement. Therefore the working

definition of productivity within RDaSH will be ***Productivity is the measure of the quality and effectiveness of treatment in relation to the cost of delivering that treatment.*** These ideas are summarised in the following visual:

Planned Productivity Gain & NCC

3.1 The National Cost Collection (NCC) is an annual, mandatory reporting process through which NHS trusts submit data on the costs and volume of care provided. This data enables comparisons across trusts to assess how well financial resources are used in delivering patient care. The NCC applies an indexing system, centred on 100, to indicate cost-effectiveness; an index of 110 means costs are 10% above average, while 90 indicates costs are 10% below. RDaSH's most recent index for the 2023/24 collection is 85, placing us as the lowest indexed combined Mental Health and Community Trust in the country, and 14th out of 205 across all NHS providers.

3.2 The chart below measures the Trust's performance against the productivity target contained within the 25/26 plan. Actual activity data for months 1 and 2 of 2025/26 shows contacts are 15% above the target, delivering £3.3m of productivity gains. There is still work to be done to translate this productivity gain into a real-world value, by adjusting for inflation and other cost pressures enabling us to understand the true financial impact.



3.4 Increasing awareness around productivity will support embedding this work into the culture of the organisation and will allow those that deliver and lead services to understand how their work can affect productivity. We will structure and deliver material which is targeted at different levels of the organisation and wider system to help shape the narrative on productivity in mental health and community services. This includes learning half day sessions, incorporating this work in to budget holder training, and delivering a presentation to the national HFMA Efficiency & Productivity conference in September on the work that we have done in this space to date.

Improvement Opportunities

4.1 It is in this domain that the real impact of our productivity work will be seen. The framework enables a more coordinated approach and by unifying productivity improvements under the single definition we can ensure projects deliver measurable value.

4.2 Our starting point will be to work with data that helps us to ask the right questions. Insights from PLICS (Patient-Level Information and Costing Systems) and NCC will help us identify high index services (those where cost and activity do not appear to align with peers or expected benchmarks). These areas will form the initial pipeline of improvement opportunities. With that said the main driver for achieving our 2025/26 productivity target is achieving a four-week wait across all services. The activity increases required to deliver this aligns with the 4% productivity target from 2023/24 (see chart 3.2). By achieving promise 14 we will also achieve the productivity target.

4.3 The introduction of consistent job plans for medical professionals will support the productivity improvement agenda by providing insight into how clinicians' time is used, ensuring that direct clinical care is maximised and used effectively in delivering high quality care, with SPAs focussed on supporting professional development and learning. To compliment these existing plans, we will test and learn through a series of productivity pilots designed to reduce variation and explore new ways of working. We will measure productivity improvements from existing projects including outputs from the High Quality Therapeutic Care taskforce.

4.4 Productivity opportunities extend beyond clinical services. Backbone directorates will use the KPIs identified during their delivery reviews with the CEO as the basis for measuring productivity gains.

4.5 Delivery will be structured, combining project management rigour with quality improvement methodology. Working in partnership with operational leaders and clinical teams, to define aims, monitor progress using our shared productivity definition, and embed learning as we go. Measuring progress, we will draw on a blend of quantitative and qualitative measures to capture the effectiveness of improvements. This includes clinical outcomes, patient feedback and staff experience, alongside traditional activity and costing data. Costing data is reported throughout the Trust using the PLICS dashboards, reports to FDE on NCC indexes, and the proportion of the RDASH £ which directly supports patient care. Broader benchmarking will take place via Model Health System and NHS Benchmarking, as well as quarterly directorate dashboards via Reportal, which will provide the transparency and insight needed to track gains.

Measuring Quality Through Outcomes and Experience

5.1 To monitor improvements in productivity meaningfully, we will integrate clinical outcomes, patient feedback, and staff experience. Our clinical outcomes work is underpinned by the use Patient Reported Outcome Measures (PROMS), including DIALOG, which captures structured feedback on quality of life and care; ReQOL-10, which assesses recovering quality of life; and Goal-Based Outcomes, which supports co-produced goal setting and progress tracking. Alongside this, patient experience will be captured through Care Opinion, providing a real-time platform for individuals to share their stories and help shape service improvements. Staff feedback will be gathered through the annual NHS Staff Survey and regular pulse surveys, enabling us to track progress against the seven People Promises. These tools will help us understand whether changes are improving outcomes, aligning with patient priorities, and creating the right conditions for staff to thrive.

5.2 In addition to addressing the opportunities for improvements in productivity, continuing to remove waste is an important step to improving productivity. The savings programme will continue to identify and deliver cash releasing savings to support increasing the proportion of the RDaSH £ spent on direct clinical care. In this area there will also be a focus on reducing DNA rates and appointments cancelled by trust.

5.3 Failure Demand is another concept which will be introduced into our work, this is the additional demand on services caused by failure elsewhere in a system, whether that is a failure to act or a failure to achieve something. Identifying failure demand provides another lens to find opportunities for improvement.

Areas of focus for the rest of 25/26

Productivity pilots & Backbone Productivity

6.1 Through engagement with directorate teams, a programme of work will be developed to making productivity improvements in each care group, using the PLICS dashboards as the enabler for these discussions. Awareness building of productivity will also take place to create a unified approach to improvement.

6.2 We will initially aim to create a case study from each care group to illustrate what improvements have been identified and how productivity has been impacted following the changes made. Our ambition is to then expand this to develop case studies from each directorate. The learning from there will inform and evidence the work required to meet the national 2% annual improvement outlined in the 10-year health plan. This work will include the introduction of the failure demand calculation for some services.

6.3 Data collection will start for Backbone services', using delivery review KPIs agreed with the CEO to create a baseline measure against which future productivity improvements can be measured.

Unpicking Block Contracts

6.4 An additional component of the 10-year health plan for England is to deconstruct the use of block contacts and start to only pay providers for the patients they treat, with a bonus being paid for high-quality care. The work we have already started to monitor activity and productivity improvements as shown 3.2, will put us in a good position to start this conversation with our commissioners. We anticipate starting these discussions once expected national guidance is published towards the end of Q2.

Benchmarking against peers in MH & Community organisations

6.5 National tools for benchmarking productivity, particularly for mental health and community services providers, are in their infancy. To continue our pioneering steps in this area we are engaging with peers across South Yorkshire ICB and across wider networks to enable a comparison and support in identifying areas for improvement.

6.6 While this work is still developing, it provides a vital foundation for understanding where we stand and how we can improve. The lessons we learn and the progress we make will not only shape our own productivity improvements but may also help influence regional and national thinking as the NHS starts to define productivity in the mental health and community space.

6.7 When national guidance is published, we will integrate the NHS productivity methodology into our existing data so that service-level comparators can be established. This will enable us to align with national direction as it develops and ensure that directorates are informed about their performance in a consistent and meaningful way.

6.8 A further update on delivery of our productivity work will be shared with the board of directors in January 2026.

The Board is asked to:

- Note the plan to link the majority of the productivity work in 2025/26 to the delivery of promise 14.
- Acknowledge the progress made in creating a method and definition of productivity which is relevant to the work the Trust has already started in delivering its strategy.
- Consider any material aspects of productivity not included in this paper, or the work planned for the balance of 2025/26.

Will Holroyd
Senior Programme Manager
14 July 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 2 – Carers: Delivery Plan	**Agenda Item**	Paper Q
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer		
Meeting	Board of Directors	**Date**	24 July 2025

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

The Board of Directors are presented with a plan for promise 2. This is an incredibly important promise for our organisation as it pertains to both how we support and listen to the voice of our parents, carers, family and friends of the people we serve, as well as how we support our staff who also have caring responsibilities. This paper succinctly details what actions we are going to take.

This paper has been considered by the Clinical Leadership Executive, and it has been strengthened since in order to reflect the challenges expressed to enhance our actions and likelihood of delivery – this is a how question. In addition, we have consulted and spoken to our people who have lived experience of being a patient of the service and being a carer. Most crucially, it is accepted we have to be able to demonstrate scale and reach in making carer's assessment referrals, and acting on them. The responsibility here is not to "tick a box" in terms of carers and to ensure we are not just offering our carers onward referral to our local authority, but we are truly listening, especially when our patients are unwell, recognising that they are often the advocate and voice we need to hear (with consent).

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

Carers network 10.07.2025 paper; considered at Clinical Leadership Executive on the 15th July 2025; consideration as part of the 'always measures' discussions at Quality Committee on the 16th July 2025.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors asked to:

CONSIDER whether the actions planned are persuasive in respect on each success measure

SUPPORT the plan as drafted and agree to receive data on implementation in November 2025

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X

Alignment to the plans: (indicate those that this paper supports)	
Quality and safety plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

Patient care risk	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
External and partnerships risk	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

System / Place impact (advise which ICB or place that this matter relates to)

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 - success action plan

Promise 2

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

1. Situation and Background

Unpaid carers play a substantial and vital role in meeting health and social care needs of friends and loved ones in our RDaSH community, this is widely acknowledged. The care they provide has enormous health and social value, both for the people they care for and for wider society. Many carers experience great satisfaction from their role, and through the help and support they provide to friends and family members they also reduce the costs to all our services.

Correspondingly, it is acknowledged both within our Trust and Nationally (for example in the Office Of National Statistics publication regarding the adverse health impact of unpaid carers available at - https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/bulletins/unpaidcareexpectancyandhealthoutcomesofunpaidcarersengland/april2024) that unsupported caring responsibilities can have with a high personal, emotional, physical, wellbeing and financial cost. This is despite the 2014 Care Act giving carers the right to receive support.

Within RDaSH we have a mixed history in terms of supporting people who have caring responsibilities, this is both for people who support patients accessing our services and also people working in our service. This is the reason that it is a focus for our Trustwide Strategy and a key promise. Our aim is to enable consistency and supportive approaches which will be expanded upon in the section below.

2. Analysis

The value of unpaid care in England and Wales is now estimated to be £166 billion, exceeding that of the entire NHS budget in England for health service spending.

Most people will have caring responsibilities at some point in their lives. More than 5 million people (9% of the population aged 5 and older) in England and Wales were providing unpaid care in 2021. 60% of carers are older than 50 and 60% of carers are women.

When we consider our carers support activity and impact, we will look at staff and patient carers separately although accepting that there will be some cross overs.

3. Patients

In all parts of our services carers have a significant impact regarding the health of a patient, the independence and home-based treatment they can be supported with and the effectiveness of the care provided.

Within our children's services, particularly in terms of our younger children's carers are present and have decision making roles and responsibilities different to many of our other services (except certain services where people have capacity issues and legal aspects such as lasting power of attorney features). These services are structured in a systemic manner and the support for carers and parents receives predominantly positive feedback. It is also consistent.

In other services for our older young people, adults and older adults we have carer involvement but the consistency of provision in terms of carers assessment, carers involvement, collective care planning and risk management is variable. We know this due to three main sources; the feedback from our patients and carers; our complaints; our investigation processes. In addition to these processes, we have also sources of external review that have noted our inconsistency of approach, this includes coroners' inquiries and also CQC reviews (MHA and standard CQC).

In addition to feedback, we also have heard from some of our carers that there are certain systems and processes in the organisation that support them to contribute to care, and some that have hindered, we want to recognise this and consider in our forward plan. These are some of the feedback examples –

- Enabling contributions to MDTs and ward round on MS Teams and Zoom has been enabling for carers who have travel issues, who have more than one caring role and for people who need to maintain work. However, this is not something that is consistent everywhere.

- Some carer have stated that they have not been informed about certain pertinent points of care which has been concerning (this includes discharge planning and leave).

- Some carers explained that when the person they care for is unwell, they do not wish to involve them, however there are ways in which people can be involved and consulted whilst respecting this choice (i.e. when people are detained under the mental health act) but that some care staff are less confident in these discussions than others.

- Feedback from some carers whose loved one was supported in our hospice service. The person identified as a gypsy, Roma, traveller, and within their 'normal' home life had multiple people in their immediate family undertaking the caring role. The feedback from carers in this space was positive in terms of how the hospice enabled a large number of carers and visitors at all points in the day which then mirrored the support that the person received in their normal home life which helped support a positive end of life experience.

- Carers have been provided positive feedback when treatment interventions have included them. Examples of this has been some of the group therapy sessions, and sessions pertaining to people with dementia diagnosis. At these sessions carers have explained that they have developed skills in supporting people through these sessions, as well as gaining a better understanding of the person they care for.

Moving forward we therefore are taking an approach of coproduction and also learning from our services which demonstrate good carer engagement and where there have been issues raised. This learning will be pulled through in the action plans in the next section.

4. Staff

RDaSH staff survey results showed that 40.82% of respondents have caring responsibilities. However, only 53 staff have declared this on ESR. There are multiple reasons for this which we need to explore, but the disconnect in data does mean that there are issues in how we understand the size and impact of carer need in the staff we work with.

Our aim is to initially increase the number of people who report that they are a carer. This has multiple stands including ensuring people are aware that there is an ask to record carer status, to what the impact may or may not be if a carer status is recorded.

In addition to staff recording, we have considered our learning from our initial staff carer network events when we have considered who has attended and who has seen themselves as a carer. The sessions have dominantly been attended by staff who identify as female (i.e. there has only been one male and this is the Exec sponsor). In addition, attendance has been predominantly from staff from a white ethnicity. We know this attendance is neither reflective of our workforce demographic or carer responsibilities so we have already started taking action in terms of promoting the benefits of declaration, the value of the carer's network, and the importance of completing the carer's section in the wellbeing passport.

As with the patient section above we have had some discussions with our staff inside and outside the carers network about some of the reasons they do and don't declare, these are some of the responses we have seen –

- Some staff have provided feedback that dependent upon the type of care they provide changes the way they feel they are differently treated, for example people have said there is more sympathy and support for their parental role rather than roles of supporting aged parents or disabled adults.

- Some staff have stated that they have applied for adjustments including flexible working due to their carer role, and this has been declined and so they do not see the benefit in declaring their carer status.

- Some staff have discussed the misconceptions and prejudice seen in terms of home working requests for some days. They accept that some roles cannot accommodate home working and this is not under debate. However, some managers have stated that if a person requires some more home working due to caring that they are not working fully and are looking after others. These carers have stated that this is not the case, however home working has enabled them to complete activities associated to care (i.e. medication administration, hygiene care and pharmacy collection) in breaks and dinner half hours if they are home working.

5. Recommendations

The Board has previously agreed success measures for the promise.

1. Achieve Carers Federation accreditation for the Trust.
2. Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.
3. Identify most and better support all unpaid carers in our workforce, recognising those carers traditionally excluded.
4. Identify all-age carers that use our services and ensure their rights under the carers act are recognised and referred for support no later than January 2026.

These actions are important to enable us to show and transact actual change. However, the way we measure the experience of the change and enhanced carer support will be an equally important measure of success. Therefore, we will consider the feedback in terms of Friends and Family Test, Care Opinion, our staff pulse check, our Schwartz Rounds and our staff meetings/1:1s as we progress.

The success action plan (appendix 1 follows overleaf):

Success Measures	Action	Timeline	Metrics
1. Achieve Carers Federation accreditation for the work that we do across the Trust.	Initial meeting with the Carers Federation.	4 June 2025	To achieve full accreditation by December 2026. (Up to 18 months process)
	Booking form and agreement signed off and sent back, requisition raised and awaiting payment.	18 June 2025	
	Initial development plan meeting scheduled, this should give us a structured work plan of what areas we need to address	1 August 2025	
	Launch the carers plan with specific milestones advised by Carers Federation. Including engagement and communications plan.	August / September 2025	
2. Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	To connect with the High Therapeutic Task Force and explore within the TOR	August 2025	
	To engage stakeholders to meaningfully understand what would be helpful for patients, carers and staff	September 2025	
	To assess patient feedback themes and insights using PALS and Care Opinion	August 2025	
	To establish any relevant themes and learning from stakeholder events.	September 2025	
3. Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Establish and grow membership of Staff Carers Network	April 2026	**Baseline**: 24 members at time of Network Launch – February 2025 **Target**: Increase membership to 100
	Promote the availability of the staff network for our working carers through events, social media and available communication mechanisms	May 2025	Programme of events
		Feb 2025 and ongoing	Messages shared via Communications

Success Measures	Action		Timeline	Metrics
			May 2025	Dedicated Intranet page https://intranet.rdash.nhs.uk/support-services/organisation-development/equality-diversity-and-inclusion/staff-networks/carers-inclusion-network/
	Encourage our staff carers to declare their caring responsibilities on ESR so that the organisation can better understand the number of working carers who may require additional support at some point		On-going and as below	**Baseline:** 53 employees declared on ESR at time of Network launch – February 2025 **Target:** 100% increase across all Care Groups
	Promotion of ESR functionality to declare caring responsibilities and increase declaration rates		April 2026	
	Explore video message from CH outlining the importance of declaring status		September 2026	
	Promote Wellbeing Passport to be completed by all Carers (link to CH video)		September 2026	
	Utilise the network to access information and resources via guest speakers, etc to better support our members		April 2025	Programme of Guest speakers (in response to network members) arranged for 25/26
	Provide a dedicated and safe space for peer support for our working carers	Network meetings	Bi-monthly meetings for 2025/2026	Meetings are taking place during LHD's
		Dedicated Mailbox	April 2025	Mailbox established

Success Measures	Action		Timeline	Metrics
		Dedicated teams channel to disseminate information and for carers to ask questions / hold discussions	April 2025	Teams channel created and monitored daily
		Monthly virtual coffee drop-in sessions	August 2025	
	Work with the organisation to ensure that any policies scheduled for review and potentially impact on our carers should evidence co-production and drawing on lived experience from our network members.	Patient and Carer information policy review	September 2025	Policy will be distributed via the team's channel prior to the LHD meeting in September to receive any feedback
	Providing a mechanism for our working carers to share their concerns regarding their caring responsibilities and support from the organisation	Themes, trends and learning captured through the development of an issues log dedicated to issues raised by working carers.	April 2025	

Success Measures	Action		Timeline	Metrics
	Ensure staff are supported in identifying flexible working opportunities to support them with their caring responsibilities. Nominated HR representative to attend Network meetings and be available for advice and guidance to Network members		June 2025/ ongoing	
	Ensure managers are confident in supporting their Teams if they identify that they may require some adjustments in terms of their caring responsibilities, particularly in terms of exploring flexible working opportunities	Undertake baseline survey to managers regarding level of confidence	TBC	Dates will be confirmed and timelines set as part of the Carers Accreditation plan in August 2025
		Carers awareness training managers via LHD sessions (carer stories, myth busting, facts and figures	TBC	
		Potential module for managers via accreditation work (Carers Federation)	TBC	
4. Identify all-age carers that use our services and ensure their rights under the carers act are recognised and referred for support no later	Carers Assessment	Make offering a carers assessment a mandatory question – two-part question: do you have a carer? and shall we refer your carer for a carers assessment?	Q3-Q4	
	Always Measure	Develop clear guidelines for all staff to show the process of recognising and signposting for Carers Assessments – See Always Measures – AM3 & AM4	September / October 2025	

Success Measures	Action		Timeline	Metrics
than January 2026.	Promise 6: poverty proofing	Our services work with Citizen's Advice to ensure, as part of Poverty proofing for our communities, that this includes our carers		
	Establish links with local authorities to understand and document the process for both young carers and adult carers. Each authority has a different process.	Engage with each LA to understand their process • Doncaster's Carers Wellbeing Service (previously carried out by Making Space) • Rotherham Council and VCSE's - https://rotherhive.co.uk/carers/ • North Lincs – Also council lead https://www.northlincs.gov.uk/people-health-and-care/services-for-adults/ Live Well North Lincolnshire webpage	August 2025	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 14 – Delivering a 4 week wait for all referrals	**Agenda Item**	Paper R
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Richard Chillery, Chief Operating Officer and Victoria Takel, Deputy Chief Operating Officer		
Meeting	Board of Directors	**Date**	24 June 2025

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

The Board have had periodic updates on the progress of the management of waiting lists since November 2023. This paper is however about waiting times. Planned emphasis and funding has been provided to meet the four week wait time promise and sustain it from April 2026. It is acknowledged that further work is needed on neurodiversity and this will return to the Board in September.

Discussions will take place with teams in July delivery reviews, as they did in May. The paper outlines the route to delivery for services to achieve 4 weeks wait for all referrals by April 2026 (Promise 14). We have expanded the number of waits across pathways to bring more visibility and sustained improvement and several services are achieving this presently. The paper then timetables when others will meet this mark. A small number of services do not yet have a route to delivery. Recognising that this is not agreeable, and that the Trust may divest itself of non-compliant services, work continues with those teams to achieve a route to success – this work will be complete by the end of August. The Board should note the planned discussion at the August Clinical Leadership Executive regarding secondary waits for some therapy pathways.

Previous consideration	
Not applicable	
Recommendation (delete options as appropriate and elaborate as required)	
The Board is asked to:	
NOTE the timetable of delivery outlined	
RECOGNISE the identified non-compliant services and timetable for further review	
ACKNOWLEDGE work to define secondary waits, recognising that the commitment made by the Board must be the one our patients experience	
Alignment to strategic objectives (indicate those that the paper supports)	
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
Alignment to the plans: (indicate those that this paper supports)	
Equity and inclusion plan	X
Quality and safety plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	176
	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	240/ 242/ 248/ 325/ 337/ 341/ 361/ 085
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	346/ 293/ 276

	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	346
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	225/ 220/ 105/ 207/ 190/ 218/ 373/ 376/ 292
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	332/ 201/ 274/ 075/ 122
	Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	153
External and partnership risks	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	081/ 378
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	286/ 352/ 379

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR2, SDR3, SDR4							
System / Place impact (advise which ICB or place that this matter relates to)							
Not applicable							
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 – Trajectories by service							

Rotherham Doncaster and South Humber NHS Foundation Trust
Board of Directors – July 2025

Promise 14 – deliver a four-week maximum wait for all referrals from April 2026.

1. Introduction

1.1 A paper was previously presented to the Board of Directors in January 2025, outlining the Trust's waiting list position at that time. That report also highlighted several services that had submitted investment bids through the Trust's 2024/2025 bidding process and underscored the need to develop clear service-level trajectories. These trajectories are essential to deliver against Promise 14's pledge to "deliver a four-week maximum wait for **all referrals** from April 2026."

1.2 Since January, further progress has been achieved. This paper provides an update on that progress and sets out a roadmap detailing the number of services anticipated to meet the four-week maximum waiting time by October 2025, December 2025, and March 2026. It is important to note that these timescales are based on trajectories utilising data from 2024/2025. A sustained or sudden increase in referral volumes, which we are seeing in a small number of services (e.g. podiatry and CYP neurodiversity) or unforeseen changes to available clinical establishment may impact these projections over the course of the year.

2. Progress to Date and Forward Look

2.1 Since the last report to the Board, significant work has been undertaken to subdivide services into additional pathways. The total number of pathways monitored has increased from 41 to 74, enabling more focused improvement efforts both at the service level and within specific pathways. This has been a deliberate move to support more detailed focus on the specific element of care patients are waiting for. This also highlights the complexities within a mental health context for waiting list visibility as often is not linear pathway such as in acute elective services.

2.2 Further plans are in place to potentially expand some pathways further for reporting purposes and due to Care Group complexities —particularly in Talking Therapies, Memory Services, and Primary Care in North Lincolnshire. This will further allow more targeted intervention and support in areas requiring intensive improvement to achieve the four-week standard.

2.3 At present, 27 pathways are sustainably achieving the four-week maximum waiting time. There are 45 pathways expected to achieve a maximum wait of 4 weeks by October 2025 that are currently working through small backlogs, whereas the pathways expected to achieve a maximum wait of 4 weeks by December 2025 (59) and March 2026 (70) are requiring intervention in the form of job planning, increasing productivity, and pathway redesign. This list is not exclusive. Some of these pathways, for example CMHT, Memory and Learning Disabilities services in Doncaster, are at a higher risk for achievement because of the scale of the improvement work required. The table below sets out projected improvements across the Trust, with further detail by service included in Appendix 1.

4WW Summary position as at 20th June 2025			Projection of Achievement by Team		
Locality	Directorate	Team	Oct-25	Dec-25	Mar-26
Rotherham Mental Health	0/2	5/13	8/13	9/13	13/13
Doncaster Mental Health and Learning Disabilities	0/3	2/11	6/11	9/11	11/11
North Lincolnshire and Talking Therapies	1/3	4/8	4/8	6/8	8/8
Children's	0/2	14/25	21/25	24/25	24/25
Physical Health	0/2	2/17	6/17	11/17	14/17

2.4 Children and Young People's Neurodevelopment Services, Adult Autism and ADHD services, and Podiatry services are currently identified as unable to achieve the four-week maximum wait by April 2026. That is not to say there is a huge amount of work taking place in these services. However, Neurodevelopment, Autism, and ADHD services have redeveloped their trajectories to reduce waiting times and continue to work to bring waits to an acceptable level. These trajectories still need to be finalised by the CEO and COO. These revised plans are based on recent investment so a focus on digital assessments through 3 potential providers; redesigned pathways with opportunities for more activity being supported by Dr Graham and more estate provision in development so more patients can be seen concurrently.

2.5 Podiatry has experienced a significant increase in referrals from an average of 381 per month January-June 2024 to 462 per month from January-June 2025 giving an overall percentage increase of 21% since January 2025 compared with the same period in the 2024/2025 financial year, which has contributed to challenges in meeting trajectory targets. This could be due to the success in the service in improving access times and some health promotion work that occurred in Q3 24/25. A large proportion of the increase in referrals is for diabetic foot ulcers, so referrals seem to be predominantly appropriate. The service has responded quickly to this change to referral behaviour, updating pathways and creating additional capacity, but if this change is sustained an investment bid may be required to enable achievement of the maximum 4 week wait.

3 Treatment Pathways

3.1 While Promise 14 sets out a clear ambition to deliver a four-week maximum wait for all referrals by April 2026, it also creates an inadvertent risk of increasing waits on secondary treatment pathways. These are those pathways where an assessment has taken place, potentially advice is given so the clock will then stop but are then referred to a secondary treatment with a potential waiting list. These are different to different to waiting lists for referrals – as the referral has been received, then the patient has been assessed or offered a short-term intervention within 4 weeks.

3.2 However, there may be several follow-on interventions which may now build up as we improve the timing of the first line assessment and treatment.

3.3 This is particularly relevant in services such as Talking Therapies (step 3) and several Psychology therapies offers in community services, where multiple

clinicians are involved and a range of treatment options are provided depending on patient need.

3.4 To address this, a separate paper is in development and will be brought forward for discussion at the Clinical Leadership Executive in August 2025. It's likely the paper will recommend that the Trust informally applies national Referral to Treatment (RTT) principles across these complex pathways in a similar way to acute Trusts and included in the Trust Access Policy. This does not negate the ambition to reduce all waits to 4 weeks, even secondary treatment waits but does give a framework by which all parts of the patient pathway can be monitored and analysed. We are anticipating this will only be a small number of secondary treatment pathways and its important this is not seen as an opportunity for other services to opt out of 4 week waits.

3.5 By aligning clock starts and stops in line with RTT principles, the Trust can ensure that secondary waits are monitored appropriately and that patients receive their definitive treatment within 18 weeks of referral, as intended with an ambition to reduce to 4 weeks. These services may subsequently link with future investment rounds but that is yet to be determined.

4 Conclusion

4.1 The Trust has made demonstrable progress in reducing waiting times and establishing the foundations required to deliver a four-week maximum wait for all referrals by April 2026. The expansion of pathway-level reporting and targeted improvement plans is driving sustained performance improvements across multiple services.

4.2 However, a very small number of services remain at significant risk of non-delivery which we have discussed. In parallel, there is now an emerging need to address the management of secondary treatment pathways to ensure patients receive timely treatment beyond their initial assessment.

5 Recommendations

5.1 The Board of Directors is asked to NOTE the timetable of delivery outlined; RECOGNISE the identified non-compliant services and timetable for further review; and ACKNOWLEDGE work to define secondary waits, recognising that the commitment made by the Board must be the one our patients' experience

Richard Chillery, Chief Operating Officer
July 2025

Appendix 1 – Trajectories by service

Improved based on last month	↓
Same not meeting 4 weeks	↔
Meeting 4 weeks	★
Increased based on last month	↑

Adult and Older People Mental Health

Locality	Directorate	Service	Current Waiting Time's as at 20th June 2025								Proposed 4 WW		
			<4 Weeks	4 - <8 Weeks	8 - <12 Weeks	12 - <18 weeks	18-<27 weeks	27-<52 weeks	52 weeks+	Waiting List Direction of Travel	Oct-25	Dec-25	Mar-26
Rotherham	Acute	CARE HOME LIAISON					X			↓			X
		CRISIS TEAM	X							★			
		HOSPITAL LIAISON	X							★			
	Community	18 WEEK RTT TREATMENT TEAMS				X				↓			X
		EARLY INTERVENTION IN PSYCHOSIS	X							★			
		ECT		X						↔	X		
		HEALTH & WELLBEING PATHWAY						X		↓			X
		MEMORY TEAM					X			↑			X
		OLDER PEOPLE'S PHYSIOTHERAPY			X					↓	X		
		OLDER PEOPLE'S PSYCHOLOGY					X			↑		X	
		PERINATAL TEAM		X						↓	X		
		PRIMARY CARE INTEGRATED MENTAL HEALTH HUB	X							★			
		YOUNG ONSET DEMENTIA TEAM	X							★			
Doncaster	Acute	HOSPITAL LIAISON	X							★			
	Community	ADULT COMMUNITY MENTAL HEALTH TEAM					X			↔			X
		ASSERTIVE OUTREACH SERVICE		X						↑	X		
		COMMUNITY MENTAL HEALTH REHABILITATION AOS		X						↔	X		
		EARLY INTERVENTION IN PSYCHOSIS TEAM	X							↔	X		
		PERINATAL TEAM					X			↔		X	
		MEMORY				X				↔			X
		OLDER PEOPLE COMMUNITY MENTAL HEALTH TEAM				X				↔		X	
		PRIMARY CARE HUB				X				↔		X	
		YOUNG ONSET DEMENTIA TEAM			X					↓	X		
	Learning Disabilities	LEARNING DISABILITIES						X		↓			X
North Lincolnshire	Acute	CARE HOME LIAISON TEAM	X							★			
		HOSPITAL LIAISON TEAM	X							★			
	Community	EARLY INTERVENTION IN PSYCHOSIS TEAM	X							★			
		HOME BASED TREATMENT TEAM	X							★			
		MEMORY					X			↑		X	
		PRIMARY CARE SEPARATE OUT ASSESSMENT /				X				↑		X	
		RECOVERY INTEGRATED - SEPARATE OUT						X		↔			X
	Talking Therapies	TALKING THERAPIES				X				↔			X

Children and Young People Mental and Physical Health

Locality	Directorate	Service	Current Waiting Time's as at 20th June 2025								Proposed 4 WW		
			< 4 Weeks	4 - <8 Weeks	8 - <12 Weeks	12 - <18 weeks	18-<27 weeks	27-<52 weeks	52 weeks+	Waiting List Direction of Travel	Oct-25	Dec-25	Mar-26
Rotherham	Mental Health	CAMHS GETTING ADVICE				X				⇔	X		
		CAMHS GETTING HELP		X						⇔	X		
		CRISIS TEAM	X							★			tbc
		EATING DISORDERS	X							★			
		INTENSIVE COMMUNITY SUPPORT TEAM	X							★			
		WITH ME IN MIND		X						⇔	X		
		LEARNING DISABILITIES	X							★			
Doncaster	Mental Health	CAMHS GETTING ADVICE		X						⇔	X		
		CAMHS GETTING HELP		X						⇔	X		
		CRISIS TEAM	X							★			
		EATING DISORDERS	X							★			
		INTENSIVE COMMUNITY SUPPORT TEAM	X							★			
		LEARNING DISABILITIES	X							★			
		LOOKED AFTER CHILDREN	X							★			
		WITH ME IN MIND		X						⇔	X		
North Lincolnshire	Mental Health	CAMHS GETTING ADVICE			X					⇔		X	
		CAMHS GETTING HELP			X					↑		X	
		CRISIS TEAM	X							★			
		EATING DISORDERS	X							★			
		INTENSIVE COMMUNITY SUPPORT TEAM	X							★			
		LEARNING DISABILITIES	X							★			
		LOOKED AFTER CHILDREN	X							★			
		WITH ME IN MIND		X						⇔	X		
All Three Localities	Physical Health	NEURODEVELOPMENT (ADHD AND AUTISM)							X	↑			tbc
		CONTINENCE					X					X	

Physical Health and Neurodevelopment

Locality	Directorate	Service	Current Waiting Time's as at 20th June 2025								Proposed 4 WW		
			< 4 Weeks	4 - <8 Weeks	8 - <12 Weeks	12 - <18 weeks	18-<27 weeks	27-<52 weeks	52 weeks+	Waiting List Direction of Travel	Oct-25	Dec-25	Mar-26
Rotherham	Community and LTC	NEURO REHAB					X			↔			X
Doncaster		COMMUNITY CARDIAC				X				↓		X	
		COMMUITY STROKE REHABILITATION				X				↔		X	
		DIABETES SPECIALIST NURSING						X		↔			X
		DIETETIC	X							★			
		EPILEPSY SPECIALIST NURSING		X						↔	X		
		HOME FIRST			X					↓	X		
		NEURO REHABILITATION					X			↓		X	
		PODIATRY FOOT PROTECTION					X			↓			
		RESPIRATORY SPECIALIST NURSING	X							★			
		SPECIALIST CONTINENCE				X				↓			X
		SPEECH AND LANGUAGE THERAPY						X		↔			X
		ST JOHNS COUNSELLING AND BEREAVEMENT		X						↓	X		
		TISSUE VIABILITY AND LYMPHOEDEMA		X						↓	X		
		WHEELCHAIR AND SPECIALIST SERVICES						X		↔		X	
TRUSTWIDE	Neurodiversity	ADULT ADHD SERVICE							X	↑			TBC
		ADULT AUTISM SERVICE							X	↑			TBC

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Readiness – our next steps	**Agenda Item**	Paper S
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Jim Cooper, Deputy Chief Nursing Officer; Rachel Millard, Interim Nurse Director; Angie Nisbet, Interim Associate Director of Governance; Laura Powell, CQC & Compliance Officer		
Meeting	Board of Directors	**Date**	24 July 2025

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

This paper follows the construction of our draft organisational self assessment and importantly, our day-to-day standard setting against "everyday is a CQC day".

To move self-assessments to goo by November requires us to introduce a small number of impactful changes during August, September and October – and to construct better and more consistent evidence file collation. This paper provides the detail on the Nursing & Facilities' leadership team's plan to:

1. Undertake peer reviews within our 111 community teams.
2. Sharing the learning and cross pollination between directorates, against the 4 CQC domains – 'time to share'.
3. Digitise our evidence lockers and check & challenge them across the directorates for consistency.
4. Detail our delivery plans that will move towards good across safe, effective and responsive by November 2025, setting the outstanding rating for caring.

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

N/A

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

DISCUSS the proposed action plans and the timescales proposed

NOTE the process and timeline for delivery

Alignment to strategic objectives (indicate those that the paper supports)	
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	x
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Alignment to the plans: (indicate those that this paper supports)	
Estates plan	x
People and teams plan	x
Quality and safety plan	x
Education and learning plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	127
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	277 / 282

Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	319 / 227
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
	Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	146

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
Not applicable							
System / Place impact (advise which ICB or place that this matter relates to)							
Not applicable							
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 – 24 July 2025
CQC Readiness

1. Executive Summary

This paper outlines the next stage of our CQC readiness programme, following the Board's May 2025 review of our self-assessment across the four CQC domains. It details the transition from self-evaluation to a structured, evidence-based model, supported by digital tools, peer reviews, and delivery plans. Our goal is to achieve and sustain a 'Good' rating across all domains, with an ambition to achieve 'Outstanding' for Caring by 2026.

2. Introduction

This paper follows the agreement from the previous board of directors in May 2025, when the Board were provided a detailed review of our self-assessment process across the **four domains**; **safe**, **caring**, **effective** and **responsive**.

Here we provide the next significant step in our plan, transitioning from our self-rating to the detail and evidence, via the delivery of the actions below:

Action 1

- Review our CQC evidence lockers to bring consistency to the information we are benchmarking against the domains of safe, caring, effective and responsive.
- Ensure all data, evidence, minutes, celebrations, RADARs have a front sheet to explain the context of the evidence. To include domain relevance, learning, improvement, sharing.
- Our process for evidence lockers and progress this to the use of AI and cloud/shared access – digital solutions.

Action 2

- Undertake peer reviews within our community teams
- Hold the time to show (share and shine) event – rescheduled due to EPPR planning with heatwave. Date to be agreed at the next CQC readiness meeting.
- Detail our delivery plans for each directorate within each care group, to get us to an overall good position, sustainably, and outstanding for caring.

3. Quality Peer Reviews (QPRs) and proposal to implement community peer reviews

Quality peer reviews are currently undertaken in all our bed-based services. These take place every month and include, Nonexecutive Directors, volunteers, peer support staff/workers and other independent team members, such as FTSU guardian.

The process for quality peer reviews that mirror our current model for inpatients is being coproduced for our community areas, this coproduction with peers, patients and directorates is vital. A draft template has already been designed, we have now shared this with directorates to iron out some of the differences to accommodate our community teams in children's, district nursing, health visiting, forensic, school nursing, wheelchair, tissue viability teams.

To ensure we keep the momentum from our work to date this year going, I am pleased to inform board that pilots are being undertaken to test out both the template and the methodology. This will be in Rotherham assertive outreach teams and care home liaison and plans are in progress to cross-review crisis and home treatment, and hospital liaison teams across the 3 geographical locations.

There are currently **111** community teams, and it would be unfeasible to run the reviews following the same methodology as the inpatient reviews in the first instance. Therefore, within a PDSA cycle we will make the necessary adjustments and learn as we do, rather than waiting to learn.

The templates for all QPRs are in the process of being developed on RADAR, which will provide a more effective and efficient solution to the reviews, which will enable immediate production of actions, and real-time feedback via the analytics within the system.

4. Timeline:

July 2025 Planning meetings with Radar and Health Informatics

Aug-Sept 2025 Initial pilot of template and methodology – schedules, number of reviews, visiting review team

September 2025 Review of findings from pilots and methodology
Agreement by CLE to methodology.
Testing in Radar

Oct-Nov 2025 Roll out of the QPRs schedule

Number of community teams per directorate (including Crisis and Home Treatment Teams, and Hospital Liaison Services in Acute directorates)

Directorate	Number of teams
Learning Disabilities and Forensics	5
Doncaster Community Mental Health	20
North Lincs Community Mental Health	5
Rotherham Community Mental Health	10
Doncaster Acute Mental Health	2
North Lincs Acute Mental Health	2
Rotherham Acute Mental Health	3
Neurodiversity	2
Community Physical Health and Long-Term Conditions	19
Rehabilitation	14
Children's Physical Health	18
Children's Mental Health	7
Talking Therapies	4

5. Evidence Libraries

Directorates are at varying stages of maturity in respect of their evidence libraries. All our evidence libraries are digital, utilising network storage to hold these within our internal network.

There is currently a scoping exercise to review whether we could migrate evidence libraries to the new RADAR system, or a cloud-based platform such as SharePoint. At this stage, a DPIA has been completed to scope SharePoint and is awaiting review, RADAR would be the preferred option.

6. Review of Care Groups Evidence Libraries

As part of our ongoing ratification of our self-assessments and evidence libraries, a review has been undertaken by Laura Powell and Angie Nisbet of each care groups evidence library to understand our baseline position, and to support a consistent approach to evidence libraries across the organisation. A summary of the review undertaken is detailed within the remainder of this section. Care Groups are completing a gap analysis of their current recorded evidence, to be reviewed and approved at their monthly quality/ business meetings.

Care Group	Directorate	Methodology	Status	Governance
Doncaster Physical Health and Neurodiversity	Community and Long-Term Conditions Rehabilitation Neurodiversity	Using the evidence register template provided, logging the evidence against the 5 CQC domains, by evidence type hyperlinked to the evidence in a folder.	• Each directorate has a separate register and evidence folders. • Evidence is saved in the evidence folders and hyperlinked on their register to these folders. • At the time of the review, there was variation in use of the register between directorates, with Neurodiversity showing fewer items of evidence than the others; this had already been identified by the Director of Nursing and being addressed.	• All staff have access to the folders and team leaders are responsible for oversight. There is no description of the process in each team for logging and reviewing. • Registers will be reviewed as a standing agenda item on directorate review meetings and quality meetings to give an opportunity for check and challenge.
Children's Care Group	Children's: Physical Health Mental Health	The care group use an evidence register template and have used this for some time prior to this being requested corporately. The evidence is logged against the 5 CQC domains and a hyperlink to the evidence in a folder. Work is currently in progress within the care group to refine the storage of evidence on the L drive to improve efficiency and to identify any evidence gaps.	• Each directorate has separate register and evidence folders. • Evidence is saved in the evidence folders and hyperlinked on their register to these folders.	• All team leaders and service managers have access to the folders and the registers and oversight in terms of managing the register is by the PAs. • The registers are reviewed regularly at Safety and Quality Directorate meetings, and it is an agenda item on the SLT meetings where they will review if there are any gaps in evidence for any KLOEs. • All teams are fully aware of the need for evidence and are encouraged to send items forward for logging.

Care Group	Directorate	Methodology	Status	Governance
	Community Services		Admin support has been identified, and the libraries have been progressed by the Matron, meeting have been held with each team to ensure requirements are understood and evidence provided. The admin support holds the central library and all teams provide evidence.	The Matron review the libraries to check and challenge with teams, but it is still in early stages. CQC is a standing agenda item at quality meetings where this is discussed.
Doncaster Mental Health and Learning Disabilities	Acute services	There is variation across the directorates with the use of a single overarching register, as provided by Laura Powell. However, this is being addressed to ensure that this is in place. Folder structures are in place in which evidence is being stored. Directorate not covered by CQC inspection process so have not started the evidence library process until recently. They are utilising the standard template provided by Laura Powell.	Evidence library in progress.	The Matron review the libraries to check and challenge with teams, but it is still in early stages. CQC is a standing agenda item at quality meetings where this is discussed.
	Learning Disabilities and Forensics		A library structure is in place with folders per service and then per CQC domain. Evidence had been stored in most cases but with some gaps. Admin have been identified who will be tasked with picking up gaps in evidence with teams to ensure completeness. No overarching register was in place for this directorate at the time of review but is being put in place with immediate effect.	
	Talking Therapies		Evidence library in progress.	
North Lincolnshire Care Group	Acute Services	Have a comprehensive wRord document with the CQC domains listed and numerous files/links embedded. It was suggested that an overarching register to link all this more effectively together is considered.	A library structure is in place with folders per service and then per CQC domain.	Matron to action.
	Community Services	No overarching register is in place and it has been suggested that this is utilised.	A library structure is in place with folders per service and then per CQC domain. All teams save evidence to these.	Matron to action.
	Acute Services	Overarching register is in place	All teams are contributing to and reviewing the register to ensure evidence is being logged. Admin support keeping the register up to date.	Matrons forming a collective sharing forum to learn together and standardise data collection for consistency – part of HQTC.

Care Group	Directorate	Methodology	Status	Governance
Rotherham Care Group	Community Services	No evidence library is currently in place, but this is being progressed by the Matron utilising the standard library register template provided.	Matron is meeting with other matrons to discuss adoption/adaption of their index. Admin support being explored.	Service manager to action.

7. Directorate/ Service Level Delivery Plans

The care group senior leadership teams are leading the development of local delivery plans, and this will enable services to move from the self-assessed and triangulated ratings of 'requires improvement' to 'good'. Where services are rated as good, we are supporting and working to maintain this position through service, directorate and care group delivery performance reviews. Currently, there is variation in the delivery plans and oversight of the evidence libraries, and this is where Nursing and Facilities are 'leaning in' to those areas.

A delivery plan tracker has been shared with the directorates to identify plans and timescales to move any criteria rated RI or below to Good. An example of the tracker, for one action in relation to safe and effective staffing, for the Doncaster physical health and neurodiversity rehabilitation directorate is shown below.

Care Group: Doncaster Physical Health and Neurodiversity

Directorate	Self Assessed Rating	SAFE Improvement Action	Milestones Lead	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Quality Statement Safe & Effective Staffing
Rehabilitation	Good	There are appropriate staffing levels and skill mix to make sure people receive consistently safe, good quality care that meets their needs:	Rose Robinson smith								✓
		Review of the roster authorisation and justification of bank staff requests. The application of the acuity tool to inform clinical judgement for safer nursing care tool data collection									
		Agreement of the principles of staff staffing and bank staff usage. Implementation of Safecare. Review of the ACP input onto the ward is progressing to inform the review of the future needs and who provides the escalation element. Observation of the ward routines by external observer commissioned by R Chillery.									
		Continuous monitoring of the processes agreed. Bank usage is appropriate and affordable. Monitoring of patient safety incidents related to safer staffing factors - learning and any actions identified. Defining of the ACP input across a 7 day period. Any clinical skills gaps for the ward staff to aid appropriate clinical decision making and escalation will be identified and a plan to address agreed.									
		Implementation of the clinical input defined and progression of the development of ward staff. The implementation of the right level of ACP input onto the ward with a defined scope and capacity.									

The significant focus and areas of improvement are in the delivery plans:

8. Consent, including mental capacity assessment (MCA)

The Mental Capacity Act 2005 (MCA) requires health and social care professionals to assess capacity and determine best interests for an individual who lacks capacity to make a specific decision. MCA and Deprivation of Liberty Standards (DoLS) are a priority area for the Trust with a focus on having minimum standards and having clarity for when these must be applied.

The Trust will also create a clear corporate audit process to assess the deployment of these standards. The recent MCA audit has inadequate outcome, and the Directorates were involved in the development of an action plan.

The MCA lead is responsible for:

- Development of MCA/DoLS standards
- Provision of MCA assessment guides and templates
- Undertaking audit of adherence to standards
- Provision of MCA/DoLS training

Alongside the granular actions our safeguarding team are undertaking, there is a need for a review of our MCA functioning both in backbone services and clinical care. Since transfer over from the CMO portfolio to N&F, the MCA function has reduced to a half time single role, creating less resource and a potential single point of failure. As such with increases in the safeguarding team; MASH and MARAC roles, and post the 360 audit of safeguarding governance, there will be an independent review of our organisational functioning. This is where N&F will establish their improvement in terms of **effectiveness** and **well-led**.

The backbone Nursing team are now moving to support each directorate to:

- Identify MCA champions in every service/Directorate
- Ensure that the champions have capacity to attend the MCA forum, initially to be held monthly, then moved to quarterly meetings
- Champions to disseminate the MCA standards across their service/directorate
- Ensure MCA standards are adhered to including that quality MCA assessments and Best Interest Decisions are recorded on the electronic patient record
- DoLS applications are submitted where required and recorded on the patient record
- Ensure colleagues are compliant with MCA training

The overarching delivery plan timescales are in Table 1 as follows:

Table 1

Action	Action owner	By when
Identify MCA Champions from each Directorate	Nurse Directors/SLT	31.07.25
MCA Champions Network Meeting	MCA Lead	31.08.25
Development of train the trainer MCA/BIA package	MCA Lead	31.10.25
Identification of training around executive functioning, fluctuating capacity and non-engagement in the assessment of capacity	MCA Lead	30.09.25
Review the current training offer including mapping of competence requirements	MCA Lead	30.09.25
Review MCA templates on S1	MCA Lead	31.03.26
Develop resources and guidance for colleagues	MCA Lead	31.03.26
Dip Sample audit	Directorates	31.03.26

9. Personalised care planning and risk assessment

There are currently three main workstreams in progress, these are significantly aligned to all five CQC domains, and as such this paper will detail the ‘hand and glove approach that considers how we are ‘drafting’ so not to cause pilot-itus or duplication-etes.

10. Higher Quality Therapeutic Care (HQTC)

Our Chief Executive has articulated the change model to implement inpatient service transformation in previous reports to Board. Significant progress has been made and will include a review the pattern of clinical meetings on each ward that support care planning.

A pilot commenced on Sandpiper ward 14 July 2025, at this stage this will be focussing upon the meetings schedule and daily MDT. Care planning will feature a key component of this work, which is a consistent

feature in what we know needs to improve for patients; how we complete them, when we complete them, updating of care plans, and ensuring that it is led by the patient, their words, their impact and shared with them in a meaningful way (audible, easy read, preferred language).
Alongside this ensuring there is one care plan, not multiple versions of different things, linkage to risk management but not 'copy and paste'.

The HQTC work will include the implementation of:

- Specific patient reported outcome measures for inpatient mental health wards by September 2025, this includes ReQoL, GBO, dialog/dialog+.
- Dr Graham and Dr Sinclair have implemented an escalation process for patients with a length of stay 15 & 32 days.
- Jon Rouston leads on the personalised therapeutic timetable of care, ranging from bespoke to group recreational activity for patients requiring more social level support. The latter is planned to be introduced by end October 2025.
- Our 'always measures' had a first preview at HQTC, with a real embrace of the five things we will always do when we have contact/therapeutic intervention with our patients or when a patient requests: review of their risk assessment, care plan, consent, carers contacts, carers assessment and recording of an unmet need.
- Our 9 themes from learning from our PSII (2024/2025) have been shared and for consistency link in with all of this work, the always measures paper to HQTC correlates the 9 PSII themes, RCPsych standards and our promises!

11. Review of assertive and intensive outreach services

This programme of work has oversight of the South Yorkshire & Humber ICBs, led internally by the Richard Chillery, COO and transformation team. The focus of the project is primarily personalised care planning (PROMs).
This includes dialog/ dialog+, risk assessment and urgent access to services/engagement/disengagement. This work is again supported by the strategic objectives, linked to our RDaSH promises and not just another 'to-do' or ask from national. We have started to deliver on this and learn from the recent national investigations. We also have started as part of this work, to implement learning from an independent investigation PSII 2024/25 with linkage to MCA, ASD, carers support/assessment and care planning.

12. Promise 14 Managing and validating waiting lists

Delivery of Promise 14 is in part, a benchmark for us to self-rate our **effectiveness**, **responsiveness** and **safe**. As our strategy is framed, we are wanting to not only ensure a responsive service for all, relating to both promise 6 & 7.
Our care groups understand this, and they are being supported by information and other backbone services to analyse their data and take action. This may include delivery plans to ensure services are better equipped. One example of this would be: - the provision of access to interpreters and multi-language written material, another being that staff are trained adequately to be dementia and autism knowledgeable and practically equipped.

13. Key milestones remain:

July's milestones are threefold

- cleansing of care group vaults
- digital solution for care group vaults and most importantly
- check and challenge of evidence vaults

August is the stage for our community teams, ward staff, corporate staff to be testing out other directorates data, with a see, show and share approach.

21 August learning half day will have 3 support sessions all 60 mins duration covering:

- Local Governance for CQC
- Building your local evidence libraries
- Open Q&A re CQC preparedness

We are however aware that August is a holiday period, and therefore there may be some leave that can delay this process, we will be monitoring this via delivery reviews and CQC engagement meetings.

September we will reconvene and regroup on the actions of each of the 13 Directorates. Seeing the extensive lean-in from nursing backbone and the do with PDSA cycle.

October will be the internal reassessment peer review – this will include the check and challenge process exercise we did in April/May: cloud-based vault, peer review reports, culture of care/RCPsych standards, self-assessment, triangulation of RADAR, any feedback from MHA inspection visits, care opinion feedback, numbers of volunteers in teams, workforce metrics and attainment to our strategic objectives evidenced in directorate delivery.

November escalation to delivery reviews via Chief Executive on areas that remain in 'requires improvement' or lower.

The overarching delivery plan will detail each directorate's plans to get from RI> Good, and to outstanding by 2026 for caring. Alongside this will be the detailed delivery plan for the focus areas for improvement Trust wide. This detail will form part of the discussion in the CQC readiness meeting 29 July 2025 and a further update to the BoD will be provided in September 2025.

*Please not that there is a 'Learning Update Paper' also served at the Board of Directors in July 2025 which should be read in conjunction with this paper and timeline, as this has activities that has actions linked with the CQC domains (specifically well-led) which are also enabling of actions within this paper.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Plans for Approval: People and Teams Plan Digital Enabling Plan	**Agenda Item**	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Carlene Holden, Director of People and OD & Richard Banks, Director of Health Informatics		
Meeting	Board of Directors	**Date**	24 July 2025

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

The Board of Directors will recall previous discussions relating to these plans. The People and Teams Plan was considered in our timeout in April, and the Digital Enabling Plan most recently featuring in the June Timeout session (the NHS Digital Board session). Both plans are congruent with the plans agreed to date – learning and education, quality and safety, and equity and inclusion.

These continue the sign off process for the overall suite of eight plans and these represent key plans, pivotal to the delivery of our Clinical and Organisational Strategy. Our colleagues are our precious resource that we will continue to "attract, belong and cultivate". Digital encompasses much more that simply IT and the successful delivery of the plan will support our colleagues, through transformational improvement and create efficiency and effectiveness in technology and process – through the availability and use of quality data.

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

Previous consideration

Previous Board timeouts in 2024/2025

Recommendation

The Board is asked to:

X	**APPROVE** the People and Teams and Digital enabling plans
X	**ASK** relevant Board committees to have oversight of their delivery in line with their already agreed terms of reference
X	**REQUIRE** adaptation of routine governance reporting from Q2 to provide the Board with regular visibility on progress with non-promise related elements of these plans

Alignment to the plans: (indicate those that this paper supports)

Digital plan	X
People and teams plan	X
Learning and education plan	X
Estate plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X

Performance risks	Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
	Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
People and Teams Plan – elements support the actions to address all SDRs Digital Enabling Plan – SDR2							
System / Place impact (advise which ICB or place that this matter relates to)							
None							
Equality Impact Assessment	Is this required?	Y		N	N	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	N	If 'Y' date completed	
Appendix (please list)							
A – People and Teams Plan B – Digital Enabling Plan							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Purpose

1.1 This paper is prepared to support endorsement of two further plans, continuing from the approval of the L&E document in July 2024, and Q&S and E&I plans in May 2025. We would expect to put the final R&I, estate and finance plans to the September Board. In the case of the R&I plan we want to be able to focus on discussing innovation at our Leaders' Conference on 30 September.

Introduction

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

2.2 But the Board envisaged in agreeing the strategy, that some further plans would ensure that we had balance across other areas of work, and in reforming our enablers to deliver the new organisational vision.

3. People and Teams Plan

3.1 The plan is specifically focussed on People and Teams rather than solely employees. We recognise we have a diverse range of colleagues, whether they be employees, students, atypical workers, volunteers or Peer Support Workers to name but a few. The plan includes all of the RDaSHian colleagues to further enhance the care which we provide and to support the culture of the Trust – given our people are the foundation of our teams.

3.2 We recognise that the plan retains what works well at the Trust, not all is changing such as the ABC model (Attract, Belong, Cultivate) but the plan is ambitious and identifies the top ten measures, that all of our Directorates will be measured upon which reinforces our Think Directorate approach.

3.3 The plan purposefully focusses on teams and leaders at all levels, to enhance the working conditions of colleagues across the Trust. We recognise the investment and development our colleagues deserve and the plan reinforces our unwavering commitment to fully utilising our training budgets and apprenticeship levy to develop our colleagues, to recruit from our local communities (fully staffed) and to 'future proof' our skill sets reflecting the changing landscape nationally. The plan does already cover some requirements of the 10 year health plan.

3.4 All colleagues have a voice within the Trust, the Staff Survey and the Quarterly Pulse check will serve as the vehicle to understanding the employee voice, with the Quarterly Pulse extended to also include volunteers (which will represent nearly 10% of our workforce and will continue to grow), alongside the direct feedback from colleagues at the Trust People Council across all colleagues to further enhance the way we do things at RDaSH.

3.5 As with all of our plans, a number of organisational promises form part of the plan - the introduction of peer support workers into every service; the delivery of Real Living Wage accreditation, and successful and meaningful delivery of our anti-discrimination plans.

3.6 The People and Teams plan will be widely socialised with RDaSHians as this a key plan for colleagues to understand their part in the RDaSH jigsaw and what it means/what to expect as an RDaSHian.

4. Digital Enabling Plan (DAP)

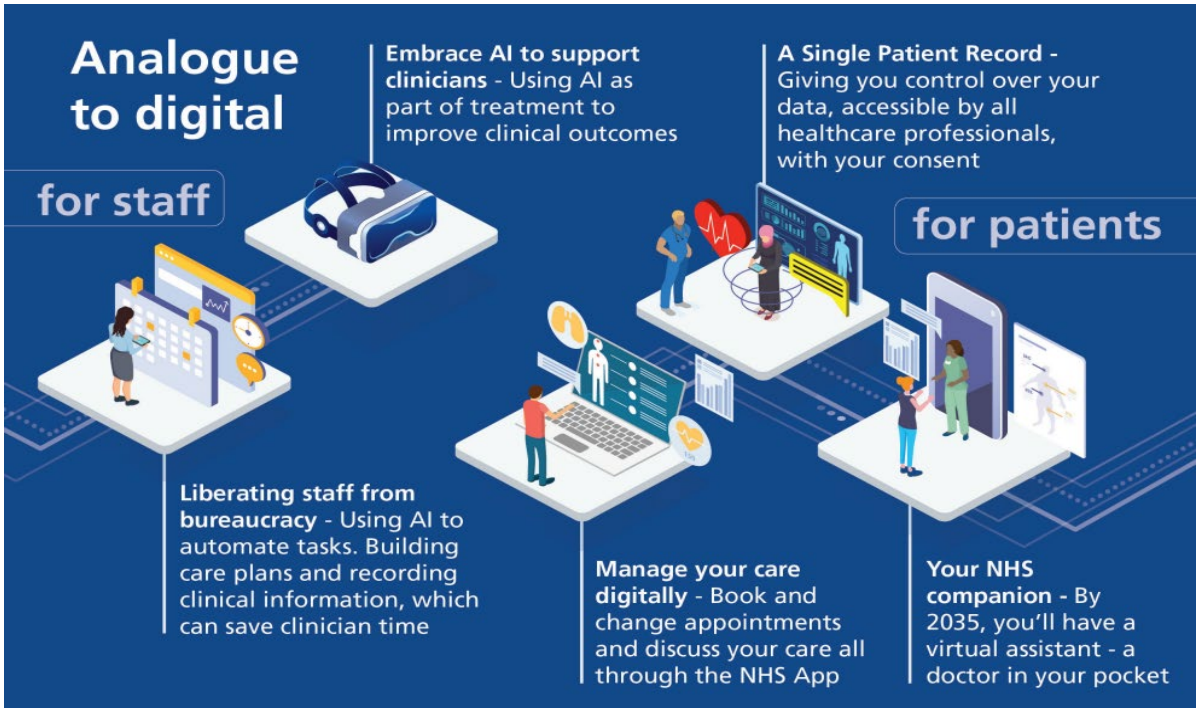
4.1 The draft Digital Enabling Plan 2023-2028 has been subject to scrutiny through a number of forums, groups or committees in the Trust's structure, adding value and developing the plan.

4.2 For the Board development session in June, which included a facilitated 'digital' component, the draft Digital Enabling Plan was circulated as prereading. The high-level ambitions of the plan are identified as digital improvements to support the delivery of our 5 strategic objectives and our enabling plans.

4.3 The Plan supports **the Digital RDaSHian** by providing a framework for enhanced digital infrastructure, improving data accessibility, and streamlining processes to deliver better, more efficient healthcare services.

4.4 Through a series of **'we will' statements**, the plan provides direction in terms of our aims for our patients and the services we deliver. Similarly, our aims for staff, both clinical and backbone are also described this way.

4.5 The draft Digital Enabling Plan is **consistent with the aims of the section of the new NHS 10 Year Plan** 'Fit for the Future – 10 Year Health Plan for England'. From Analogue to Digital, Power in Your Hands, describes five areas for development and improvement:



5.6 The Trust has identified Artificial Intelligence (AI) and Robotic Process Control (RPA) as key areas for discovery and rapid onboarding work, enhanced through active pilots and engagement with wider NHS and industry.

5.7 The DAP identifies development of and access to **the patient record** as a key enabler. The Trust already benefits from a multi-level electronic patient record (EPR). With the appropriate sharing arrangements in place, clinicians are able to view patient records created at both primary and secondary care level. Access to the Yorkshire and Humber Care Record provides data provision and consumption which allows clinicians to access certain data recorded in other local healthcare providers. Our position and direction of travel clearly aligns with the NHS plan, which aims to take this a step further, creating a Single Patient Record.

5.8 The benefits of enabling people to **manage their care digitally** and to book and change appointments themselves, is a feature referred to in the DAP as Patient Facing Apps. The ability to transact directly with the Trust's services is an efficiency improvement opportunity that should result in **shorter waiting times**, and a **reduced number of DNAs**.

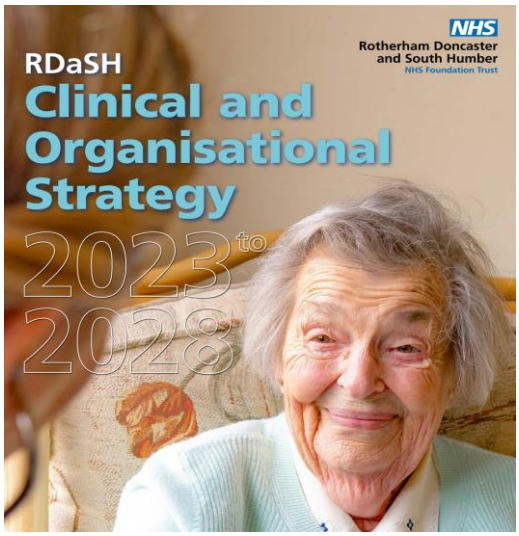
5.9 In addition to metrics included associated with the ambitions included above, the draft DAP also includes **key success measures**, incorporating data quality, digital capabilities, website accessibility, IT support service accreditation, and data protection and cyber security.

5.10 One of the key reflections from the June Board development session was a shared understanding that digital is **whole Board business**. Further reflections indicated an appetite for the Board to provide oversight of the Trust's position and future developments associated with cyber security, the benefits of automation [RPA/AI], accessible data, clinical and human centred solutions including self-help. The draft DAP provides a framework where these aspirations are in-scope and with sufficient flexibility to build and develop excellence in these areas.

Toby Lewis, Chief Executive

16 July 2025

2025 – 2028 People & Teams Plan



The context to our plan

The culture of our organisation, system, and of our NHS matters. It is the context in which our work is shaped, in which we learn, and in which we fund value and reward for what we are able to bring. A culture is our way of life. It involves our values, beliefs, aims and actions. Supporting and adapting that culture is essential to delivering compassionate and meaningful care. We are looking to change our culture, through the restorative, just and learning culture approach, and our work to strive to become an anti-racist organisation and to deliver the wider commitments of Promise 26.

Teamwork lies at the centre of the care we provide, and the support offered by backbone colleagues. Many people within the Trust will be members of a variety of teams, and over a career with us those teams will change. As we look to offer more consistent models of care, we need to be skilled in creating teamwork, whether that is with longstanding colleagues or those who are leaning into a particular situation. The development of teams is central to this plan. Whilst place-based differences will always be part of the Trust, increasingly Our RDaSH Way is intended to support employees to see the opportunities and benefits of a large and diverse organisation, with specialism and significant development opportunities.

Our people are the foundation for these teams, for our culture, and make RDaSH what she is. Increasingly the diversity of those who work with will reflect the full diversity of our local populations: at senior level and in those joining the Trust. Over 500 new people join the Trust each year, whilst dozens serve beyond thirty years with the organisation. This plan is framed in the context of work during 2024/25 to become Fully Staffed. Work which has seen vacancies fall to their lowest recorded level and turnover begin to drop. Professions and disciplines vary and those differences are important if we are to deliver the best care possible. This plan outlines a significant expansion of our Peer Support workforce. As a Trust we continue to support a large number of students and other learners, and our wider strategy expects us to have over 350 volunteers, equivalent to over 10% of our workforce. So, the context to the plan is both retaining what works well at the Trust and augmenting that with radical changes intended to improve the care offer.

Our 2023 – 2028 clinical and organisational strategy

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

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

5. help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations

Locally, including within the Trust, the strategy is understood through Our 28 Promises. These promises are deliberately framed as commitments to put our patients, carers and communities first. But to do this effectively, we must be a fully staffed organisation, and one in which teams feel supported to innovate, to reflect, and to support one another – with emotionally intelligent leaders able to listen, develop, and coach those they work with.

Why the people and teams plan matters

Much of the employment culture of the NHS is negotiated and set nationally. That creates a standard that the Trust must exceed in how we work and how we lead. But how we apply those agreements and commitments will be varied locally – both by the Trust and within the Trust. *Since 2024 we have focused significant effort on supporting leaders at every level to be able to lead their teams with skill and compassion. That work continues*. We know from feedback from those who work within the Trust that colleagues seek **flexibility** from their employer, from their manager, and from their colleagues. Yet they also seek **fairness** and to be treated consistently. This plan seeks to find a balance and to describe the kind of organisation that we wish to be. It has been developed over time, with significant involvement from people across the Trust, and the engagement of the Trust People Council, which brings together staff network, trade union, patient and volunteer leaders and professional leaders as well.

Teams in the Trust are increasingly organised into Directorates, which within a clinical context then form the operational units of our Groups. As we develop this plan, and our culture, *we want to see all twenty-three directorates consistently delivering the ambitions within this plan*, and receiving feedback that positively reflects the inclusive manner in which this is done. Of course, these groups and directorates must implement a handful of changes determined nationally, or by the senior leadership of the Trust, but they also have scope to act above and beyond those promises.

Alongside this plan is a distinct plan which focuses on learning and on education. The commitments within that plan are aligned to this one, as the Trust looks to emphasis formal and informal structures of learning, and to create time to improve, to reflect and to develop.

This plan focuses on a tri-partite framing: *attract, belong and cultivate*. This ABC approach reflects a commitment to inclusion and the positive promotion of difference that is throughout the organisation's strategy. It recognises that individuals will grow and develop, and that the role of the Trust is to help that to happen. Helping that to happen will occur through line managers, including professional mentors: and developing skilled managers is very much the focus on this plan – their role is to translate this plan into practice.

A number of organisational promises do sit under the auspices of this plan: the introduction of peer support workers into every service; the delivery of Real Living Wage accreditation, and successful and meaningful delivery of our anti-discrimination plans. **Delivery of those promises is outlined below, alongside more detail on the ABC approach.**

The culture we wish to be part of

Culture cannot be prescribed. It brings together the learnings and beliefs, symbols and behaviours of the Trust as it is today, experiences from the past, and hopes for the future. But a culture can be enhanced by intention, altering what is working less well, adjusting to bring greater consistency framed around best practice. It is this cultural adaptation that this Plan can contribute to, that leaders can enhance, and that we can measure through feedback and another means – testing our success against that intention, recognising that cultures change slowly.

Colleagues have developed ideas about the culture that they wish to be part of:

- Caring, Supporting, Fair and Equitable culture for all: we want staff to treat patients with respect, care and compassion, so all leaders and staff must treat their colleagues with respect, care and compassion
- Climate that supports equality, diversity and inclusion: celebrate the diversity and different thoughts, perspectives and views
- Climate that supports 'nurturing the power of our communities': encouraging learning and innovation, working alongside those within services and in neighbourhoods
- Collective leadership: where staff at all levels are empowered as individuals, within and between teams to act to improve care within and across health and care organisations and systems – 'leadership of all, by all and for all'

In an organisation the size of RDaSH it is unlikely we will have one culture. Indeed, the climate of diversity and innovation described will come best from the fusing of different cultures; by place, profession, tradition, and team. But some common threads are needed if we are to support the care we provide to be outstanding in its caring nature, and the development of individuals and teams to be respectful and compassionate. Those common threads will come with behavioural expectations that reflect the pace and ambition set by the Board's strategy, as well as the expectations for reform anticipated in the NHS Ten Year plan.

What is success by 2028?

Delivery of the People and Teams Plan promises is not a sufficient measure of our culture, nor of the individual or team development we wish to see. It is a necessary condition, nonetheless. **Looking forward to the Trust we aspire to become in 2027/28 the following 'top ten' measures are judged significant, and will be the focus of IQPR analysis as a Board and relevant committees from 2025**:

1) We are fully staffed: with vacancies persistently below 100 substantive roles

2) We invest in our colleagues' development, with annually increasing training spend, demonstrably equitably distributed against TNA plans from 23 directorates

3) We are a Real Living Wage employer, with low or no rates of agency spend, and no material gender pay gap

4) We are acknowledged as an anti-racist organisation and address discrimination through delivery of the actions contained in plans to execute Promise 26

5) We have improved our retention ((turnover and turbulence) above sector norms and reduced the number of colleagues that choose to leave within the first 24 months of employment against a 2023/24 baseline

6) All colleagues have a PDR with role-relevant improvement objectives, that they consider meaningful, and performance is measured and supported.

7) We are supporting recruitment in our local communities, including through delivery in full of Promise 9 (in fact, we are an anchor institution with a variety of employment opportunities/career pathway for our local communities which includes bespoke recruitment initiatives)

8) We have seen greater diversity in our workforce across all protected characteristics, (including significant change in the ethnic diversity of leaders at band 8 and above)

9) The Trust is recognised regionally for our work on flexibility, and colleagues with a disability, including in specialist clinical roles, positively promote the organisation to peers based on their experiences of working at the Trust

10) Our pulse and annual staff survey results show improvement in line with the measures agreed by the Trust's Board in May 2025, including holding engagement above a score of 7 notwithstanding the challenges of change we face

Delivering three promises: 1, 25 and 26

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.

Current state

Since 2023/24 the Trust has invested over £1m in additional peer support worker roles across the Trust. From 2025/26 roles will exist in all five Care Groups in the organisation, with especially strong coverage of roles in community mental health teams both for adults and CYP.

We retain a mix of Trust employed, and VCSE employed, roles. But no community of practice or consistency of role is yet embedded within the Trust. This may lead to isolation for practitioners and can, certainly, inhibit learning as we grow the roles we need within the Trust. In 2024 we indicated that we had no preference about how such roles would be employed but would review in 25/26 whether employment practice was materially impacting on the effectiveness of roles or was a neutral factor.

Forward look

The clinical leadership executive has agreed to review all existing Peer Support Worker roles within the Trust, as we look to move to greater consistency of approach. This will include the

development of a community of practice by November 2025, which provides an opportunity for PSW roles to influence the wider agenda of the Trust – and to help govern the expansion of roles within 2026/27 and 2027/28.

To the same timescale, the organisation will conclude a reset of its Health and Wellbeing offer, and applicable policies, to reflect the introduction of a significant group of colleagues with Lived Experience into our workforce. In doing so we will work with neighbouring organisations who have larger PSW cohorts to understand and foresee some of the risks and opportunities that colleagues may face.

By September 2025, a trajectory will be presented to the Board, after due consideration across our six groups, about fulfilment of this promise, indicating how service configuration and PSW roles will align to ensure that all pathways from 2027 have access to this expertise.

October 2025 TNA submissions from directorates will be analysed prior to the commitment of funds to ensure that due consideration is being allocated to these new roles as we look to establish a very significant cohort of colleagues within our organisation. A peer-employed model cannot become a barrier to investing in the development of this key workforce.

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.
- Pay the Real Living Wage to our own employees from April 2025, or sooner.
- Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).

Current state

As at April 2025, 668 employees within the Trust will move to a Real Living Wage adjustment on their base salary. Increment and pay award progression will be paused until their banded role exceeds this adjusted RLW salary.

The Board agreed, in January 2025, to a proposal from the procurement service as to how to define 'local spend' at the Trust. Reporting against this measure will commence not later than Q2 25/26.

The director of People and OD will take the lead in submitting a RLW Accreditation proposal to the Foundation during the first half of 2025/26.

Forward look

Being a Real Living Wage employer is an important part of the organisation's work to define itself by its values. It needs to feature prominently in our activities to promote the Trust to students, potential employees, partners and patients. As an overtly anti-poverty employer, we need to recognise that our practices, and those of our suppliers, should and will be scrutinised. All procurement decisions will see a binary qualifying question focused on RLW compliance.

The Trust is actively engaged with work led through the Rotherham Together Partnership to focus on social value. This work will incorporate an active trajectory to transition at least the 25% spend outlined in our success measures. The focus of change is expected to be in our food, facilities, transport, and estates functions: recognising some more clinical purchases

are governed through regional supply chain. The Board has asked the Finance, Digital, and Estate committee to pay particular attention to delivery of this transition during 2025/26.

We would expect our Annual Report for 2025/26 to analyse and validate the transition of the Trust since 2023/24 to being compliant with this promise by the end of the year under report.

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.
- Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.
- Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.
- Tackle our gender pay gap.

Current state

The move to a Real Living Wage may have allowed the Trust to continue progress since 2023/24 in eliminating the Gender Pay Gap. This an important measure of equity and one that will require persistent attention.

The agreed seven-point anti-racism plan for the Trust and accompanying plans to address wider discrimination is not yet fully embedded and implemented. That may inhibit delivery of a WRES gap closure plan to the timescale outlined.

Forward look

Taking the plans together, and making use of the skills of our REACH and other staff networks to hold us to account, the Trust will implement its agreed workplan to ensure that:

- Our HR practices are positively ensuring appropriate practice (for example, racism investigations will be undertaken by independent people of colour rather than by predominantly white British line managers).
- Our line managers, including those operating at a senior level, are suitably trained and skilled, including in tackling Bystander behaviours within our organisation.
- Our staff survey action plans, being finalised in Q1 25/26, take further action to address examples of discrimination identified with WDES/WRES and other data, notwithstanding some positive movement since 24/25

Rather than the commitment to promise 26 being advanced through ‘people’ or HR committees, either within the executive space or the Board, this work will be taken forward at the most senior level of the Trust: using the Trust People Council and Board as a whole to address the changes in behaviour and practice required. This will include routine audit of our Appropriate Behaviour Policy in practice.

It will be important that the work to deliver these plans reflects the positive and inclusive contribution made by employees, volunteers and students, as well as addressing the required standards among all.

Attract

What does this mean in practice?

Building on our recent recruitment success the Trust wants to attract new and mid-career professionals. We want to hire people with local knowledge. And we wish to draw people back into employment, perhaps in later life or after a break from employment. We need to be seen as a flexible employer, and one investing in individuals. Post-pandemic we see more and more people considering careers associated with caring: but growing barriers to progression as roles are 'cut back' elsewhere. There is every prospect of success as an employer of choice locally and regionally – one that is focused on development and career opportunity.

How will we judge our success?

Joining RDaSH has to be about joining thriving teams. Doing so provides chance to induct, to consider and to bring your best self into the workplace. We have a very strong platform from which to build and need to ensure that this is true across all 23 directorates. We know that presently some do not meet the organisation wide metrics we apply.

The measures we will focus on sustaining or improving include:

- Being fully staffed (97.5%) in every team within the Trust, based on aligned data between HR and Finance that is widely shared with local employees
- Having a Peer Support Worker in every Clinical Team by 2027
- Implementation of our Apprentice First model, initially for all Band 2/3 vacancies
- Implementation of a support plan for all HCSWs inside 3 months of induction
- Work with over 350 volunteers and offer a pathway into employment
- Full utilisation of all our Training budgets, spend to increase year on year - our commitment to staff development
- Implementation of half day learning programmes for all colleagues
- Internal promotions as a % of all colleagues (due to training and development opportunities colleagues are promotion ready)
- Maintain and then improve % of colleagues recruited from our local communities
- Full Utilisation of Apprenticeship Levy
- Develop tailored recruitment programmes to recruit from underrepresented groups
- Pathway into employment opportunities - Student/Training Placements/Work experience

Why does this matter so much?

Some measure of turnover – exiting the Trust – and turbulence – movement within the Trust is desirable and inevitable. We will be consistently recruiting in predictable, and some unanticipated ways, every month until 2028. The experience of being recruited is hugely impactful on not only joining us, but staying with us, and thriving in role. For all professions and disciplines a consistent standard and quality of experience is needed. This standard ranges from 'hygiene' factors that can be common (contracts, pace, equipment from day one..) through the personal factors that reflect the value we place on someone's contribution.

Approximately 15% of roles changes in any given year at the Trust. The culture of the organisation is hugely influenced by the new RDaSHians who join us. Our ability to change and innovate depends on them, as well as on 'us'.

Belong

What does this mean in practice?

The Trust as a whole, embedded within our communities, and teams at a very local level have to be consistently welcoming of individuals and of difference. An element of this comes from the tone and style of leaders across the organisation. The organisation has to celebrate the new joiners, distinguished service, someone who returns from elsewhere, and those developed internally. We must recognise that attachment to RDaSH may to our values, promises, team working, or partnerships.

How will we judge our success?

The Trust has worked hard to develop and reinvigorate our staff networks. Equal attention needs to be paid to professional advisory groups which form a critical part of the identity of many colleagues in the organisation. In reflecting those points of allegiance we will consider our success against measures including those listed below:

- Develop and embed a restorative, just and learning culture across the Trust: this will see increased reporting of good practice and of concerns among colleagues - across all areas and protected characteristics
- Deliver our plans to secure Promise 26, judging them in part by fulfilment of a commitment to change to protected characteristic diversity of band 8+ diversity in the Trust (including within CLE and the Board)
- Continue to invest in the Health and Wellbeing of our workforce – reducing long term and repeat absence from work, whilst reducing the number of colleagues who leave the Trust within their first 24 months of employment
- Implement a comprehensive programme of required leadership development including our Leadership Development Offer, Clinical Leaders' programme and First Line Managers Training programme
- Reduce the length of time taken to conclude employment relations cases to 8 weeks consistently across all directorates by April 2026
- Increase the number of staff with protected characteristics who believe they have equality opportunity for career progression/promotion
- Expand the number of employees able to access staff and professional networks on a consistent basis
- Receive credible accreditation against frameworks for inclusion, across all protected characteristics - starting with global majority
- Positive feedback on the induction experience of the Trust, and the support provided to individuals at 100 / 365 days and beyond.

Why does this matter so much?

The organisation wishes to be available, accessible, and responsive to the needs of all of our communities. Trust will be critical to that work. Local people will look to our staff, to their

wellbeing, diversity and perspective in forming views on how sincere and authentic our commitment to change is.

Conversely, for some inside the Trust there will be a nervousness about aspects of our community, perhaps where we need to work outside our own lived experiences. The diversity and inclusion of our organisation, and the ability to hear voices and ideas outside our own experience, can be honed safely inside the Trust if we can create a sense of belonging.

Belonging will always be defined by an individual for themselves. Loyalties and alignment will often be local, before it is Trust-wide. But if we need to have advocacy for the scale and breadth of RDaSH it will be important that we make progress with how we welcome people into our organisation as a whole.

Cultivate

What does this mean in practice?

Individuals working within the Trust have a range of skills, some central to their roles, and others available to the organisation to learn from. No-one should feel that they must change role in order to develop, but equally we want to be investing time and attention in developing the careers of those who work for the Trust. In an organisation of some size and scale, it ought to be possible to create significant opportunities for people to grow and to learn.

Traditional employment practices focus this support on individuals. And as outlined below, we would wish that to be true at the Trust: good quality appraisal or PDR, support for personal development and opportunities internally – increasingly in a structured manner which facilities intra-directorate working.

But we also intend to actively cultivate outstanding teams. The TED measure of effective teams will be used to support and judge this work. Ideally the benefit for this work will mean that it progresses on a ‘social movement’ basis, but it will also be introduced into measures of directorate and team calibre used in assessing funding bids and other considerations.

How will we judge our success?

The cultivate measures should not be seen in isolation from this wider plan. However, the list of measures below will be explored at directorate level to assess progress over time:

- All colleagues to receive a quality PDR and regular supervision to discuss progress
- Mandatory training and policy adoption compliance at required rates from 2026
- All colleagues to have a career conversation as part of their PDR/Appraisal
- % of Teams adopting TED to assess Team Effectiveness > 75%
- Improvement in staff survey scores at or above the Trust as a whole
- Succession plans will be in place for all band 7s and above
- Demonstrable progress with digital compliance visible within PDR outcomes by 2028
- Impactful use of the ‘voice’ scorecard to hear signals of concern from colleagues

Why does this matter so much?

Team development is central to our safety culture. Individual assessment can only ever achieve a measure of personal competence. This plan focuses on ensuring that we have adaptable teams, with individuals skilled at working across and within those teams.

As we sustain a Fully Staffed position, and as we move from a mindset of employee scarcity, to one of genuine mutual choice, it will be team behaviours that will increasingly be the basis for hiring into senior roles whether they be clinical or non-clinical. Developing people internally, who have an insight into the culture that we are seeking to cultivate makes sense.

That team focus cannot become a closed culture. This why diversity is written through this plan. Diversity of background and tradition, but also an openness to diversity of thought and style. Cultivating an organisation that permits, accepts and adapts to disagreement and challenge will make us a safer place in which to receive care and a more innovative place in which to work.

Getting things done

This plan is not going to be delivered by the "HR Department" or by the directorate of people and organisational development. Instead, it is the work of all line managers, and senior leaders, supported by professional people practices, to execute the commitments in this plan.

Cultural oversight will be led by the Council of Governors, Board and Trust People Council. We will use regular Pulse surveys, 360-degree feedback on line managers, PDR material and the nationally mandated staff survey, including protected characteristics analysis, to test our progress.

Perhaps the most crucial dynamic within this plan is a recognition that in a large and diffuse organisation 'whole Trust' analysis may not get to the heart of the experiences of staff, students and volunteers. A directorate level, or below, standard needs to be achieved – aggregated to provide a group and then Trust picture. A team that is struggling, or an area that is not meeting standard, cannot be 'averaged' against great practice elsewhere. The focus of the Well-Led effort of the Trust as a whole is on ensuring that our people management practices have a consistency across the organisation.

During 2025 we would expect to introduce further changes in practice to deliver this plan:

- Sustaining the fully staffed work begun in 24/25
- Implementing the plans to address discrimination addressed through Promise 26
- Supporting staff to understand and value the Real Living Wage
- Ensuring that high quality OD support is available to support team development
- Creating a clear trajectory to implement Promise 1 in our organisation by 2028
- Adapting our PDR and objective setting practices across the organisation and
- Finalising plans to provide remote working standards for the organisation to 2030

Implementation of a number of these policy and practice changes may take place in 2026, allowing time for pilot testing, engagement, and adaptation.

Whilst work to ensure training, learning and education prosper at the Trust is covered by another plan, it is important that the foundational people practice covered by this People and Teams plan is put in place if that developmental work is to be successful.

RDaSH has a mission to nurture the power in our communities. Perhaps the greatest insights into those communities that we have comes from our own employees, our people and teams: whilst altering the balance of power within RDaSH is essential it cannot be achieved without the support, experience and wisdom of RdaSHians.

Concluding summary

We need to retain skilled and experienced people within our organisation. Simply filling roles is not an adequate measure of our ambition. Reducing turnover and building stable teams is critical. To do this the practical rhythm of good line management supported by outstanding HR practice has to become in 2025 and 2026 our standard. It is clear from staff survey results, and objective data, since 2020 that that has not always been consistently the case.

But the People and Teams Plan is about the culture of the Trust. How we deliver the promises covered by this plan, and top ten measures on which we are focused, matters as much as the delivery of those markers. All leaders must align to the behaviours that are expected not only by our policies, but also by the statements of cultural expectation in this plan. That is why we support an overwhelming focus on leaders' development, as clinicians, first line managers, senior leaders or others. As we evolve our PDR model, line managers will be expected to undertake 360-degree appraisal to allow them to consider their impact on individuals within their team. That PDR model will nonetheless introduce more overt accountability into our organisation by 2026/27. Supporting teams to develop will become the aspiration of our professional OD function, working to address dysfunction, and to support teams to have developmental conversations. This work will be developed alongside our Change and Improvement function.

The organisation wishes to be known for its focus on learning, on education, on improvement and on training. This plan provides for equity in the application of those ideas and focuses on developing those traditionally excluded by prior practice. Directorates will be expected to have a focus on their culture, and on education, within the Trust: as we look to retain and attract talented experts to join our teams, either in peer or clinical expert roles.

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Digital Enabling Plan 2023 - 2028

Digital Enabling Plan 2023 - 2028

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What do we mean by digital…

Digital ways of working pertain to both equipment and services.

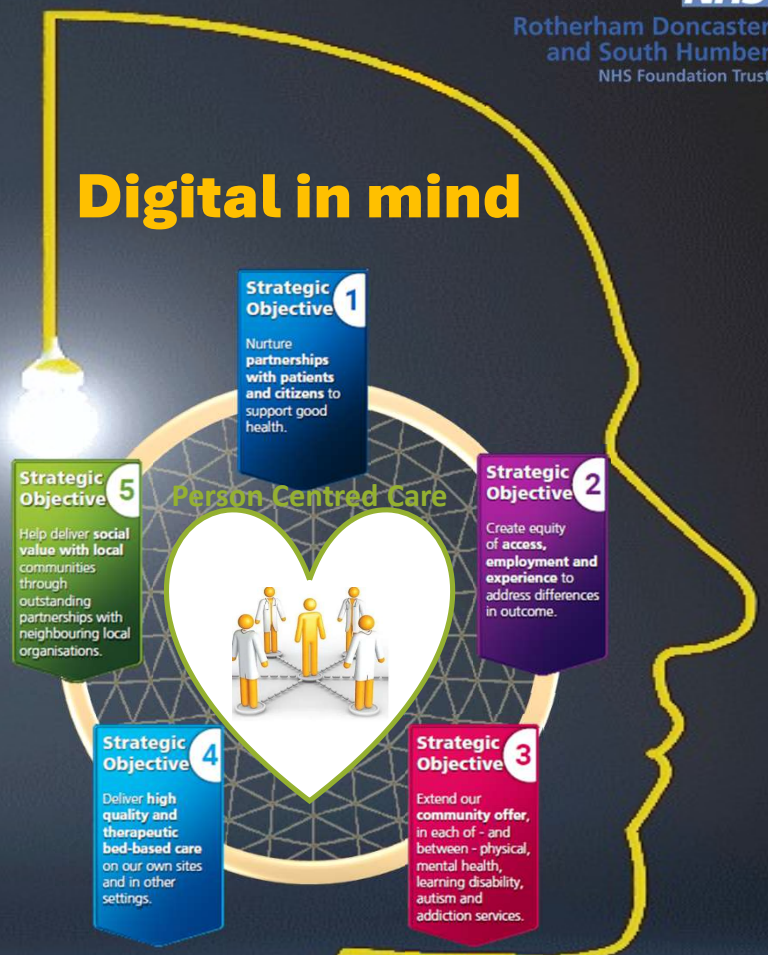
Digital improvements relate to each of our 5 strategic objectives, and our strategic enabling plans:

- Digital improvements are required to improve our partnership working capability.
- Digital Improvements will support us to create equity of access, employment and experience to address differences in outcomes.
- Digital improvements are required to extend and enhance our community and inpatient care offer.
- Digital improvements are required for our staff to fulfil their role and to enhance the services we provide.

"Digital is not just about technology, it is about applying the culture, processes, operating models and technologies of the internet-era to respond to people's raised expectations.

Digital is not a case of entirely replacing one way of working with another, it provides new approaches to addressing problems old and new"

NHS Providers, 2023



"Nurturing the Power in our communities"

NHS
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Strategic Objective 1
Nurture **partnerships with patients and citizens** to support good health.

Strategic Objective 2
Create equity of **access, employment and experience** to address differences in outcome.

Strategic Objective 3
Extend our **community offer**, in each of - and between - physical, mental health, learning disability, autism and addiction services.

Strategic Objective 4
Deliver **high quality and therapeutic bed-based care** on our own sites and in other settings.

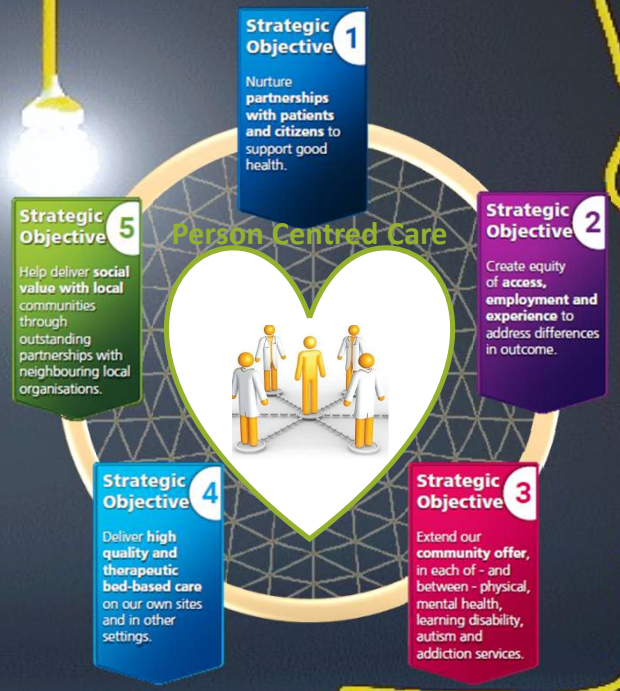
Strategic Objective 5
Help deliver **social value with local** communities through outstanding partnerships with neighbouring local organisations.

28promises

The Digital Enabling Plan translates the Trust Strategic objectives and 28 promises into five supporting Digital themes to enable:

- Person centred care and innovation
- Increased digital maturity
- Digitally optimised pathways
- Data integrity and Assurance

Digital in mind



Nurturing the power in our communities…

Digital Enabling Plan 2023 - 2028

Prologue…

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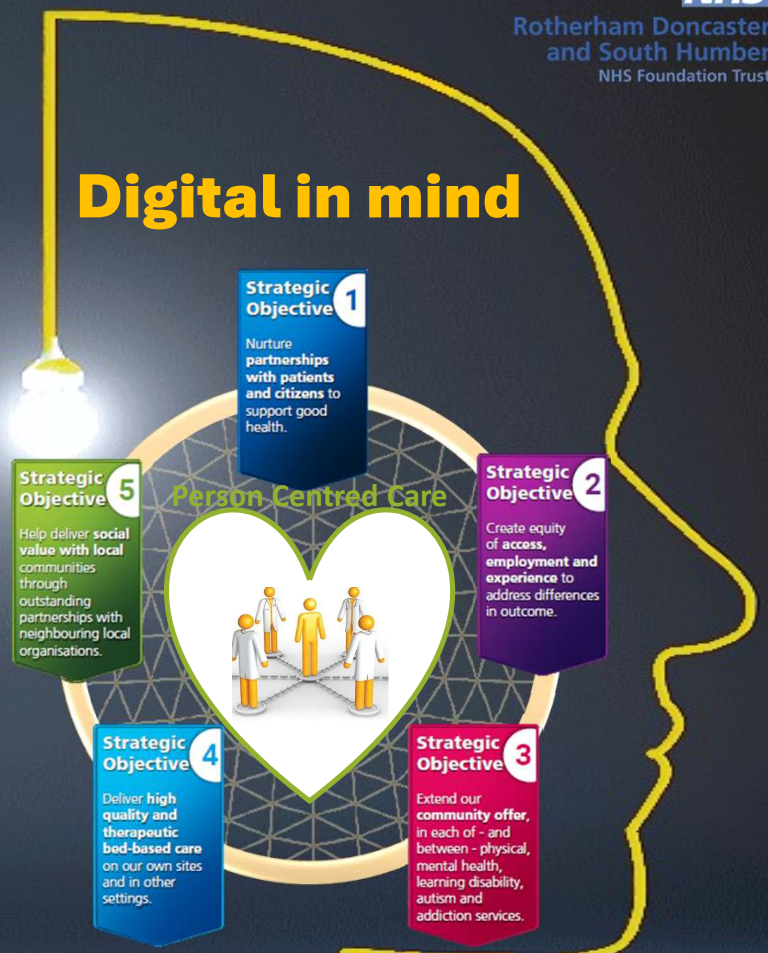
The new RDaSH Digital Enabling Plan highlights priorities around utilising technology to improve core clinical systems, empowering patients, advancing the use of information, promoting seamless system-wide working, improving efficiency, and developing safe and secure systems.

The new plan builds upon the successes of the NHS England Digital Aspirant Programme where RDaSH collaborated with local Place and ICS partners to deliver an ambitious digital transformation programme providing a step-change in local service provision and improve our ways of working, for both patients and staff.

The Plan supports the Digital RDaSHian by providing a framework for enhanced digital infrastructure, improving data accessibility, and streamlining processes to deliver better, more efficient healthcare services.

The Plan has been purposefully designed to support the delivery of the ambitions and 28 promises identified within the Trust Strategy and consideration has been given to the interconnections between the Trust Strategy and the role Digital can play in its successful delivery. The plan focuses on five areas for development…



"Nurturing the Power in our communities"

Digital Enabling Plan 2023 - 2028

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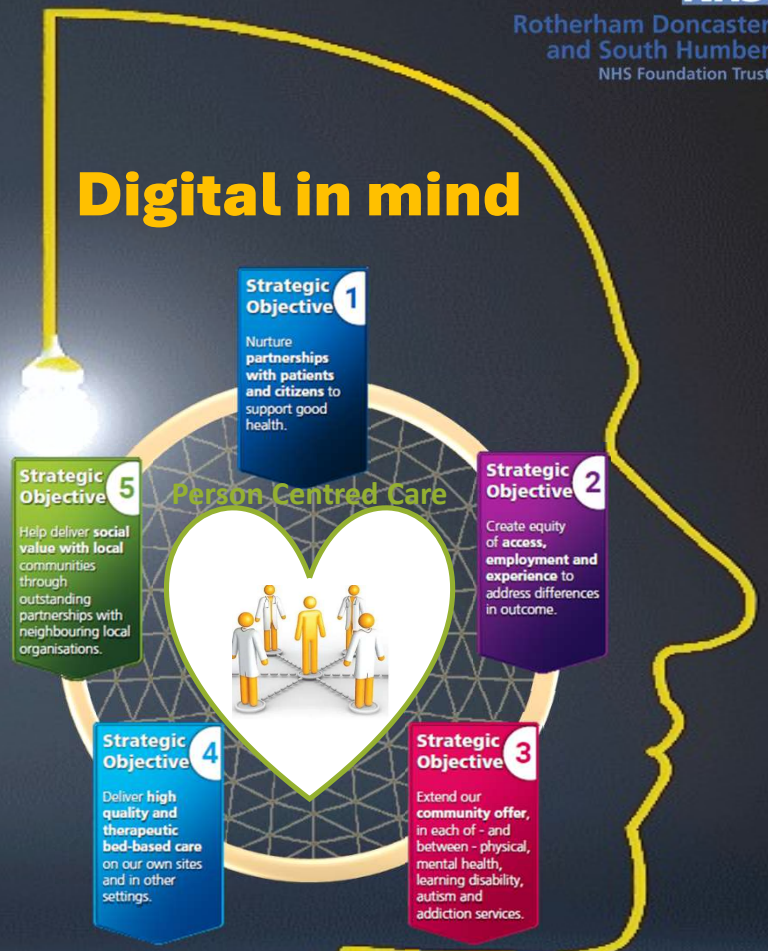
Strategic Objective-1: The Digital Plan aims to mitigate the risk of excluding people unable or unwilling to access digital offers, and to design pathways to include all target users both digital and non-digital. The digital tools offered will help reduce health and social care inequalities, they are designed to be part of a multi-channel offer, alongside non-digital channels and will be provided with appropriate support for those who need it.

Strategic Objective-2: The Digital Plan recognises that technology can provide improvement opportunities in how health and social care professionals carry out everyday tasks and interact with patients and clients. It considers human factors to ensure that systems, products, and services will be designed to make them accessible, safer and more effective for people to use and that to keep up with and use this technology efficiently, all will need to constantly update and refresh their digital literacy knowledge and skills.

Strategic Objective-3: The Digital Plan recognises the need to increase access to shared care records and data for improved decision support and quality care outcomes. Continued collaboration with partners to support improved pathway connection, transition, and visibility through the deployment of integrated apps for improved public, patient, clinician and staff engagement, interactions, and feedback.

Strategic Objective-4: The Digital Plan will support the Trust Research Programmes by providing access to comprehensive clinical data and enabling the use of technology to help health and care professionals communicate better by giving easy access to connected systems that give the information needed to help make the best decisions for patient care creating an integrated environment across the care system giving healthcare professionals more confidence and time to care.

Strategic Objective-5: The Digital Plan is designed to support the strategies of South Yorkshire Integrated Care Board and Humber and North Yorkshire Care Board by expanding the use of place and regional shared care record solutions, sharing best practice and infrastructure to provide a digital framework for patient care. The Digital Plan understands that nurturing the power in our communities and collaboration with our partners is a critical aspect to providing staff and patients with solutions, to enable the right care,
at the right time, in the right place.



"Nurturing the Power in our communities"

Digital Enabling Plan 2023 - 2028

Our aim for our patients & the services we deliver…

- **We will** work alongside clinical services and our communities, rural and urban, to develop and deliver the best models of digital care to address health inequalities.
- **We will** empower patients, families, and staff to use digital platforms.
- **We will** increase our support to meet the health needs of the population
- **We will** improve access to digital self-help and ensure that everyone, has the opportunity to access and engage with digital technologies
- **We will** enable people to manage their appointments digitally and provide access to services remotely using apps and digital therapies where this is part of the clinical offer.
- **We will** support people with physical healthcare needs through mobile observations where possible.
- **We will** work with place based and system partners to poverty proof our services and tackle digital poverty including supporting services with device banks.
- **We will** enable colleagues to work in an agile way within the ward environment, reducing the need to spend prolonged periods in offices away from patients.
- **We will** enable digital healthcare in the community through innovative solutions and ensure that these can be accessed through the NHS app and devices patients already own such as wearable tech.
- **We will** work with NHS England, researchers and our local communities to explore cutting edge technologies such as VR, process automation and AI, to increase efficiencies & deliver more care at home.

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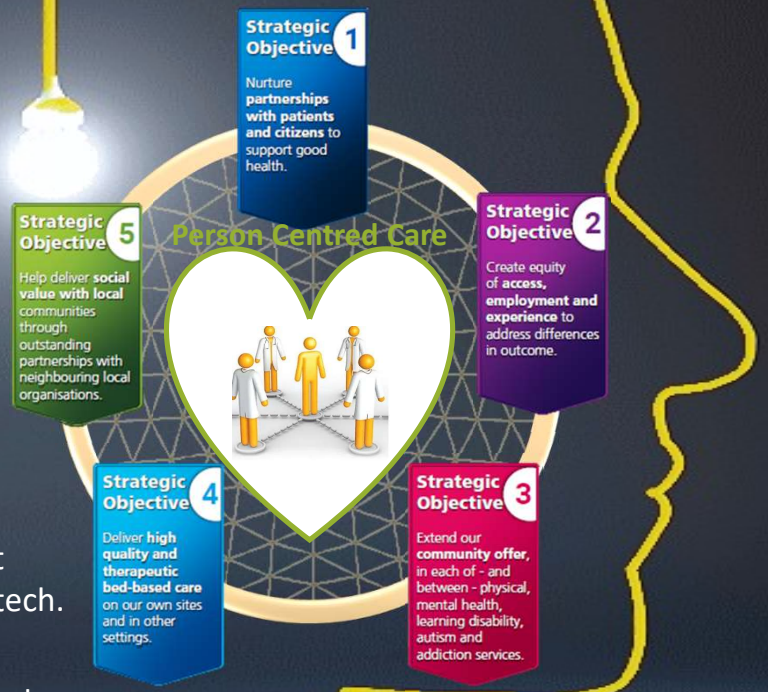
Digital in mind



"Nurturing the Power in our communities"

Digital Enabling Plan 2023 - 2028

Our aim for our colleagues – Clinical & Backbone…

- **We will** work alongside clinical services and our communities to develop and deliver the best models of digital care.
- **We will** foster a workforce who are pro-digital and digitally minded.
- **We will** horizon scan and support or workforce to explore innovative solutions for the tasks they complete.
- **We will** digitise and automate services and tasks where possible.
- **We will** help colleagues to work more digitally through our leadership development programmes and our education and learning offer.
- **We will** explore the best technology on the market and work with services and patients to find solutions to technological challenges.
- **We will** support a data led, digitally confident workforce with integrated simple to use digital platforms and tools.

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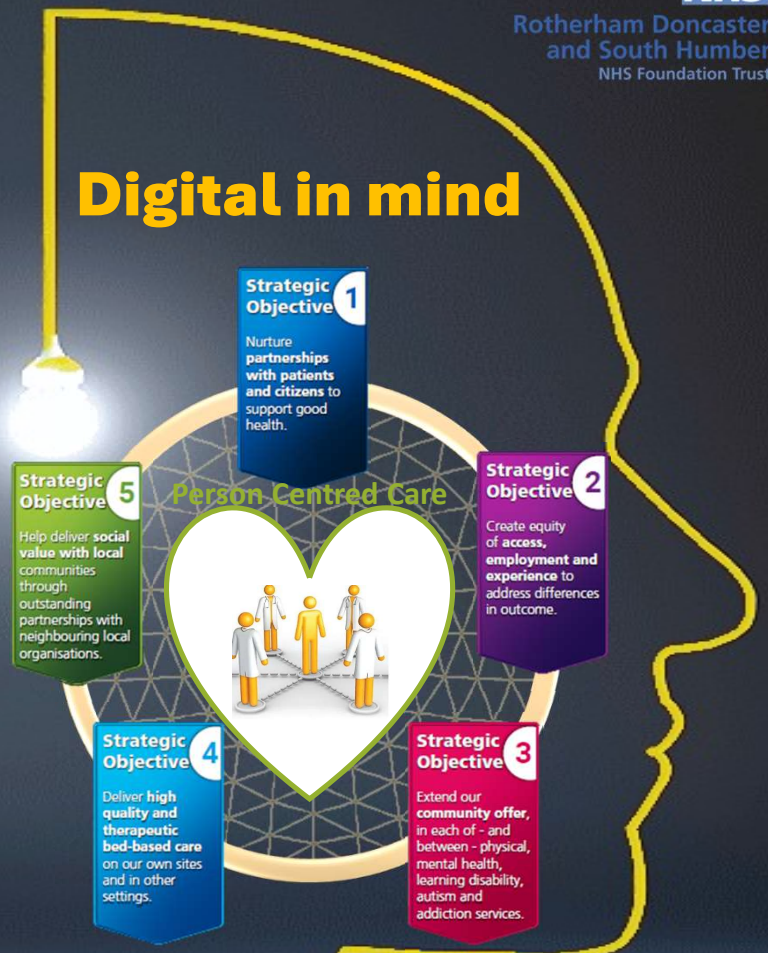

"Nurturing the Power in our communities"

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- ∞ Success Measures
- ∞ Shift-Left
- ∞ By 2028
- ∞ Appendices

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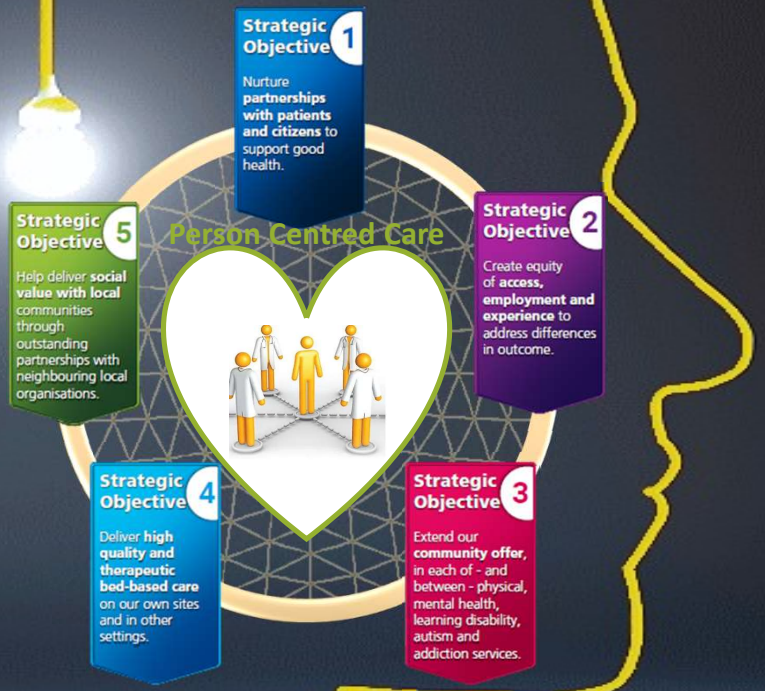
Digital in mind



"Nurturing the Power in our communities"

Digital Inclusion & Inequalities…

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We can help reduce health inequalities through digital inclusion by ensuring that the benefits of the internet and digital technologies are available to everyone.

However, to do this we have to overcome certain barriers:

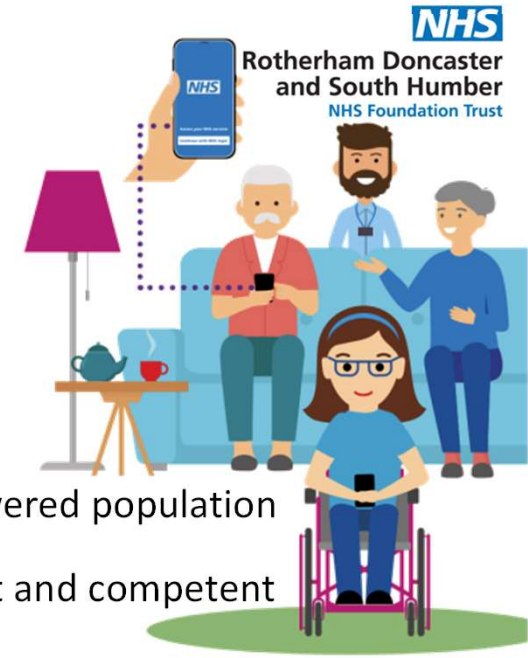
- **Access** - not everyone has the ability to connect to the internet (no broadband or smart device)
- **Skills** - not everyone has the ability to use technology and online services
- **Confidence** - some people fear online crime, lack trust or don't know where to start.
- **Motivation** - not everyone sees why using technology could be relevant and helpful

Our People

Ensuring that everyone who can or wants to, has the opportunity to access our services with digital technologies.

"Providing staff and patients with access and skills, to enable the right care, at the right time, in the right place."

Digital Inclusion & Inequalities…



- Our actions aim to mitigate the risk of excluding people unable or unwilling to access digital offers, and to design pathways to include all target users – digital and non-digital.
- Digital inclusion creates an opportunity to unlock the benefits of digital transformation for everyone and address long-standing health and care inequalities
- Our digital tools will not exacerbate health and social care inequalities. They should be part of a multi-channel offer, alongside non-digital channels, with appropriate support for those who need it
- Health Informatics works in collaboration with our partners to upskill users in line with technology improvements

✓ We will have a more digitally empowered population

✓ We will have a digital, data confident and competent workforce

✓ We will provide multi-channel offer to support the digitally excluded and improve speed of access to care

Our Priorities:

- Patient Facing Applications – SMS, Email, App & Web Portal
- Health Inequalities Reporting

Human Factors & Digital Literacy…

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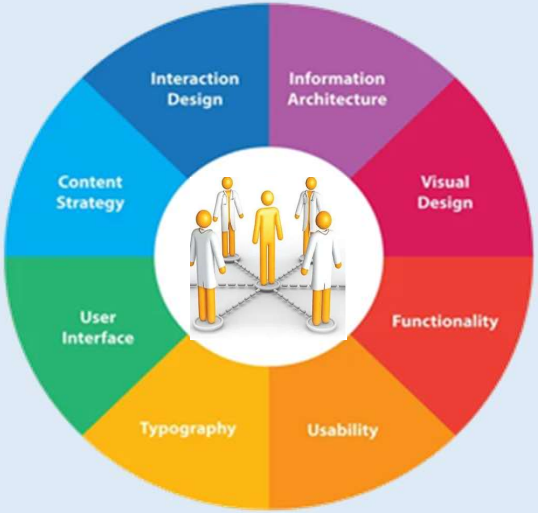
"Providing staff and patients with solutions, to enable the right care, at the right time, in the right place."

- Technology can provide improvement opportunities in how health and social care professionals carry out everyday tasks and interact with patients and clients.
- Considering human factors ensures that systems, products and services are designed to make them accessible, safer and more effective for people to use.
- To improve the effectiveness of care we must use this technology efficiently. We each need to constantly update and refresh our digital literacy knowledge and skills.

Our Priorities:

- Shift–Left thinking
- Public Website Accessibility
- Clinical Systems, Reporting and Data Quality Training

Person Centred Care & Innovation

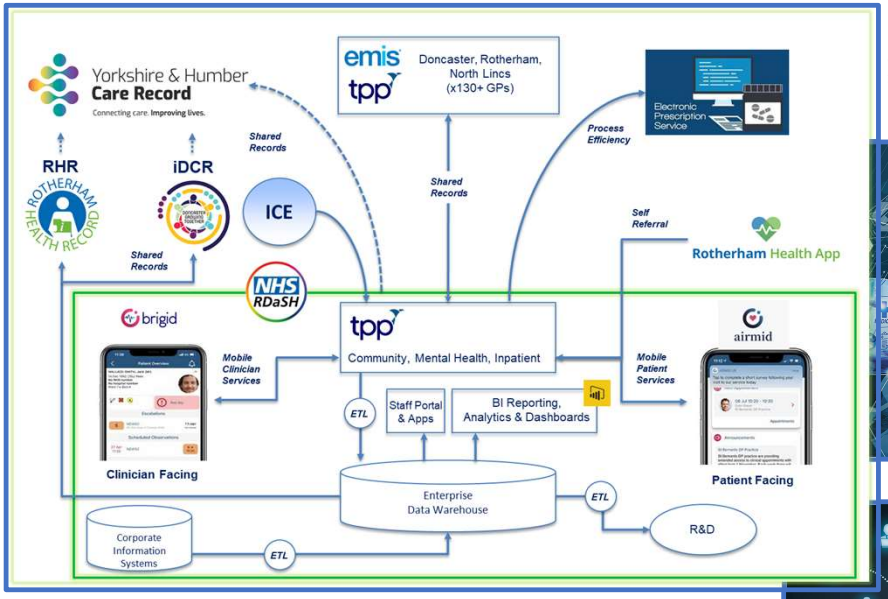


- **Design** – For people
- **Data Driven** - Solve the right problem
- **Simplify** - Standardise innovation
- **Focus** – Accessible, safe and efficient

Integration & Interoperability…

- Increased access to shared care records and data for improved decision support, more effective efficient care, better outcomes.
- Increased digital solution collaboration with partners, supporting improved pathway connection, transition and visibility.
- Deployment of integrated apps for improved public, patient, clinician and staff engagement, interactions and feedback.
- Increased flow and integration of data, for improved insights, decisions, aligned to our Safety & Quality metrics.

Our Priorities:
- Yorkshire & Humber Care Record
- Clinician App - Brigid
- SMS Patient Messaging & Feedback



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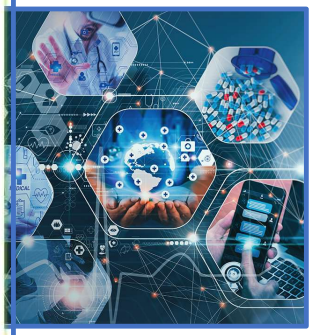

- ✓ Shared care data, benefits and value
- ✓ Partner collaboration on improved digital pathways
- ✓ Integrated apps and multi-channel communication
- ✓ Quality flow and integrated data solutions e.g. Red to Green Days

Innovation & Exploration…

- Supporting Trust Research Programmes to improve clinical care and reduce the cost of healthcare
- Use technology to help health and care professionals communicate better
- Enable patients to access the care and information they need quickly and easily.
- Easy to access connected systems that give the information needed to help make the best decisions for patient care, including Red to Green days.
- Create an integrated environment across the care system giving healthcare professionals more confidence and time to care
- Technology needs to be embedded at each point of the patient's clinical pathway for both patient and clinician.

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- ✓ Person centred care & innovation
- ✓ Increased digital maturity
- ✓ Digitally optimised pathways
- ✓ Data integrity and Assurance

Our Priorities:

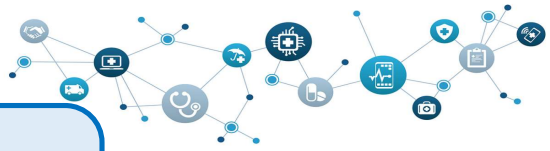
- Community Clinical Coding
- Clinician Facing App (Brigid)
- Patient Medication Request

Collaboration with our Partners & Communities…

Rotherham Doncaster and South Humber NHS Foundation Trust

The Trust continues to work to support the strategies of South Yorkshire ICB and Humber and North Yorkshire ICB

- Enabling and expanding use of place and regional shared care record solutions (YHCR, RHR, iDCR)
- Sharing of best practice
- Cyber forum
- Data sharing & security
- Network linking
- Shared infrastructure



Our Priorities:

- New Public Website
- CMHT Transformation
- Virtual Wards

Health Inequalities
Work with partners to improve understanding of the experience, perspectives and needs of the people and communities that experience the worst of health inequalities

Assets
Work with partners to better understand the assets in our communities that will help improve population health and strengthen our understanding of community needs

Person Centred Care & Innovation
Design services in partnership with people to meet their needs and preferences

Solutions
Develop collective improvement approaches with our partners and communities to address concerns about quality, patient safety and experience.

Prioritise Resources
To where they have the greatest impact, based on the needs, knowledge and experience of our partners and communities

Understand Barriers
Understanding barriers to access which impact on the efficiency and sustainability of services and work together with our partners and communities to develop solutions to address them

"Providing a digital framework for patient care"

Success Measures…

We will continue to measure our performance by objectively comparing ourselves with recognised best practice standards and other similar organisations.

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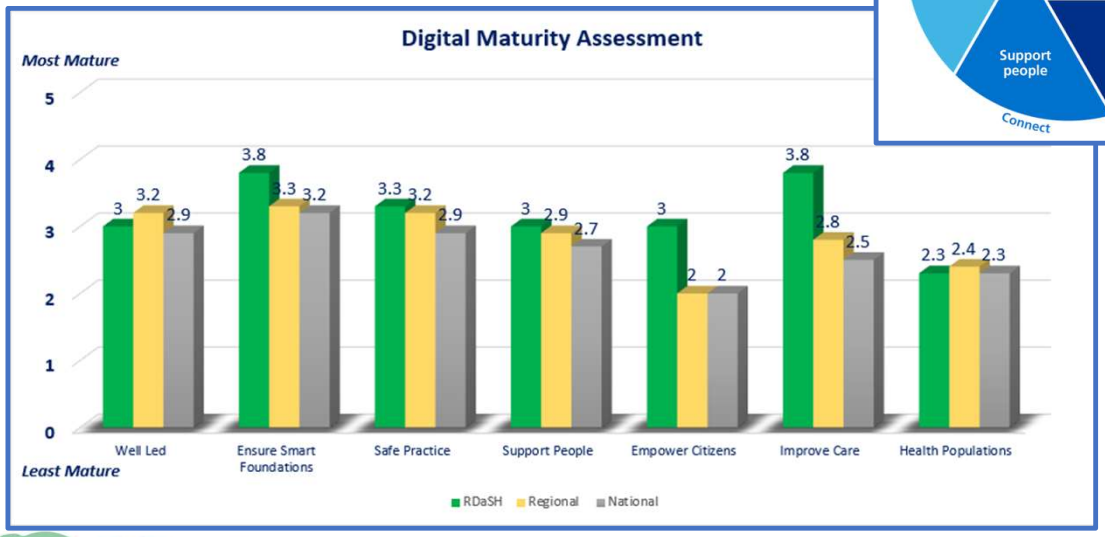
Metric-1 - Digital Maturity Assessment…

In 2023 all NHS Trusts were subject to a Digital Maturity Assessment based on the seven What Good Looks Like (WGLL) dimensions:



- Helps Trust and ICS to understand our level of digital maturity by identifying key strengths and gaps in the provision of digital services.
- Enables the Trust to focus on key areas for digital investment and improvement towards national standards.
- The Trust aims to maintain and improve its digital maturity, which will be reassessed in 2024.

Success Measures…

Metric-2 – Digital Capabilities Framework (DCF)

DCF is based upon ‘Core Capability’, but also offers the facility to self-assess against ‘transformation’ and ‘innovation’.

The DCF measures performance in the following areas:

- Storage and Management of Records, Assessment and Plans
- Support for Transfers of Care
- Diagnostic Management
- Ordering Optimisation Admin and Management of Medicines
- Decision Support Tools
- Support for Remote and Assistive Care
- Asset Resource Optimisation and Administration
- Business and Clinical Intelligence

RDaSH DCF Assessment

Capability:	Total Available:	RDaSH Current	RDaSH Post Roadmap
Core	45	41	45 (+4)
Transformation	39	26	27 (+1)
Innovation	9	2	5 (+3)

The Roadmap is driving the Trust towards the highest group

‘Group 3 – Already meets core capabilities’

Success Measures…

Metric-3 – Public Website Accessibility Standard…

Almost 1 in 5 people have a disability of some kind. Many more have temporary or situational impairment, like an illness or injury. NHS digital services should meet accessibility standards.

- Making our websites and documents more accessible and with multi-language options allows us to provide information to harder to reach groups.
- In September 2023 the RDaSH public website ranked 9th out of 220 Trusts for accessibility with a compliance rating of 95%
- The Trust aims to maintain or improve its accessibility ranking with the introduction of a new website

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SDI Service Desk Institute Certified customer-led service desk

Metric-4 - Services Desk Accreditation…

The Service Desk Institute's (SDI) Service Desk Certification (SDC) is a globally recognized best practice standard that establishes a set of unambiguous and quantifiable benchmarks for IT service operations.

- The Trust achieved Level-2 accreditation in 2021. This demonstrates the maturity level of our service and support operation, and serves as a catalyst for improvement.
- The Trust seeks to maintain accreditation and drive up its score in this area

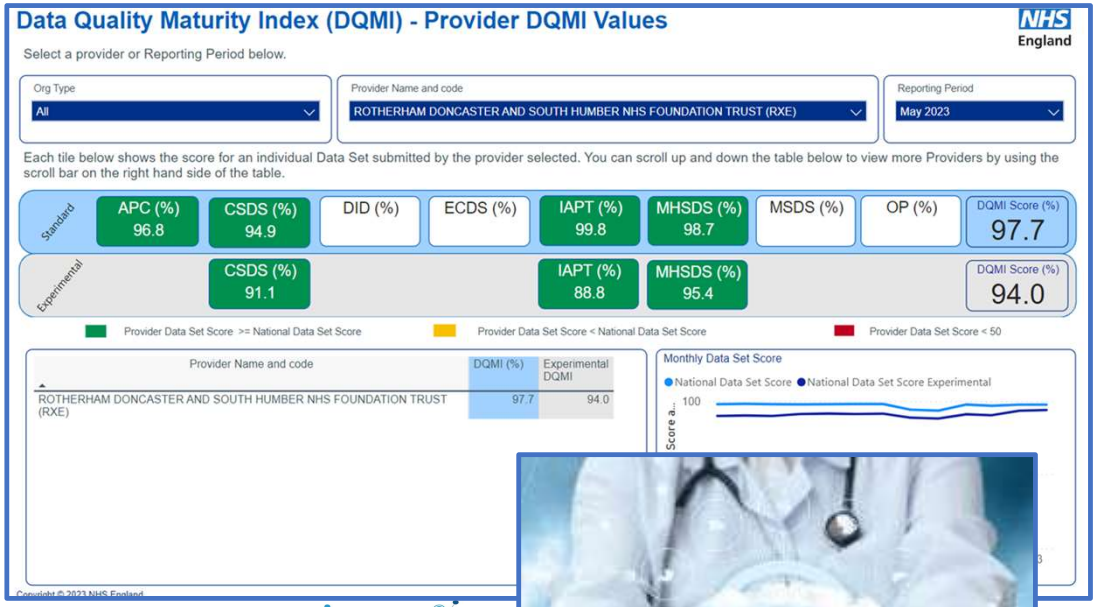
Success Measures…

Rotherham Doncaster and South Humber NHS Foundation Trust

Metric-5 - Data Quality Maturity Index…

The NHS England measure for data quality on national data sets submitted by the Trust on a monthly basis (IAPT, MHSDS, CSDS and APC), with a compliance target of (95%+).

- The Trust continues to meet and exceed this target, currently reporting (97.7%) vs National average of (74.3%).
- Assures a high level of data submission quality for the Trust.
- A high level of data quality for submissions supports Trust and national service delivery quality, enabling continuous improvements for delivery of quality care and decisions.
- The Trust aims to maintain & improve its DQMI Score



Success Measures…

Rotherham Doncaster and South Humber NHS Foundation Trust

Metric-6 – Microsoft Defender for Endpoints (MDE)…

All Trust assets run Microsoft Defender for Endpoints (MDE) which provides NHS England with a view of the health of NHS computer assets.

- Provides NHS organisations better cyber security protection.
- Links to the NHS Digital's Cyber Security Operations Centre, to improve cyber security protection for local health and care communities, and the NHS as a whole.
- Monitors the Microsoft Windows operating system on PC, laptop or server to identify any indicators of cyber attack to maintain the health of NHS computers.
- RDaSH are running 100% supported Microsoft software and have the lowest risk score in the region
- For server systems RDaSH are in the lowest 2% risk score nationally.
- A programme of server OS upgrades has taken place to keep this essential infrastructure in Microsoft support to October 2031.

MDE Risk Assessment	
Windows Exposure Score	Server Exposure Score
35.8	9.5

Microsoft Defender for Endpoint

Threat & Vulnerability Management

Attack surface reduction

Next generation protection

Endpoint detection and response

Automated investigation and remediation

Microsoft Threat Experts

Success Measures…

Metric-7 - Data Protection & Security Toolkit (DSPT)…

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health and Social Care policy.

- Contractual requirement in the NHS England standard conditions contract (section 21.2) that relevant providers undertake DSPT assessments on an annual basis.
- The Trust continues to meet Standards Met with a high veracity of confidence in evidence submitted.
- High level of compliance supports better security and better care.
- The Trust will maintain and improve across the DSPT submission

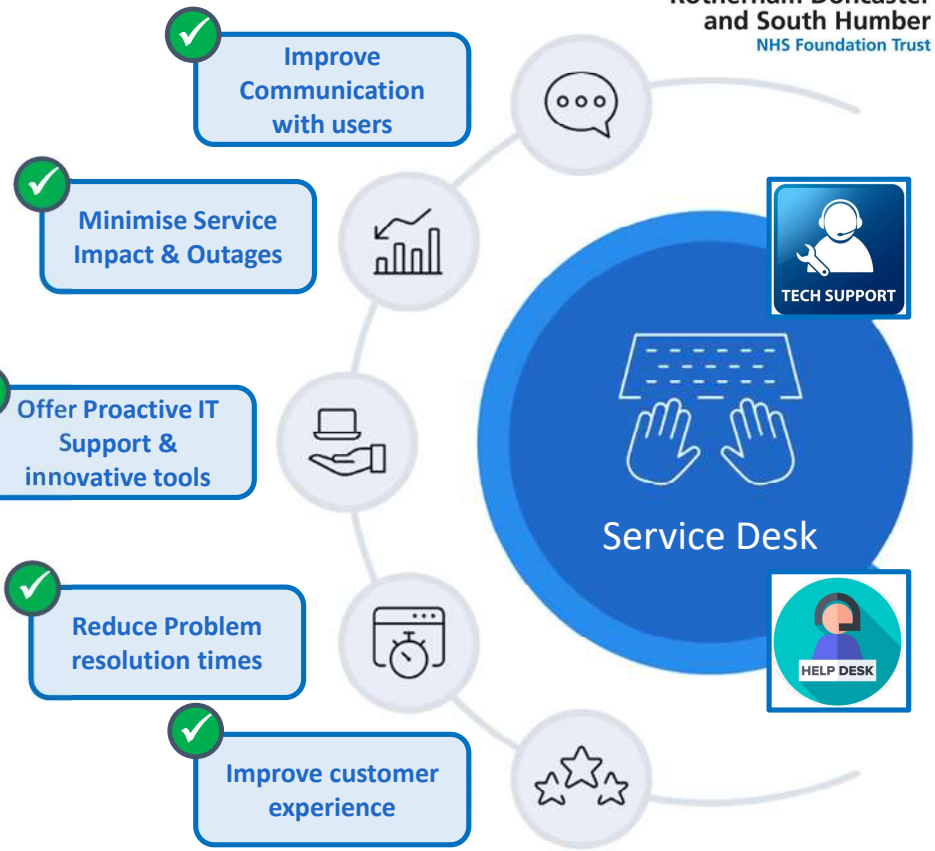
Independent Auditor Assessment	
Overall risk assurance across all 10 standards	**Confidence in the veracity of the self-assessment**
Substantial	**High**

Success Measures…

Metric-8 – IT Support…

The Service Desk is the front door to our IT services & giving our customers the best support, advice & experience will always be paramount.

- We will position the customer at the centre of our service improvements and strive to improve the customer experience
- We will continue to monitor our performance throughout all IT Support Functions, be data driven, and work towards improvements in all areas
- We will use process automation, digital technologies and process improvements to drive efficiencies



"Placing you at the centre of what we do"

Success Measures…

Metric-9 – Electronic Patient Record (EPR)…

Electronic Patient Records ensure health and care staff have access to accurate up-to-date patient information when and where it's needed, supporting them to deliver care efficiently, effectively and safely.

Continual evolution of our Electronic Patient Record helps us to help our service users have better experiences in our care by allowing processes to be optimised for our staff.

- We will make our care records more used, useful and usable by improving our user accessibility and reducing the number of 'clicks'
- We will improve processes to reduce the time taken to retrieve and update records. Using new User Interface (UI) capabilities to display information on a single screen
- We will use automation and process improvements to drive efficiencies and improve system usability. We will explore technology such as voice recognition and natural language processing (NLP)

"Placing you at the centre of what we do"

Success Measures…

Metric-10 – Patient Facing Applications…

- We will increase the number of Patient Reported Outcome Measures (PROMs) completed by a digital method of choice *(SMS/email link, patient app or web portal)*
- We will increase the number of appointments booked and managed by a digital method of choice
- We will increase the number of requests for medication by Patient App or Web Portal, supporting repeat and once only medication requests

Shift Left…

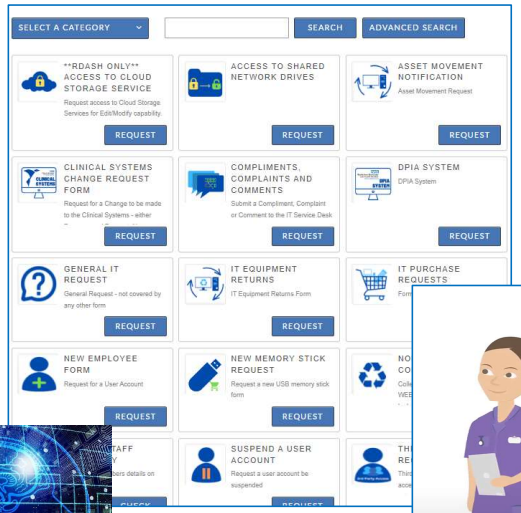
Rotherham Doncaster and South Humber NHS Foundation Trust

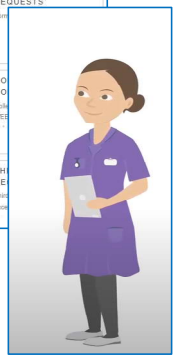
So What….

Creating value through robotic process automation (RPA)

By simply automating high-volume, repetitive processes, we can streamline the patient experience, as well as offering precious time back to clinicians and operational staff.

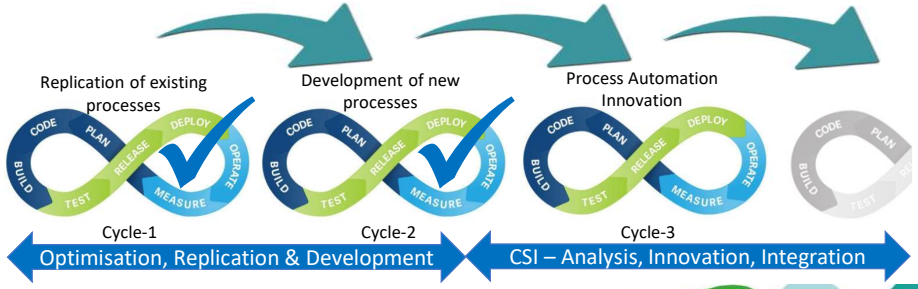
- Increased productivity and time management
- Increased clinical efficiency
- Improved process consistency
- Focus on continuous improvement

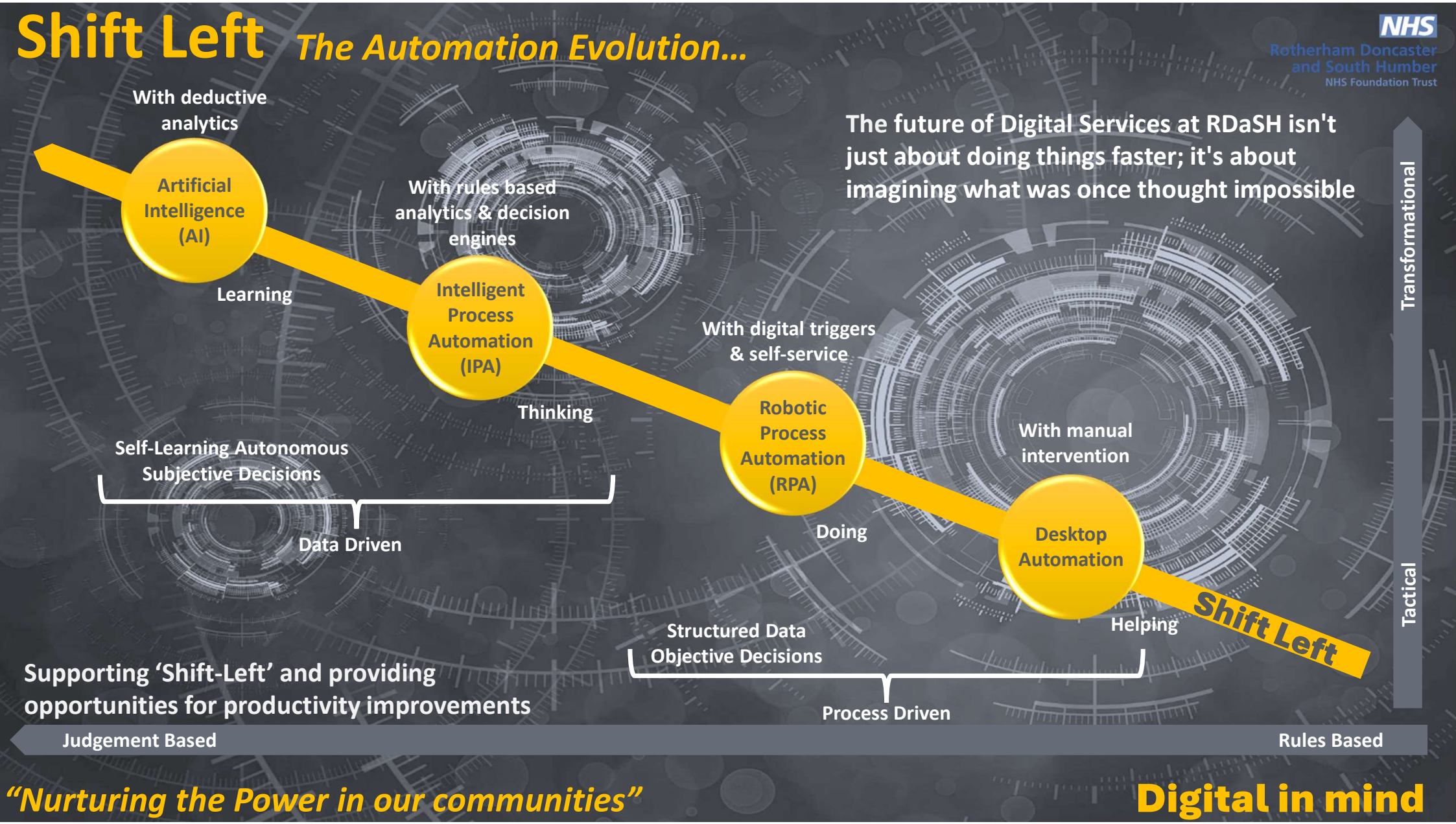




Now What….

- Deliver currently identified Service Desk CSI Initiatives
- Drive continuous improvement
- Benefit realisation through data driven developments
- Work with our users – We need their engagement to make the *'Shift Left'* MISSION CRITICAL




Shift Left
The Automation Evolution…
NHS
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NHS Foundation Trust
With deductive analytics
Artificial Intelligence (AI)
Learning
With rules based analytics & decision engines
Intelligent Process Automation (IPA)
Thinking
With digital triggers & self-service
Robotic Process Automation (RPA)
Doing
With manual intervention
Desktop Automation
Helping
Shift Left
The future of Digital Services at RDaSH isn't just about doing things faster; it's about imagining what was once thought impossible
Transformational
Tactical
Self-Learning Autonomous Subjective Decisions
Data Driven
Structured Data Objective Decisions
Process Driven
Supporting 'Shift-Left' and providing opportunities for productivity improvements
Judgement Based
Rules Based
"Nurturing the Power in our communities"
Digital in mind

Shift Left *Artificial Intelligence (AI)…*

The cascade of innovation Transforming the future of Healthcare

"Nurturing the Power in our communities"

Digital in mind

Shift Left *Artificial Intelligence (AI)…*

Transforming the future of Healthcare

There are numerous AI developments within Health Care. At RDaSH we will continue work with existing, new partners and suppliers to monitor and assess which specific technologies may benefit our services to provide productivity improvements that can help support person centred care, innovation and outcomes for our patients examples of areas of interest are:

- **Mental Health**

We are following opportunities that may be possible through AI supported precision mental health care. Digital Front Door – AI based triaging chatbots to support service users to self- refer. Risk escalation pathways and immediate signposting.

- **Waiting Lists**

AI and analytics to support clinicians to review data to help with patient prioritisation. Technology can structure the electronic data the trust has for the patients and offer proposed prioritisation based on acceptance criteria agreed with each clinical specialty.

- **Free-text Summaries**

AI technologies are already being developed to read non-coded electronic patient text and summarise this helping to provide clinicians with the information they need quickly to make better data driven decisions.

- **Microsoft Copilot**

Generative AI assistant that is integrated with several Microsoft Apps and allows users to create content with Copilot. The aim of Copilot is to automate tasks such as drafting an email or creating a slideshow and providing users with access to genAI without the security concerns of consumer tool

- **Wearables**

An important development in healthcare is the combination of wearables and AI (Artificial Intelligence). We all know that wearables bring immense value in capturing health data and they will be crucial for healthcare delivery of the future. Artificial Intelligence (AI) can do so much, from analysing large amount of data, early diagnostics, automation of processes and allow us to embrace a proactive approach to healthcare

"Nurturing the Power in our communities"

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NHS Foundation Trust

Digital in mind

Cyber Security

Business Continuity & Disaster Recovery

As the Trust progresses along its digital maturity path, we continue to maintain and update our infrastructure and devices whilst also enhancing our support systems.

These systems are fundamental in achieving our digital ambitions whilst maintaining our business continuity and the safety and security of the Trust.

Our robust infrastructure provides a strong foundation to support our innovation, integration, and interoperability ambitions.

- **Security**
  Maintaining cyber security and compliance across the entire IT estate.
- **Networks**
  Managing over 1000 pieces of network equipment supported across 81 geographic locations.
- **Storage**
  Managing over 250 server to maintain a highly resilient environment ensuring maximum uptime and minimal disruption.
- **Infrastructure**
  Protecting and configuring over 6500 endpoint devices to maintain the latest and most secure software standards possible.

"Nurturing the Power in our communities"

Digital in mind

Summary....

By 2028 we will have:

- ✓ Expanded opportunities for people to connect digitally, to make our services increasingly accessible when it's right for them
- ✓ Created more self-help opportunities for staff & patients
- ✓ Improved access to data in agile and mobile environments
- ✓ Automated an increased number of processes
- ✓ Maintained and enhanced cyber safety and security

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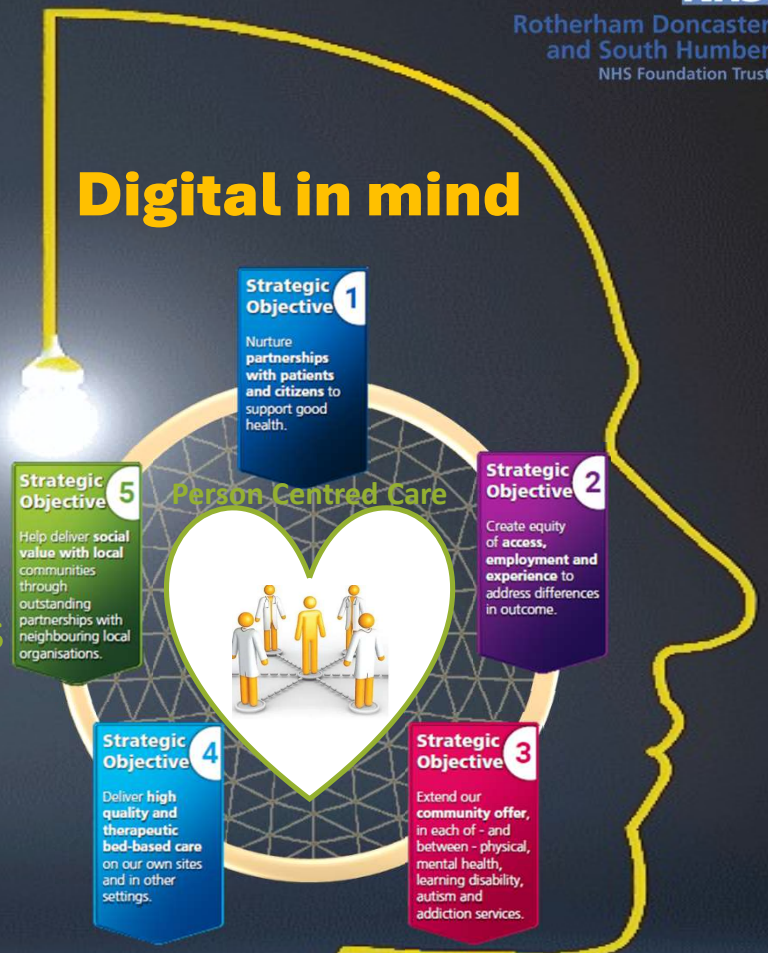
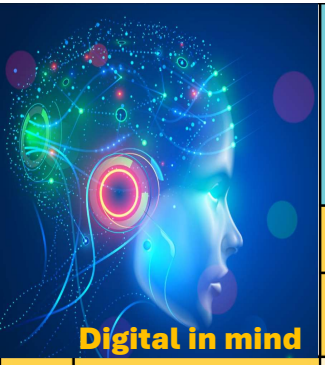
NHS Foundation Trust



"Nurturing the Power in our communities"



The RDaSH Digital Enabling Plan highlights priorities around utilising technology to improve core clinical systems, empowering patients, advancing the use of information, promoting seamless system-wide working, improving efficiency, and developing safe and secure systems.

The Plan has been purposefully designed to support the delivery of the ambitions and 28 promises identified within the trust strategy and consideration has been given to the interconnections between the trust strategy and the role Digital can play in its successful delivery.
The plan focuses on five themes for development…

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Rotherham Doncaster and South Humber
NHS Foundation Trust

Plan Themes

Success Measures	Digital Inclusion and Inequalities	Human Factors and Digital Literacy	Integration and Interoperability	Innovation and Exploration	Collaboration with our Partners and Communities
Digital Maturity	CMHT transformation	Increased flow and integration of data across EPR systems	Community Clinical Coding	Focus on key areas for digital investment and improvement towards national standards	Performance against NHS England Digital Strategy and digital maturity
Digital Capability	Work in collaboration with our partners to upskill users	Records Management	Clinician App - Brigid	Virtual Wards Red to Green Days	Assessment against nationally recognised transformation and innovation
Accessibility	Public Website Accessibility	Public Website Accessibility	Document accessibility with multi-language options	Accessibility ranking improvements	New Public Website
Service Desk Accreditation	Support colleagues to support patients	Ensures that systems, products and services are designed to make them accessible, safer and more effective for people to use	Support and signpost colleagues to appropriate support teams	Maintain accreditation and drive further improvements	Independent audit against global best practice standards for Service Desks
Data Quality	Digital, data confident and competent workforce	Clinical Systems, Reporting and Data Quality Training	Increase access to shared care data	Maintain and improve Data Quality Maturity Index Score	High quality data submissions to national service delivery
Device Protection	Digital, data confident and competent workforce	Ensures that systems, products and services are designed to make them accessible, safer and more effective for people to use	Provide improved cyber security protection	Essential infrastructure server operating system upgrades	Links to NHS Digital Cyber Security Centre
Data Protection	Digital, data confident and competent workforce	Compliance that supports better security and patient care	Observe IG and Clinical Safety guidelines	Maintain and improve across the DSPT submission	Performance efficiency measurement across the NHS
IT Support	Shift-Left Thinking - Supporting self-help and self-service to expedite solutions	Customer centred service improvement	Support partners	Digital technologies to support and drive efficiencies	Work with local and national NHS Organisations to accelerate innovation
Electronic Patient Record	Health Inequalities reporting	Reduce time taken to retrieve and update records	Yorkshire and Humber Care Record	Drive efficiencies and improve system usability	Improve care coordination and collaboration across different healthcare settings

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

Strategic Objective 2
Create equity of **access, employment and experience** to address differences in outcome.

Strategic Objective 3
Extend our **community offer**, in each of - and between - physical, mental health, learning disability, autism and addiction services.

Strategic Objective 4
Deliver **high quality and therapeutic bed-based care** on our own sites and in other settings.

Strategic Objective 5
Help deliver **social value with local** communities through outstanding partnerships with neighbouring local organisations.

Digital Enabling Plan 2023 – 2028…

Appendix

NHS RDaSH

Digital Enabling Plan 2023 - 2028

NHS
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NHS Foundation Trust

Collaboration

The Digital Plan understands that nurturing the power in our communities and collaboration with our partners is a critical aspect to providing staff and patients with solutions, to enable the right care, at the right time, in the right place.

The Trust have, and continue to, develop strategic supplier partnerships some of which are described below:

- **Ark - Staff App development**
- **Akrivia - Worked extensively with Akrivia, our research partner, to flow both structured and unstructured data from the EPR. This enables research to be done at scale using the wealth of data available from our EPR system.**
- **AccuRX - Partner with Accurx, becoming one of the first secondary care organisations to do so, for patient engagement via SMS and Video Consultation**
- **Cisco - Work with Cisco for SMS messaging for all appointment confirmations, appointment reminders and ad-hoc messaging, direct from the EPR using open APIs. We are deploying (already deployed in NHS Talking Therapies, becoming the first secondary care organisation using patient-facing apps functionality) across the Trust. This will increase SMS usage for booking appointments via URL link through a SMS, sending letters via SMS, requesting medication via a patient app, managing appointments via a patient app**
- **Concept Health – Partner with Concept Health for VR in Children's Services. This included setting up interoperability through Black Pear, using open APIs, to automatically write-back to the EPR with a summary of the therapy provided**
- **Oxehealth (Oxevision)**
- **ICE/Pathlinks – Interoperability between our EPR and systems used by acute Trusts for results to be automatically received back into our EPR system**
- **Isosec – Piloted virtual Smartcards once these were assured nationally. The virtual Smartcards enables different hardware to be used (that aren't physical Smartcard dependent).**
- **Microsoft - Various, AI, collaboration, PBI, Azure etc..**
- **TPP - Supplier 'trailblazer site' for both community and mental health, becoming a pilot site for several new functionality developments:**
  - **EPMA - First Mental Health Trust in the UK to fully deploy ePMA (fully electronic inpatient prescribing)**
  - **EPS - First community and mental health Trust in the UK to fully deploy EPS (community prescriptions, replacing paper).**
  - **AutoPlanner - Early adopter for intelligent visit scheduling & automatic allocation of visits based upon staff skills & availability.**
  - **First organisation using SystmOne to deploy Visualisations & improving the UI/UX for data entry**

"Nurturing the Power in our communities"

Digital in mind

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – (June 2025)	**Agenda Item**	Paper Ui
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	24 July 2025

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

The report summarises in month (June) and YTD performance. With new metrics published within the oversight framework – and the intent to amend our quality and safety indicators – the measures in the IQPR will evolve in the balance of H1. Alongside the IQPR, is an analysis of Health Inequalities indicators, developed by Jo McDonough.

For workforce metrices sickness (POD10) is 5.45% YTD vs 5.1% target. While a slight increase recent benchmarking data has shown that sickness levels benchmark high compared to other similar Trusts.

Two important areas of core service are behind plan, albeit with improving trajectories. In Talking Therapies (OP03a) the access rate (4,381) is below target (5,414) but has improved by 426 compared to last year. In terms of CYP services (OP13a, OP14, OP59b) there is an improvement in the access but is below target (9,209 vs 9,424).

SMI annual health checks (using our QOF measure - OP61c) sees YTD performance at 71.49% vs 95% full year target. There remains a focused improvement plan, including register consolidation and the introduction of POC blood test machines for key services.

While it appears Racist Incidents (QS29) have dropped 15 to 10 in June, through other data sources, including staff telling us of their experiences, this is an area of under reporting. We are hoping the report will be improved due to RADAR system changes.

Financially we have an overall YTD Position (FIN01) of £38k better than plan at Month 2. However, within this we have 6 (although has improved for previously reported 9) of the 23 Directorates overspent and local financial control may be removed.

We reported 7 inappropriate out of area placements for the month, which represents performance broadly consistent with our quality and financial ambitions and plans

Previous consideration	
Quality Committee and Clinical Leadership Executive – July 2025	
Recommendation (delete options as appropriate and elaborate as required)	
The Board of Directors is asked to:	
NOTE delivery in Q1	
CONSIDER areas of particular concern with a view to Q2 and full year	
Alignment to strategic objectives (indicate those that the paper supports)	
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
Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	x

Finance plan	x
Quality and safety plan	x
Equity and inclusion plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	281 / 124 / 356
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	380
Financial risks	Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
	Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	098 / 291
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	225 / 220 / 201
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	136
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

SDR2, SDR4

System / Place impact

All indicators have wider 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: SPC Icon description

Integrated Quality Performance Report

July 2025 Review

Data as at the 30th June 2025

Contents

1.0 Executive Report

This report presents the June 2025 year end performance across operational efficiency, quality, workforce, and financial metrics.

Performance Highlights and Areas for Improvement

Talking Therapies Directorate

The Access Rate (OP03a) for the cumulative period ending June is reported at 4,381, compared to the target of 5,414. When benchmarked against the same period last year, access rates have increased by 426, rising from 3,955, indicating a sustained improvement in access to the service. This performance continues to be closely monitored through the Weekly Operational Group. From 1 June 2025, the service has been working to expand the pathway to accept referrals for young people aged 16 and over. Additionally, pre-calls have been introduced to reduce the incidence of non-attendance.

During the reporting month, confirmation was received of funding for an additional 8 Step 3 trainees and 2 Step 2 trainees (a total of 10) from Autumn Statement allocations. These trainees are scheduled to commence in October 2025 and March 2026.

Reliable Recovery (OP03c) and Reliable Improvement (OP03d) continue to be adversely affected by the proactive management of waiting lists, which has resulted in an increased number of discharges during June 2025. This has contributed to a further decrease in both measures due to a higher proportion of patients disengaging from treatment and initial patient scores not meeting the threshold to achieve recovery and improvement outcomes. There has also been a slight increase in the complexity of cases presenting to the service. To address this, efforts remain focused on enhancing patient engagement once treatment has commenced, through reducing DNAs and encouraging patients to remain engaged beyond four sessions.

Children and Young People (CYP) Services

The number of Children and Young People receiving at least one clinical contact within a rolling 12-month period (OP13a) remains below the required target, with 9,209 CYP accessing services against a target of 9,424. The anticipated increase in neurodevelopmental activity from digital providers, which is not yet fully integrated into the clinical system, is expected to bring overall activity to the required levels.

Interventions to improve access rates include weekly meetings of service leads to review live waiting lists and the development of a ‘here and now’ model, with a pilot launch planned in Doncaster.

The Children’s Eating Disorder Service continues to perform strongly, achieving 100% compliance with the target to see the most urgent cases within one week across the full year (OP15), and achieving 93.83% of referrals seen within four weeks (OP14), marginally below the 95% target. It is noted that the five breaches recorded over the 12-month period primarily relate to appointments offered slightly beyond four weeks due to cancellations initiated by carers or parents. The service continues to ensure appointments are offered within the four-week timeframe wherever possible.

Physical Health Services

Physical Health Services continue to demonstrate consistently strong performance across all metrics. The 18-week referral-to-treatment measures (OP08b and OP08c) remain positive, with 97.71% of patients seen and treated within the 18-week period for AHP led services and 98.63% for consultant led services, exceeding the 92% target. Proactive monitoring of assessment and treatment waiting times, led by the Deputy Care Group Director and supported by the performance team, continues to have a demonstrable positive impact. Notably, there are no patients waiting over 52 weeks for treatment within Physical Health Services (OP10c). The Virtual Ward (LTP06), an initiative providing patients with care in their own homes as an alternative to hospital admission, has maintained an occupancy rate of 96.67%, significantly surpassing the 80% target at day 30 of the reporting period.

1.0 Executive Report

Adult and Older Adult Mental Health Services

Adult and Older Adult Mental Health Services continue to perform well across all metrics. The Trust continues to exceed targets for the 18-week referral-to-treatment measure (OP08d), reflecting an ongoing commitment to reducing waiting times and improving the quality and timeliness of care.

The metric measuring occupancy hours lost due to breaches within the three Section 136 suites reported 56 hours during June. Of these, only one of the three breaches, totalling 18 hours, related to an RDaSH patient in North Lincolnshire. The remaining two patients, accounting for 38 hours, were non-RDaSH patients (OP73a).

Inappropriate Adult Acute Out-of-Area Placements (OAPs) (OP17c)
At the end of June, there were 7 inappropriate out-of-area placements, representing a reduction from 15 in the previous period. This remains well below the Trust target of 27. A multi-phase improvement programme to further reduce inappropriate placements is currently under implementation, led by the Executive Team.

Neurodevelopmental Services
For adults awaiting ADHD assessment, there are currently 5,108 individuals on the waiting list, compared to the trajectory target of 4,509 (OP59a). This variance is primarily attributable to a number of assumptions underpinning the original trajectory that have not been realised within the intended timescales, including recruitment challenges and delays in implementing new systems. The Care Group, with support from the performance team, is revising the trajectory to better account for operational nuances and capacity constraints within the service. A draft revised trajectory has been presented but is yet to be formally approved.

The CYP Neurodevelopmental waiting list reported 3,778 children and young people awaiting assessment, compared to the target of 2,341. As with the adult pathway, the trajectory is under revision. It is also noted that activity increased by 588 children due to the transfer in April 2025 of cases from the Doncaster and Bassetlaw Hospital Autism Service.

Quality and Patient Safety

Venous Thromboembolism (VTE) (QS08)
The percentage of VTE assessments completed within 24 hours remains marginally below the 95% target, at 94.08% (136/140) for June. Weekly monitoring will be implemented across all Care Groups during July to support improvement and enable prompt learning. Feedback will be provided to individual clinicians, and corrective actions taken to address any delays. Additionally, any data quality issues will be collated and shared with the informatics team.

Racist Incidents (QS29)
There was a reduction in reported racist incidents during June, with 10 incidents compared to 15 in May. The introduction of RADAR functionality now enables staff to record whether an incident involved racial or discriminatory abuse, while still categorising the event under the primary incident type. This enhancement has improved the accuracy of reporting, as previous data from Ulysses did not fully capture the extent of racial abuse experienced by staff.

Malnutrition Universal Screening Tool (MUST) (QS36)
A three-month sustained improvement in the completion of MUST assessments was recorded in June, with compliance rising to 87.01% (134/154), compared to 83.33% (120/144) in May and 79.86% (115/144) in April. The MUAC template has been implemented to include step 4 completion, improving clarity. MUST assessments have also been incorporated into the admission checklist, with daily oversight provided by inpatient ward managers, and are scheduled for discussion at PIPA.

1.0 Executive Report

Falls (QS37) This new metric, measuring the proportion of patients receiving a falls assessment within 12 hours of admission to inpatient wards, decreased to 80.25% in June. Some data recording errors occurred due to the transition to the new template. These issues have been addressed directly with the staff involved.

Workforce Development: The percentage of employees receiving a performance and development review (PDR) has increased from 91.06% to 92.15% exceeding the 90% target.

TRUST RETENTION RATE (POD09) - Total retention rate on a 12 month rolling period is reporting 10.19% and remains above the 10% target. In June we experienced a higher number of leavers than in previous months 37 in totals, 31 of which were voluntary resignations primarily at Band 3 and Band 5. We expect the levels to return to normal/anticipated levels in coming months.

SICKNESS (POD10) The Sickness Absence % is above target (5.45% vs 5.1%) but this is an improving position compared to the previous financial year. The approach and compliance is being monitored given the launch of the new policy on the 1st April 2025. Areas of focus, both to celebrate and those of concern will be reviewed at Group level meetings

RECRUITMENT (POD25) - The recruitment KPI has breached this month this is primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance.

Safeguarding Compliance (POD 28/29): Adult and child safeguarding compliance remains below the 90% target. Targeted actions, including bespoke sessions for the half-day LEARN event calendar, are underway to improve compliance. Any non-compliance will be shared with Directors of Nursing for targeted improvements.

Vacancy Rate: The Trust vacancy rate is currently 5.50% against a target of 2.5%. Whilst the vacancy factor has increased, the establishment has increased to reflect two significant development, Community Rehabilitation and also the High Dependency Unit, which don't 'open' until September and October 2025. The budgeted establishment is included in advance to facilitate recruitment.

Finance : The Trust is reporting a deficit position of £716k at the end of June (month 3); this is £24k better than planned. Within this position, there are variances compared to budget and 6 of the 23 directorates are overspent. Where overspends occur, the directorates are at risk of losing decision making autonomy and the budget being returned to the control of the Chief Executive. Further work is being carried out to fully understand the nature of the overspends compared to information provided during the budget setting process before next steps are determined.

The forecast is to breakeven in line with the plan. This assumes that all £2.4m deficit support funding will be received in year, however, there is a risk that will not happen if the system does not achieve its **combined** financial targets. The Q2 deficit support funding is expected to be withheld from the South Yorkshire system as 3 other providers and the ICB were overspent at M2 compared to plan; £0.6m funding will be withheld for RDaSH. There will be opportunity to recover the funding in future months if the system position improves. The impact on the RDaSH forecast will be reconsidered at M4 but, in the interim, this has been highlighted as an unmitigated risk to NHS England in the M3 reporting.

2.0 - Performance – In Focus

Indicators for June 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)		People first episode in psychosis started treatment in 2 wks		9/10	90.00%		91.00%	>= 60%	91.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1481		4381	>= 5414	4381
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		278/623	44.62%		46.00%	>= 48%	46.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		429/657	65.30%		66.00%	>= 67%	66.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		18/23	78.26%		71.00%	>= 70%	71.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			561		561	>= 574	561
OP08b (L)		18 wks RTT for AHP led Physical Services		341/349	97.71%		99.00%	>= 92%	99.00%
OP08c (N)		18 weeks RTT for consultant led Physical Health services		72/73	98.63%		97.00%	>= 92%	97.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		225/228	98.68%		98.00%	>= 92%	98.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			0		0	= 0	0
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			0		0	= 0	0
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			9209		9209	>= 9424	9209
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		671/4872	13.77%		14.00%	>= 20%	14.00%
OP13d (L)	LTP 01 a	Adults accessing community mental health services (DW)			10394		10394	>= 8533	10394
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		77/82	93.90%		94.00%	>= 95%	94.00%

Narrative

OP03a – Reporting 4,381 for the year-to-date position against a target of 5,414. When compared with activity in the same period last year we are reporting 426 above last year's actual which was 3,955.

OP03c – Performance reported as 44.62% for June, a further reduction from 45.47% for May 2025 and below the 48% target.

OP03d – Performance reported as 65.30% for June, an increase from the 56.25% for May 2025, year to date target improves to 66% against the 67% target.

OP7b – PLACE TARGET ACHIEVED -a rolling 12-month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (561) and Maternal Mental Health Service (SHSC) (255) is counted the number of women receiving support is 816, remaining above the target of 598.

OP13a – The RDaSH contribution to the place target is reported as 9,209 against a target of 9424.

OP13b – The CYP access 2 contacts and a paired scored has improved very slightly in performance from 13.44% in May to 13.77% in June 2025.

OP14 – Children and young people with routine eating disorders is reporting 5 breaches (2 in March 2025, 1 in January 2025, 1 in Nov 2024 and 1 in May 2024) in the rolling 12 month period.

2.0 - Performance – In Focus

Indicators for June 2025/2026 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)			10390		10390	>= 8533	10390
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		76/81	93.83%		94.00%	>= 95%	94.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		2/2	100.00%		100.00%	>= 95%	100.00%
OP17 (N)		Inappropriate out of area acute mental health bed days			373		1490	<= 305	1490
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			7		7	<= 27	7
OP54c (L)	LTO 06 a (iii)	Virtual ward occupancy - on day 30		58/60	96.67%		97.00%	>= 80%	97.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			5108		5108	< 4509	5108
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			3778		3778	<= 2341	3778
OP60 (L)	LTO07	Dementia Diagnosis rate		7333/9789	74.91%		75.00%	>= 67%	75.00%
OP61c (N)	LTP08c	Patients with SMI having full annual physical health check		2580/3609	71.49%		71.00%	>= 95%	71.00%
OP73a (L)	LTP 10 a	Section 136 Breaches – Occupancy hours lost to breaches			56		89	= 0	89

Narrative

OP14 – The metric measuring over a 12 month rolling period is reporting at 93.83% slightly below the 94% target.

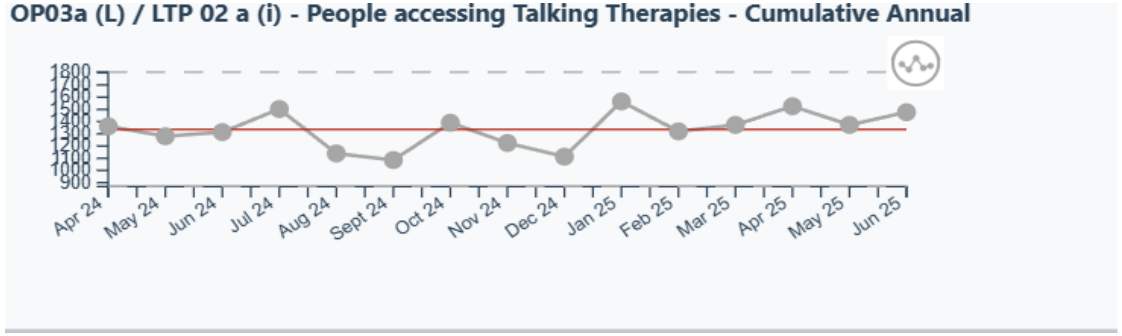
OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 5,108 adults waiting for assessment against the target of 4,509. The Care Group are redeveloping the trajectory to build in nuances that were not already accounted for regarding capacity within the service.

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual with 3,778 CYP waiting against the target of 2,341. The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

OP61c – The metric is measuring the RDaSH performance against the QOF Performance is reported as 71.49% a reduction from 72.77% in May against the 95% target.

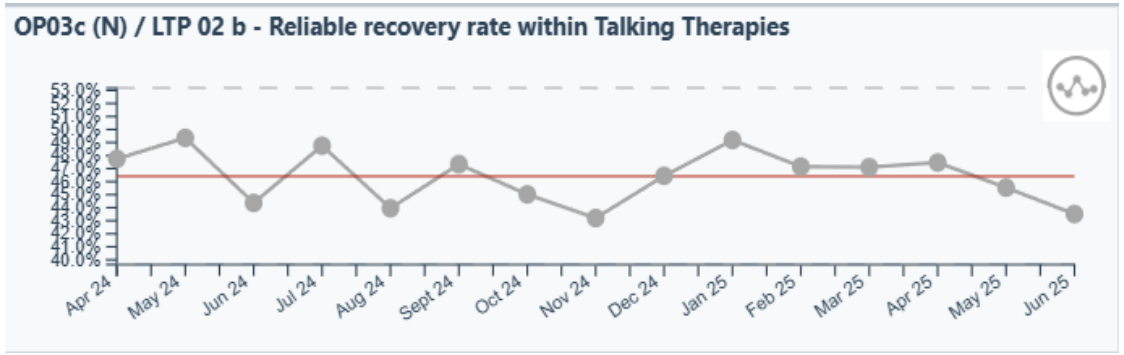
OP73a – There have been 56 occupancy hours lost within the section 136 suites for the month of June 2025. It is noted that 38 hours relate to 2 non-RDaSH patient breaches.

2.1 Performance In Focus - Exceptions



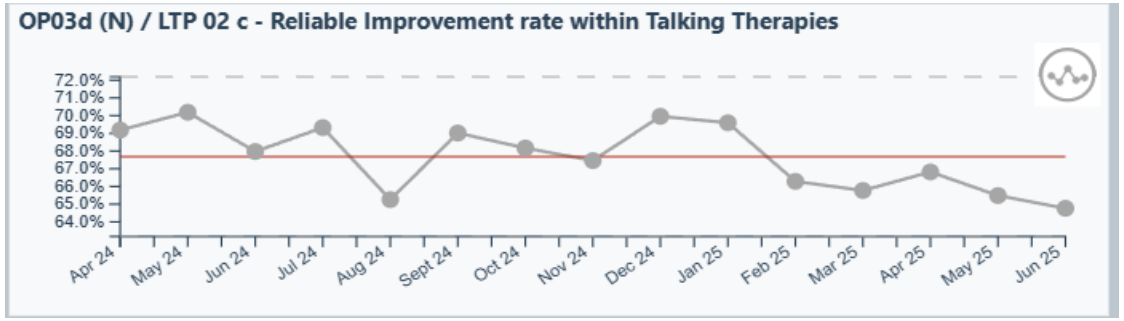
Trend, Reason and Action

OP03a The Access Rate Performance for the Q1 period is 4,381 against the target of 5,414. There is a continuing increase in access when compared to the same period last year with 426 more people accessing the service compared to the same period in 2024/25. This is continuing to be monitored via the Weekly Operational Group, From 1st June 2025 referrals opened to 16+ along with pre calls introduced to reduce DNAs. Confirmation of an additional 8 x step 3 trainees and 2 x step 2 trainees (total 10) from Autumn Statement monies with October 2025 and March 2026 start dates anticipated.



Trend, Reason and Action

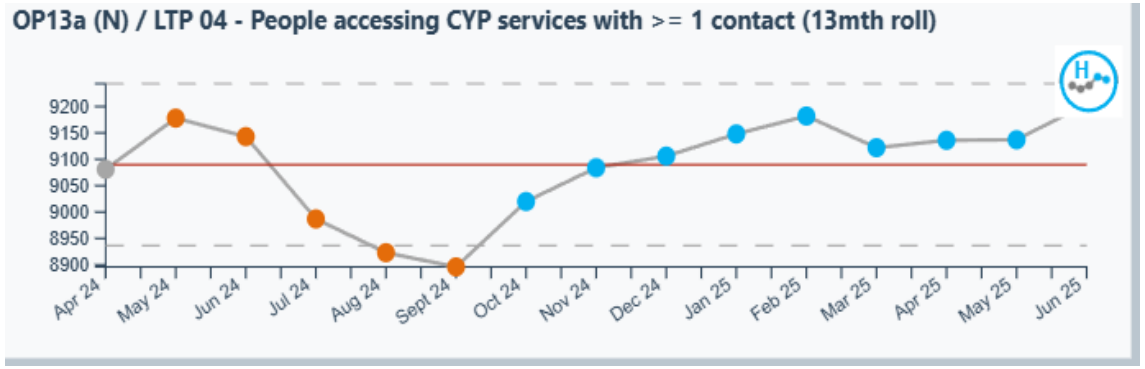
OP3c Proactive management of waiting lists has seen a continued increase in discharges in June 2025, which has contributed to the continued decrease in Reliable Improvement when combined with patient scores not being high enough at the start of treatment to hit Reliable Improvement (this has been an expected result of the increase in access). There has also been a slight increase in complexity of patients.



Trend, Reason and Action

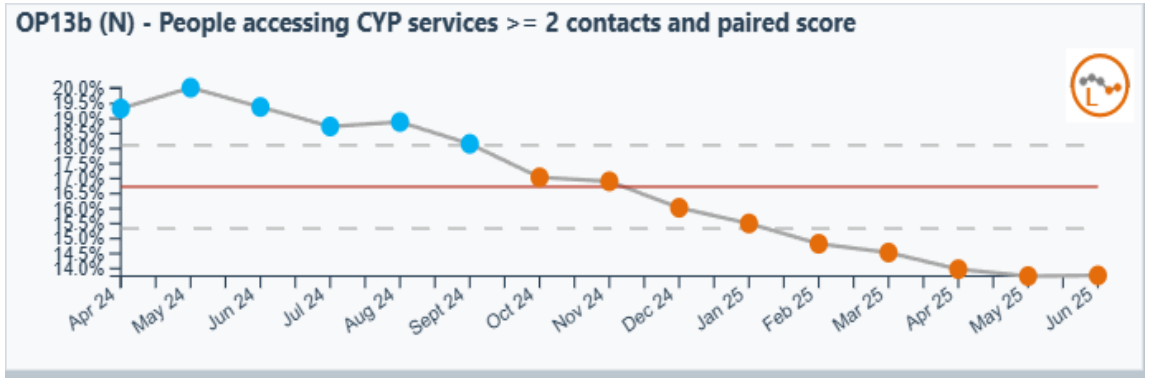
OP0dc - Proactive management of waiting lists has seen a continued increase in discharges in June 2025, which has contributed to the continued decrease in Reliable Improvement when combined with patient scores not being high enough at the start of treatment to hit Reliable Improvement (this has been an expected result of the increase in Access). There has also been a slight increase in complexity of patients.

2.1 Performance In Focus - Exceptions



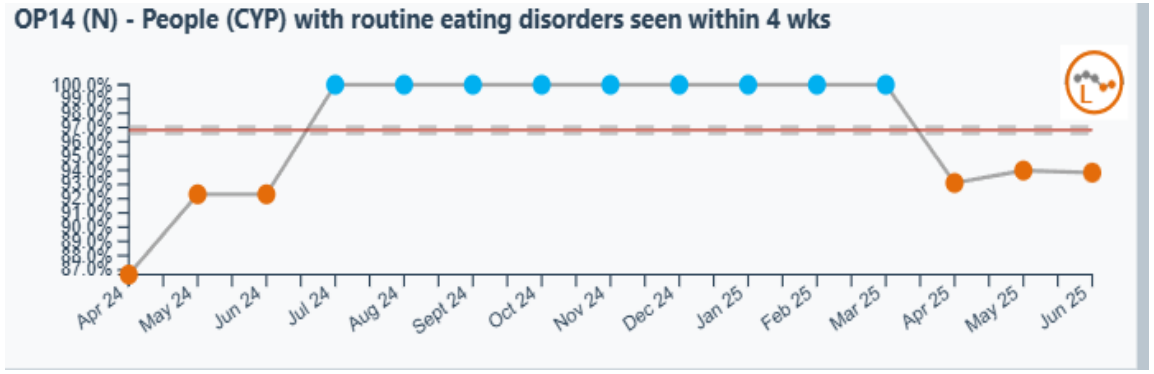
Trend, Reason and Action

OP13a The children and young people access rate (OP13a remains below the required target (OP13a), with 9,209 CYP accessing services, remaining below the target of 9,424. The expected rise in Neurodevelopment activity from the digital providers, which is not currently flowing through the clinical system, will bring the activity to the required level. Intervention to meet the access rate includes service leads meeting weekly to review live waits and in development of a 'here and now' model with a pilot launched in Doncaster in June 2025.



Trend, Reason and Action

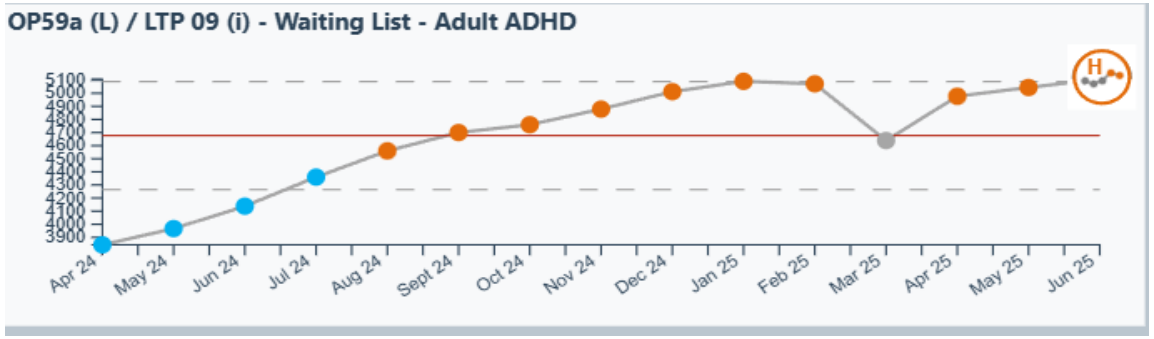
OP13b - - The CYP access 2 contacts and a paired scored has seen an upturn in performance to 13.77% in June 2025. CYP do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with CYP in the process of transitioning across to this.



Trend, Reason and Action

OP14 - Children and young people with routine eating disorders is reporting 5 breaches (2 in March 2025, 1 in January 2025, 1 in Nov 2024 and 1 in May 2024) in the rolling 12 month period. This is a rolling 12 month target with appointments offered slightly over the 4 weeks due to patient choice and cancelled appointments. Current wait times within this pathway remain below the 4 week wait target.

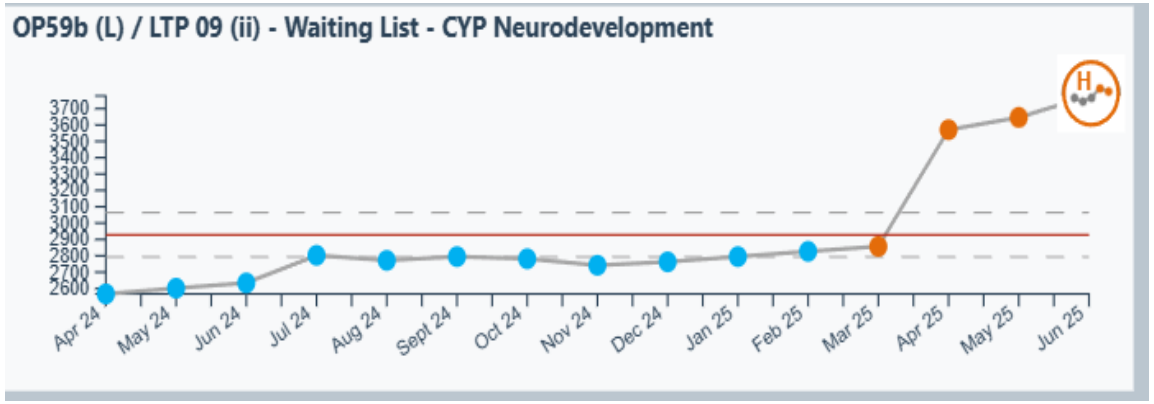
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 5,108 adults waiting for assessment against the target of 4,509.

The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The migration of data is now completed. Weekly performance meetings in place and diary management processes enacted.

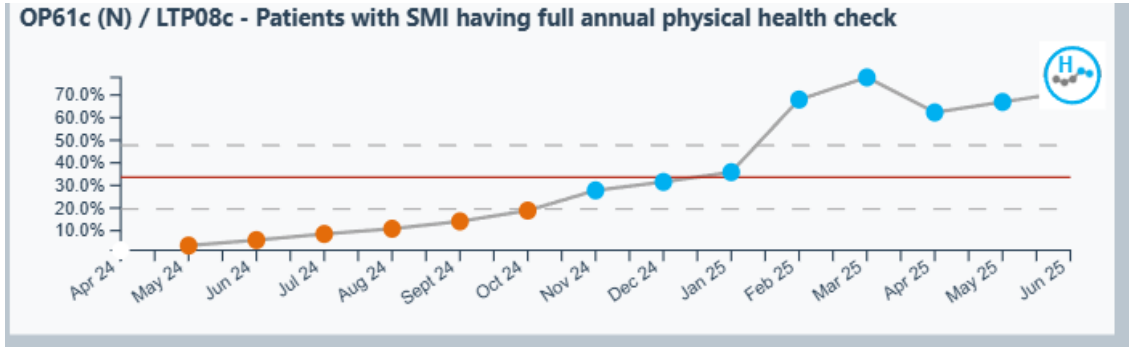


Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting 3,778 CYP waiting against the target of 2,341.

The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

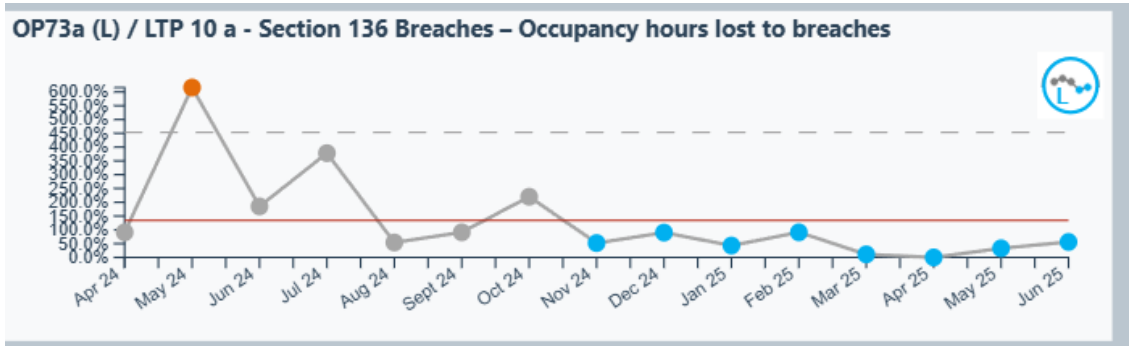
Activity will show a rise in children (588) waiting for assessment due to the transfer of children and young people from the DBTH Autism Service.



Trend, Reason and Action

OP61C– Reporting against the QOF for the place target. Graph indicates performance against the SMI checks for Promise 7 OP61c, reporting 71.49% Trustwide. Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups and register consolidation which is underway with a target end date of September 2025. To support blood test compliance all Care groups are to receive a POC machine which will support easy access to blood tests for patient eligible for these healthchecks and improve compliance. The impact of this is expected to show by Q3 25/26.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP73A—the metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, North Lincolnshire had one 17 hour breach (RDaSH patient) Rotherham had one 18 hour breach (SHSC patient) and Doncaster had a 20 hour breach (SWYPFT patient).

3.0 Quality & Safety In Focus

Indicators for June 2025/2026 Trust	Quality and Safety							
Indicator	Metric	Target		Value	QTD Target	QTD Actual	YTD Target	YTD Actual
QS05	Number of MRSA Infections (Monthly)	0		0	0	0	0	0
QS06	Number of Clostridum difficile infections (Monthly)	0		0	0	0	0	0
QS07	Number of gram-negative bloodstream infections (Monthly)	0		0	0	0	0	0
QS08	Bi patients >= 16 admitted with completed VTE	>= 95%	136/140	94.08%	>= 95%	96%	>= 95%	96%
QS15	No of wards reporting registered staff on nights/days >90%		16/16	100%		100%	>= 90%	100%
QS19	Number of AWOL's from low secure (Amber Lodge)			0		0	0	0
QS20	No of detained patients absconded acute adult / OP inpatient MH			2		4	0	4
QS21a	Physical agression incidents mod or above to staff (%)		4/25	16.00%		10%		10%
QS21b	Physical agression incidents mod or above to staff/pats (%)		0/25	0.00%		2.00%		2%
QS23	Number of Suspected Suicides (inpatient settings)	0		0	0	0	0	0
QS27	Ligature incidents mod or above all inpatient areas			1		7%	>=10%	7%
QS29	Number of racist incidents against staff members			10		31	0	31
QS31	Episodes of seclusion - Internal MDT within 5 hours		10/11	90.90%		83.00%	100%	83.00%
QS36	Inpatients that have a completed MUST assessment		134/154	87.01%		83.00%	100%	83.00%
QS37c	Inpatients commenced falls assessment in 12 hrs		65/81	80.25%		78.00%	100%	78.00%

Narrative

QS08 - The percentage of VTE assessments completed within 24 hours is below the 95% target for June at 94.08% (136/140).

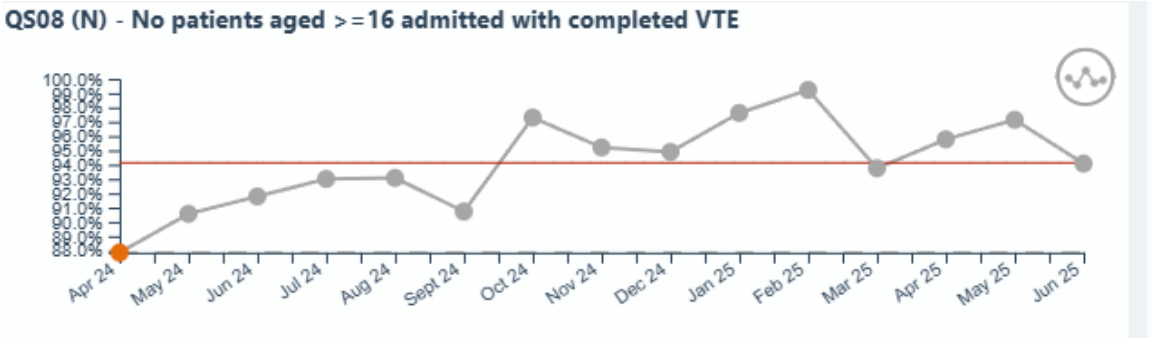
QS20 -There were 2 patients reported as absconding in June from acute adult and OP inpatient mental health units .

QS29 –Reporting a decrease in June to 10 from the 15 racist incidents against staff members reported in May.

QS36 - Reporting a three-month sustained increase in June to 87.01% (134/154) from the 83.33% (120/144) in May and 79.86% (115/144) in April of the % of Inpatients that have a completed MUST assessment.

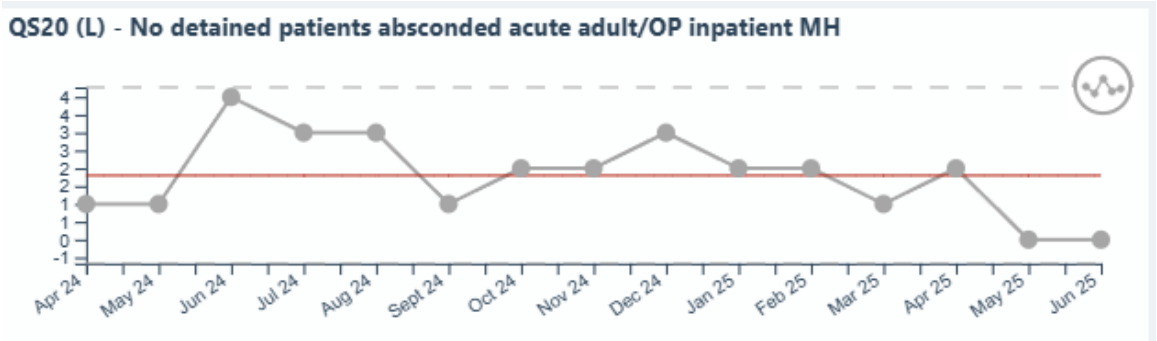
QS37 –This new metric has decreased to 80.25% (65/81) in June from the 85.90% (67/78) in May of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

3.1 Quality and Safety In Focus - Exceptions



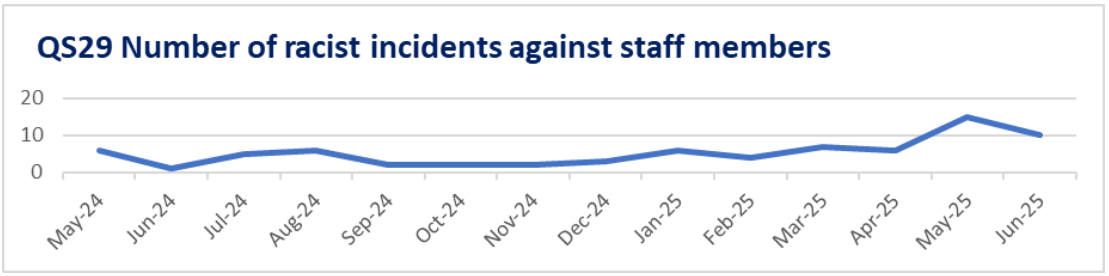
Trend, Reason and Action

QS08- The percentage of VTE assessments completed within 24 hours is below the 95% target for June at 94.08% (136/140). There will be weekly monitoring in all Care Groups during July to ensure there is an improvement, and any learning can be addressed more promptly with feedback to individual clinicians and any actions to learn from each delay implemented. Any data quality issues can be collated and fed back to the informatics team.



Trend, Reason and Action

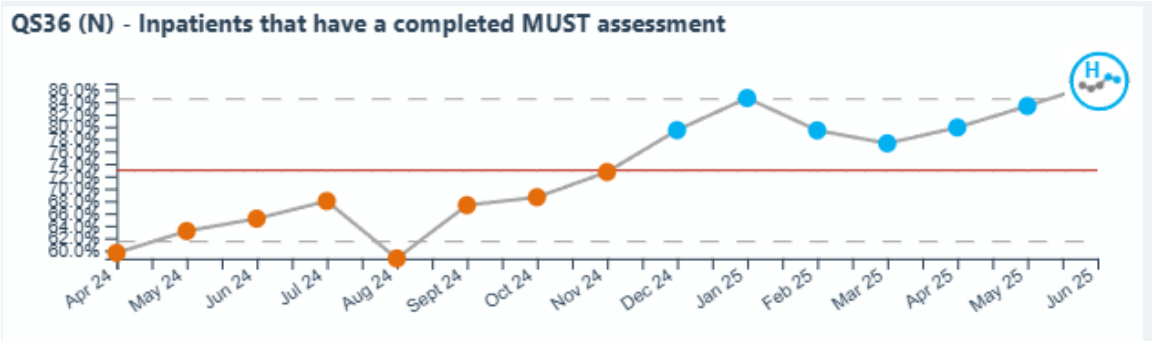
QS20 –There were 2 patients reported as absconding in June from acute adult and OP inpatient mental health units . Following a deep dive both patients failed to return from unescorted leave. The first patient was returned by the Police and the 2nd patient was returned by family.



Trend, Reason and Action

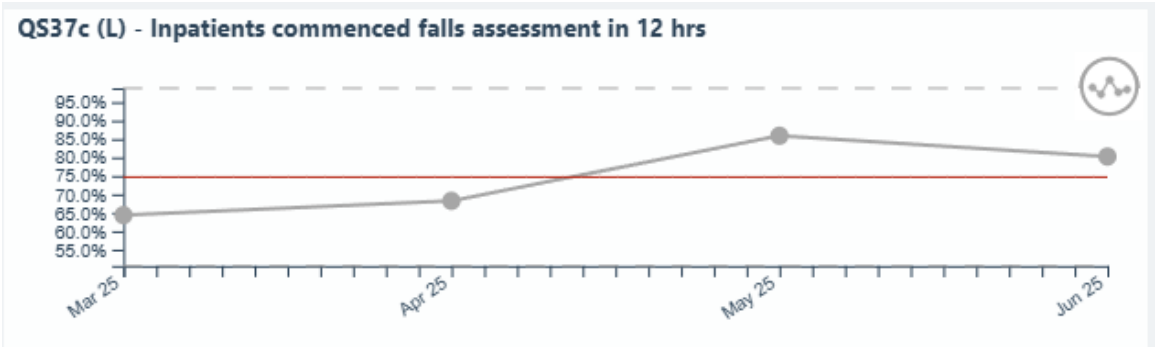
QS29 – Reporting a decrease in June to 10 from the 15 reported in May. On RADAR we can now report on the question 'does this incident include racial/discriminatory abuse?' which means staff can report the incident under the main category and still report the racial abuse which means we are now seeing a more accurate picture of our racial abuse incidents. As we knew the data provided from Ulysses was not the full picture of the racial abuse received by staff.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS36 - Reporting a three-month sustained increase in June to 87.01% (134/154) from the 83.33% (120/144) in May and 79.86% (115/144) in April of the % of Inpatients that have a completed MUST assessment. The MUAC templated has been implemented to include step 4 completion to ensure this is clearer. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers and is planned to be discussed in PIPA.



Trend, Reason and Action

QS37 –This new metric has decreased to 80.25% (65/81) in June from the 85.90% (67/78) in May of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. There continues to have been some errors in recording this month due to moving to the new template, these have been addressed with the staff concerned.

4.0 People and Organisational Development – In Focus

Indicators for June 2025/2026 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	10.19%		10.00%		10.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.45%		5.00%		5.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	9		9		9
POD16 (L)	Qualified nursing vacancies	<= 2.5%	7.15%		7.00%		7.00%
POD17 (L)	Support worker vacancies	<= 2.5%	5.79%		5.00%		5.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	92.15%		92.00%		92.00%
POD19a (L)	Individuals completed mandatory/statutory training	> 90%	94.69%		94.00%		94.00%
POD23 (L)	Number of individuals currently suspended from employment		2				
POD24 (L)	Average suspension length in calendar days	<= 150	0		0		0
POD25a (L)	% recruitment completed in 8 wks [Advert to checks complete]	>= 95%	61.94%		83.00%		83.00%
POD26 (L)	Compliance for safeguarding children's training		94.84%		95.00%		95.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		94.48%		94.00%		94.00%
POD28 (L)	Total Vacancies		207		207		207
POD29 (L)	Total Vacancy Rate %		5.50%		6.00%	<= 2.5%	6.00%

Narrative

POD09 – Total retention rate on a 12 month rolling period is reporting 10.19% and remains above the 10% target.

POD10 – working days lost to sickness is reporting 5.45% against the 5.1% target.

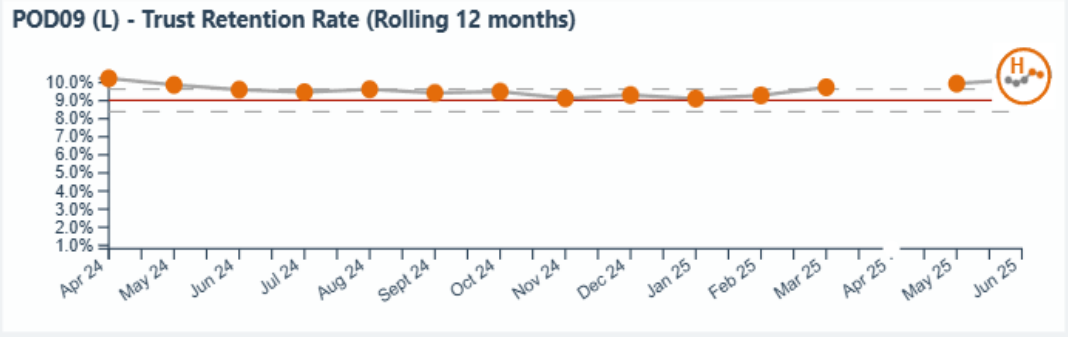
POD16-17 – Reporting as 7.15% and 5.79% against the revised target of 2.5% both qualified and support worker vacancies. Clear trajectory is in place to deliver the 2.5% vacancy factor across staff groups and roles.

POD25 – Metric changed and aligned to the national reporting from June 2025. Recruitment completed in 8 weeks has dropped below target reporting 61.94% due to a national reporting change – the National reporting requirements have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance.

POD26 and POD 27 - Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance.

POD29 – reporting as 5.50% against the target total vacancy rate percentage of less than or equal to 2.5% with 207 vacancies currently across the trust. The Trust vacancy rate is currently 5.50% against a target of 2.5%. Whilst the vacancy factor has increased, the establishment has increased to reflect two significant development, Community Rehabilitation and also the High Dependency Unit, which don't 'open' until September and October 2025. The budgeted establishment is included in advance to facilitate recruitment.

4.1 People and Organisational Development - Exceptions



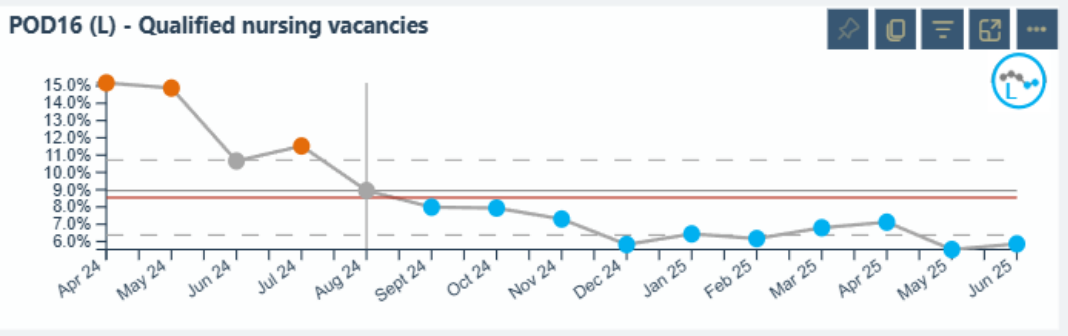
Trend, Reason and Action

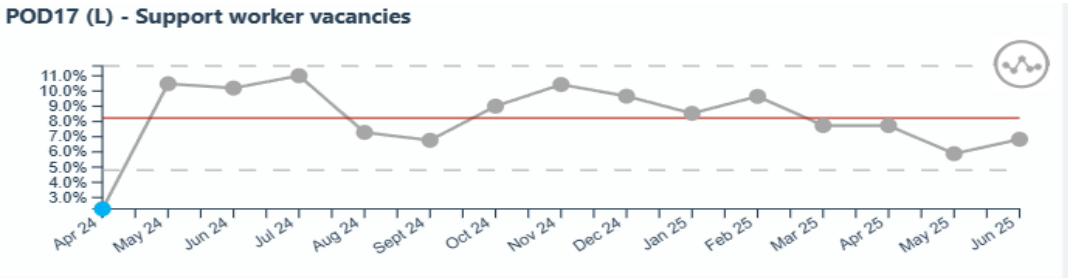
POD09 – The trust retention rate on a rolling 12 month has increased to 10.19% and remains above the 10% target. The Trust vacancy rate is currently 5.50% against a target of 2.5%. Whilst the vacancy factor has increased, the establishment has increased to reflect two significant development, Community Rehabilitation and also the High Dependency Unit, which don't 'open' until September and October 2025. The budgeted establishment is included in advance to facilitate recruitment.

Trend, Reason and Action

POD10 – The Sickness Absence % is above target (5.45% vs 5.1%) but this is an improving position compared to the previous financial year. The approach and compliance is being monitored given the launch of the new policy on the 1st April. Areas of focus, both to celebrate and those of concern will be reviewed at Group level meetings

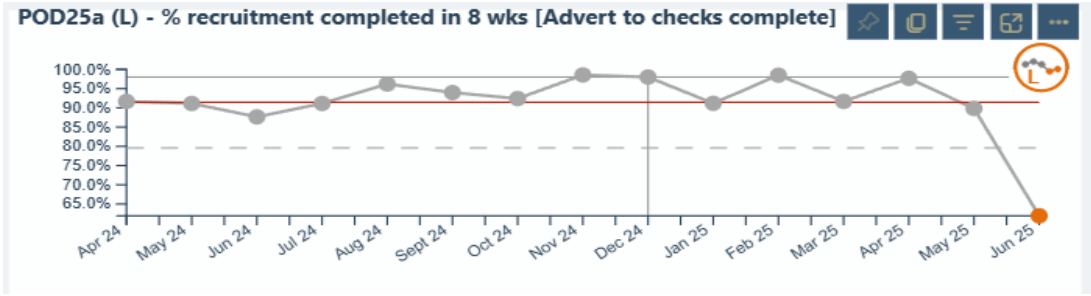
4.1 People and Organisational Development - Exceptions





Trend, Reason and Action

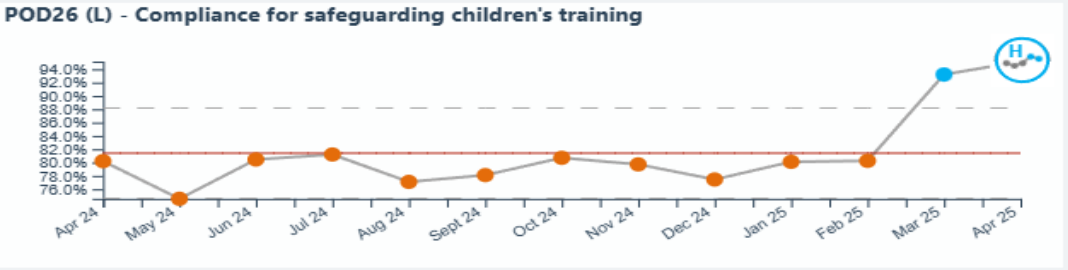
POD16/17 Reporting against the revised target of 2.5% both qualified and support worker vacancies. A full review of all vacancies were presented at the June People and Teams meeting and there is a clear trajectory to deliver the 2.5% vacancy factor across staff groups and roles.

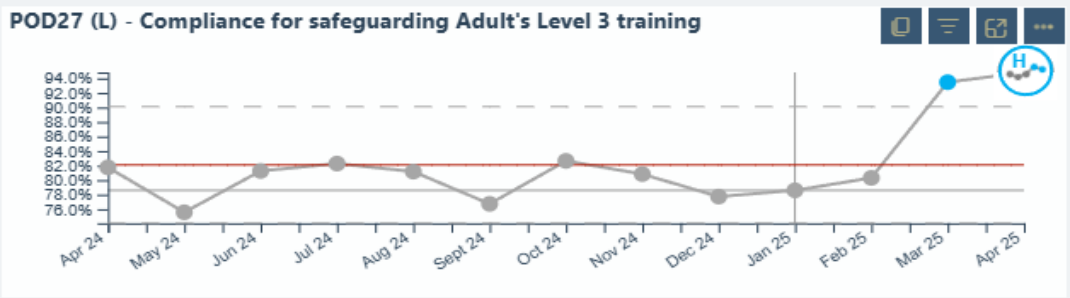


Trend, Reason and Action

POD25 The recruitment KPI has breached this month this is primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance. Metric was

4.1 People and Organisational Development - Exceptions

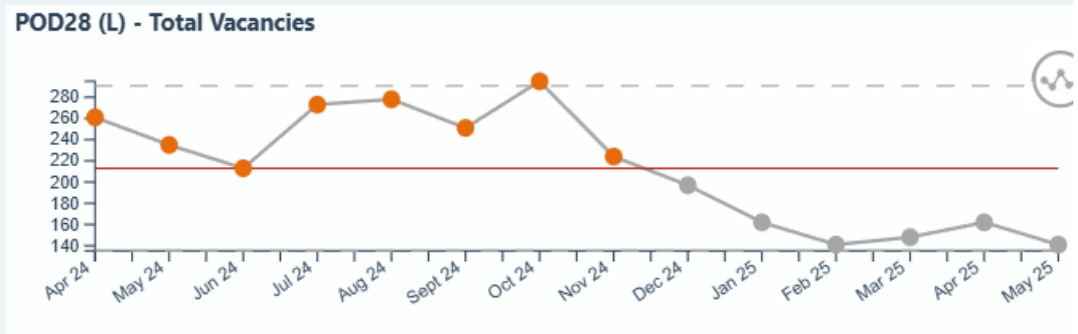


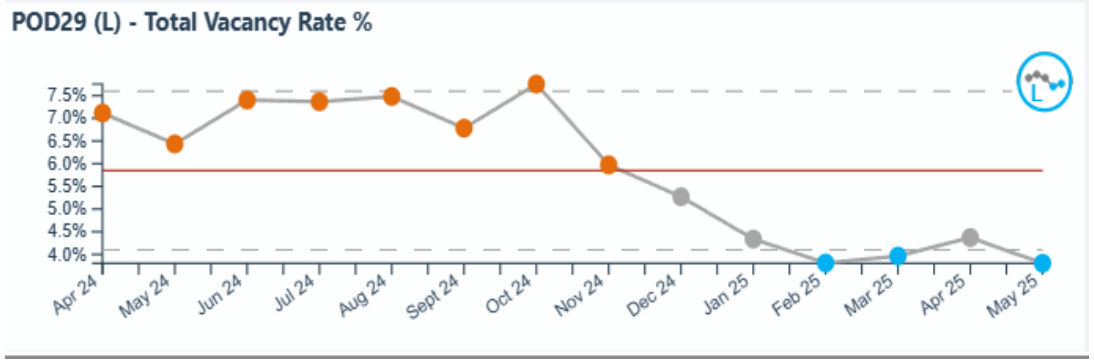


Trend, Reason and Action

POD26/27 Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance.

4.1 People and Organisational Development - Exceptions





Trend, Reason and Action

POD28 and POD29 - The Trust vacancy rate is currently 5.50% against a target of 2.5%, at the start of the financial year we do have further vacancies liked to retirements which tend to be at the end of the previous financial year and the confirmation of investment posts. In addition, we have ongoing change management where posts are being shared with colleagues to mitigate any employment risks. It is anticipated by H2 the position will be much improved.

4.0 Finance – In Focus

Finance

Indicator	Metric	Target	Actual	Variance
FIN01	Year to date actuals vs budget	(740)	(716)	24
FIN02	Forecast outturn vs budget	0	0	-
FIN03	YTD savings target vs schemes identified	2,441	2,276	(165)
FIN04	Annual savings target vs schemes identified	13,254	13,254	-
FIN05	Agency spend as % of total pay bill - year to date	1.57%	0.36%	(1.2)%
FIN06	Year to date capital plan vs spend	1,163	321	(842)
FIN07	Annual capital plan vs forecast spend	9,764	9,764	-
FIN08	No of directorates compliant with budget - year to date	23	17	73.9%
FIN09	No of directorates compliant with budget - forecast	To be reported from M4 onwards		
FIN10	***Directorates not compliant with budget - YTD:***			
	Childrens Mental Health	(3,676)	(3,772)	(96)
	Childrens Physical Health	(4,345)	(4,380)	(35)
	Strategic Development	(268)	(277)	(9)
	Doncaster Acute *	(2,928)	(2,943)	(15)
	Community & Long Term Conditions	(5,627)	(5,781)	(154)
	Neurodiversity	(596)	(739)	(143)

Narrative

FIN01 – At M3 the year to date (YTD) position is £24k better than planned. Within this position, there are variances compared to budget with 6 directorates showing overspends as reported at FIN10.

FIN02 - the forecast at M3 is to breakeven in line with the plan. This assumes that all £2.4m deficit support funding will be received in year, however, there is a risk that will not happen if the system does not achieve its combined financial targets. The Q2 deficit support funding is expected to be withheld from the South Yorkshire system as 3 other providers and the ICB were overspent at M2 compared to plan; £0.6m funding will be withheld for RDaSH. There will be opportunity to recover the funding in future months if the system position improves. The impact on the RDaSH forecast will be reconsidered at M4 but, in the interim, this has been highlighted as an unmitigated risk to NHS England in the M3 reporting.

FIN03 /04 Schemes have been identified in full for the 25/26 savings program and the forecast is to achieve the plan. At M3 however, the savings are behind plan by £165k related to a delayed non-recurrent scheme, which is now expected to be achieved in M5. A savings target of 0.5% has been delegated to each directorate and taken out of budgets. An additional £500k of savings have been identified from backbone services and removed from budgets. The out of area savings target of £3,000k has been adjusted against the out of area cost centre. There are no centrally held savings targets in 25/26.

FIN05 - Agency costs have reduced significantly since July 2024. The nominal target contained in the IQPR references the 24/25 outturn and is provided for comparison purposes only. YTD costs are significantly below this amount and are forecast to continue to be so for the remainder of the year.

FIN06/FIN07 - Capital spend is behind plan year to date by £842k. This is not unusal in the early part of the year and spend is expected to accelerate significantly in the coming months. The forecast is that capital funding will be used in full by year-end.

FIN08 & FIN10 - 25/26 budgets were agreed and signed off on the basis that all directorates would manage their budgets and not overspend. (* The exception being Doncaster acute which has a permitted overspend to M6 due to the continued need for agency medics while substantive recruitment processes are completed). At M3, 6 directorates are not compliant, this has improved by 3 directorates since M2. Where overspends occur, the directorates are at risk of losing decision making autonomy and the budget being returned to the control of the Chief Executive. Further work is being carried out to fully understand the nature of the overspends compared to information provided during the budget setting process before next steps are determined.

Appendix 1`

SPC Icon Description

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(common)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Health Inequalities – Review of IQPR	**Agenda Item**	Paper Uii
Sponsoring Executive	Joanne McDonough, Director of Strategic Development		
Report Author	Ray Hennessy, Deputy Director of Strategic Development		
Meeting	Board of Directors	**Date**	24 July 2025

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

The Board is being asked to receive the analysis of our IQPR data that has been analysed through a health inequalities lens. The overall conclusion from the analysis is that a significant number of our services do not fully reflect the communities that they serve in relation to at least one protected characteristic. Key points to consider are:

- Does the Board agree with the conclusions drawn in section 4 of the paper?
- Are there any other conclusions that should be considered?
- Does the Board support the proposed next steps?

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

Not previously discussed elsewhere: but concept socialised in May Board

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the comparison of the IPQR data to our local population, against four of the protected characteristics.

CONSIDER any other conclusions that can be drawn from the data.

AGREE the conclusions and proposed next steps.

Alignment to strategic objectives (indicate those that the 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

Alignment to the plans: (indicate those that this paper supports)	
Quality and safety plan	x
Equity and inclusion plan	x
Education and learning plan	x
Research and innovation plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	078
Performance risks	Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	294 / 130 / 186 / 082

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

SDR2

System / Place impact (advise which ICB or place that this matter relates to)							
Not applicable							
Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	
Appendix (please list)							
IQPR HIE Data – Provided within Board paper Pack B							

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

IQPR Data reviewed through a Health Inequalities Lens

Jo McDonough
Director of Strategic Development

and

Ray Hennessy
Deputy Director of Strategic Development

July 2025

RDaSH nurturing the power in our communities

1.0 What is the Board being asked?

1.1The Board is being asked to receive the analysis of our IQPR data that has been analysed through a health inequalities lens.

2.0 Background

2.1 There is a requirement for the NHS to publish a core set of data, up to and including Board level - NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006) published in 2023. https://www.england.nhs.uk/wp-content/uploads/2023/11/PR2128-i-nhs-englands-statement-on-information-on-health-inequalities.pdf

2.2 The Statement references information relating to health inequalities to describe powers available to relevant NHS bodies to collect, analyse and publish information, and the views of NHS England about how those powers should be exercised in connection with such information. It also outlines a range of data it expects to be published and relevant NHS bodies are required, in their annual reports, to review the extent to which the body in question has exercised its functions consistently with NHS England's views set out in this Statement.

3.0 Analysis and conclusions

3.1 The IQPR for 2024/25 has been analysed through the lens of four protected characteristics: namely ethnicity, deprivation, age and gender.

3.2 As a reminder, the overall 'denominator' is based upon our population. For the four characteristics analysed, the table below breaks this down.

Local authority	20% most deprived	% aged 18 to 64	% aged 65+	%female	%male	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	White	Other ethnic group
Doncaster	41%	59.8%	19.4%	50.4%	49.6%	2.9%	1.2%	1.5%	93.1%	1.2%
Rotherham	36%	59.1%	19.6%	51.0%	49.0%	5.3%	1.1%	1.4%	91.0%	1.1%
North Lincolnshire	21%	58.0%	22.0%	50.7%	49.3%	3.3%	0.5%	1.1%	94.3%	0.8%
TOTAL	34%	59.1%	20.1%	50.7%	49.3%	3.9%	1.0%	1.4%	92.7%	1.1%

4.0 Conclusions

4.1 The analysis undertaken leads us to draw the following conclusions:

- A significant number of our services do not fully reflect the communities that they serve in relation to at least one protected characteristic;

- Patients from an ethnic minority are inappropriately over-represented in some of our mental health services e.g. assessment for psychosis, in-patient services (given higher numbers of 72 hour follow-ups) and we are secluding more patients from an ethnic minority population;

- Some services are seeing more patients from a deprived area than the population, e.g assessment for psychosis, talking therapies, 72 hour follow-up mental health which could be seen as positive. However, it is not clear that we understand why and whether this is by accident or design. We also don't know whether services meet their needs?

- Some services are seeing more patients from a deprived area than the population which might indicate this as a concern? For example, more people from deprived areas are inappropriately placed in out of area mental health placements and more are experiencing episodes of seclusion;

- For a number of services we cannot draw a robust conclusion in relation to ethnicity because the data about patients' ethnicity is not as complete in our patient records.

5.0 Further analysis

5.1 The detailed data is provided in the data pack in Part B of the Board pack. Below is a summary of the analysis for those services where there is reasonable variation in representation in our services compared to the population, under or over representation. It also shows where variation is in relation to one or two protected characteristics or up to four.

5.2 Analysis of the data is represented in the table overleaf.

Table 1 - Analysis of IQPR data – Variation to population and protected characteristics

Variation	**High**	Physical health crisis assessment – more males than females. 18 weeks RTT for consultant led MH services – fewer people from deprived areas and fewer males are referred. CYP with eating disorders seen within 4 weeks – fewer people from lower deprived areas are referred, referrals mostly females. People accessing CYP services with more than one or more than two contacts more over 16 young females than males having or more than two contacts. Virtual Ward occupancy – people of Asian heritage are only minority population to receive the virtual ward service. Gender variations regarding virtual ward occupancy on days 1, 15 and 30. Adult ADHD waiting list - more females than males on ADHD waiting list. •CYP Neurodevelopment waiting list - more males than females on CYP Neurodevelopment waiting list.	First episode of psychosis assessments – more people from minority backgrounds, from deprived areas and males are being assessed for their first episode of psychosis. People accessing talking therapies – females make up around two thirds of the people accessing talking therapies. More people from more deprived areas accessing talking therapies. Fewer older adults are accessing talking therapies. 52 weeks RTT for consultant led PH services – more males than females are being referred to the service, fewer people from minority communities and fewer from deprived areas (noting small numbers) receiving a consultant led PH service in 52 weeks. MH discharge follow-up in 72 hours – suggest higher level of follow-up for people from minority backgrounds, people from deprived areas also make up almost half of the follow-ups, more males than females having MH discharge follow-ups. Inappropriate out of area – more people from minority backgrounds, more people from deprived areas and more males than females are placed inappropriately out of are for their mental health care'. Episodes of Seclusion – More people from minority backgrounds, more from deprived areas and more males than females are experiencing episodes of seclusion.
		Low (variation in 1-2)	**High (variation in 3-4)**
	Variation in number of protected characteristics		

5.3 There may be more variation than shown in some services because the data is incomplete in patient records, namely in relation to ethnicity. These services are:

- Physical health crisis assessment;
- 18 weeks RTT for consultant led MH services;
- CYP with eating disorders seen within 4 weeks;
- MH services including CMHTs.
- Women supported by perinatal mental health
- People accessing CYP services with more than one contact or more than two contacts –
- Women supported by perinatal mental health
- 18 weeks RTT for AHP led PH services
- 18 weeks RTT for consultant led PH services
- Adult ADHD waiting list
- CYP Neurodevelopment waiting list

6.0 Next steps

6.1 The analysis will be reviewed by the Equity and Inclusion Group in August 2025. From this a range of actions will be taken to:

- better understand local need of patients with different protected characteristics;
- understand any variances in provision versus community population;
- how to provide targeted, culturally appropriate services.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises scorecard – July 2025	**Agenda Item**	Paper V
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	24 July 2025

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

We have delivered our first promise: promise 25! The work continues to shift spend locally. We are working hard to deliver promise 3 by October: and promises 14 and 19 in year. The operating guidance we adopted at CLE focused on executed on a short list of promises in 25/26 predominantly concentrated on strategic objective two in relation to health equity.

The scorecard is updated bi-monthly. We should continue to be concerned that not every promise has a delivery plan consistent with our success measures. Of those plans, our carers' promise is before the Board this month, and we expect a more detailed discussion on promise 1 next time. I would encourage any board member keen to understand a specific promise to approach me or the director whose plan it falls within.

Consistent with discussions within the AMM, and via the Council of Governors, the underpinning focus for us poverty as a core health need remains – and the cover paper reflects on what remains to be done and some of the challenges in making it happen.

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

NOTE and discuss any promise of specific interest

RECOGNISE the ambition to deliver a suite of promises over the next twelve months

AGREE to continue to emphasis the primacy of our promises

Alignment to strategic objectives (indicate those that the 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
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
Digital plan	X
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X

	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks	Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
	Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	X
	Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	X
	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
	Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
	Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
	Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR 1, 2, 3, 4 and 5							
System / Place impact (advise which ICB or place that this matter relates to)							
Supports wider delivery of ten year plan							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex A – Promises report 2024/25 (as per AMM) Annex B – Promises report 2024/25 (easy read summary)							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update: Q1 2025/26

Purpose and introduction

1.1 Accompanying the scorecard, which follows the format agreed by the Board in September 2024, is a commentary here on key matters arising over the past 8 weeks, together with any new risks to delivery, which the Board needs to be sighted on. Challenge on the pace and depth of progress is welcomed, and the report should provide a basis for that to happen.

1.2 Since we last met, we have published our second annual 'Promises Report'. In addition to a range of local languages, we again issued an Easy Read version. It is heartening to see comment from local people on some of our promises, which are broadly, but not uncritically, positive. Annex B includes this material.

Looking forward to October

2.1 The scale and diffuse nature of what we are trying to do can be distracting at times and, of course, that feeling may be greater among frontline managers and leaders. **Promises 14 and 19** form the centrepiece of what we have committed to achieve this year, and we need to ensure that there remains absolute focus on both. For out of area placements, good progress has been made – and presently we are within the sums we had budgeted. The task is a daily one, as we look to shift how risk is managed and where it is held. There is a distinct report before the Board on promise 14 and the sense is that the collecting, and reporting of performance – and the analysis of demand and supply, are in place (with a small number of adjustments needed). But to consistently deliver a four week wait, we want to ensure that we are able to make decisions about appointments (and, therefore, to allocate patients to professionals), inside a week of referral. This redesign is being actively explored this summer before we can define an implementation path.

2.2 The intention remains to have 350 volunteers into roles to match or exceed **Promise 3 by October**. By creating these roles within ESR, we will be better able to support local line managers with that work and, by putting the volunteers themselves onto ESR, better able to report numbers and, indeed, ensure protected characteristic analysis and recruitment diversity. At the time of writing, it would appear that three of our six groups have hit their 'ask' in terms of both roles and volunteers: our three adult mental health care groups are slightly behind this but catching up rapidly. With some changes in the Aspire cohort within Doncaster, it is that Care Group who probably have furthest to go now to achieve that minimum ask. Detailed weekly support for both the corporate function and clinical teams will be in place through August and September to maximise our chances of delivery on time.

2.3 We have now completed engagement work with local stakeholders in relation to our first steps on **Promise 10**. This should lead us, in October, to begin to recruit into the new homeless health team, which we want to embed with local authority colleagues, but also to integrate with our drug and alcohol service. During Q3, we will begin to commission, to the peer-led audit work of access to our mainstream services, and examination of our policies to revise those to alter any unintentionally excluding arrangements. The Board has taken a particular interest in Gypsy, Roma and Traveller (GRT) access and outreach and we are looking to understand whether we have begun to make a difference for those communities.

2.4 In September we will discuss, as a Board, progress to date with **Promise 1**. In 2024/5 and 2025/6, we have invested to expand our Peer Support Worker (PSW) cohorts, achieving coverage across a number of new teams. It will be important to be confident that the support to these PSWs is clear and sufficient, that we have considered carefully the policy implications for those who are employees (in the main, our model is not employment, unlike some neighbouring Trusts) – and that we can see a path to full coverage over the following three calendar years.

2.5 **Promise 27** is clearly the basis for our Green Plan. As is outlined in the covering report, this will require us to explore routes to reduce business mileage (including our digital patient and remote staff offers), as well as smarter scheduling. This has to be accompanied by a shift in energy supply models away from gas (which anyway is increasingly unaffordable). Ready for Q3, we hope to have in place cogent plans for these steps, albeit the latter will rely on a business case funding model being approvable. It will be important that momentum is not lost with changes of leadership across finance and estates. Jo McDonough will coordinate the work, drawing in professional advisory support as needed to maintain pace.

<u>Poverty: key to our mission</u>

3.1 In reporting back to local people at the 2025 Annual Members' Meeting, we chose to emphasis the underpinning importance of our work on poverty. This has also, organically, become something of a focus for our Trust People Council, responsible for our cultural work. The Board will recognise that a lot has happened, not least our intervention in the low wage element of the NHS pay structure. Work continues to ensure that our hardship fund, debt advice and food cupboards, are known, available, and de-stigmatised for our staff, notwithstanding delivery of Promise 25.

3.2 Our audit work for Promise 6 continues, and over 30 reports are now available on our website. Richard Chillery is leading work to seek to establish a Poverty Truth Commission locally with local authority peers. But the key step is change and delivery. It is proving challenging to get into place travel funding help on a pre-payment basis and to pre-identify excluded patients – we are looking to learn from the local Children's Hospital, who have

successfully intervened in was-not-brought rates. We will confirm at the next Board meeting an implementation timetable for these changes as we had hoped in March to have them in place not later than June. *At our leaders' conference in September, every single recommendation from the reports, so far, will be visible as 'wallpaper' to provide an opportunity for leaders across the Trust to see the changes that are being recommended* and indeed to annotate the wallpaper with steps taken and to be taken.

Conclusion

4.1 Increasingly, we are using **delivery reviews** to test the transition of key promises from discussion within committees into frontline delivery. This step can only occur with the use of good data, and so it is helpful that we now have a standard report for promises 7, 8, and 11: in due course we can augment this with promise 10 and 12. Key data items for promise 9 form part of the E&L report and in September we will begin to use this in delivery reviews, as we did the research scorecard (promise 28) in May. These steps will help us to make the work of executing on our promises 'core business' as distinct from additional projects.

4.2 Over coming weeks, we aim to find **a similar reporting model** for promises 3 and then 1 and 2, with the plans for those promises developing at pace. Of course, promise 4 is already routinely discussed by teams from frontline level into the Board.

4.3 The shadow CLE is due to kick off during Q2, and, over the latter part of the year, Glyn Butcher and Jude Graham will undertake work reviewing how we support co-production. **Delivery of our Community Involvement Framework** cannot be successfully achieved without a more structured relationship between the Trust and voluntary sector partners, and we are actively considering presently how best to do that, acknowledging that the intention is for Care Group "cakes" to hold lead responsibility for VCSE partnering at place.

Toby Lewis, Chief Executive
23rd July 2025

Promises and priorities – delivery plan and delivery self-assessment

Annex 1

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
1. Employ peer support workers at the heart of every service that we offer by 2027.	Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Amber red	We have more PSWs in place than before, but as yet have not converted our learning from this into a forward plan. Papers before the Board explain that this will occur for September via the E&I group, and in time for the 2026/27 Investment Fund cycle.	Amber red	This work will require the focus learnt on promises 3 and 6 in recent weeks if we are to purposefully introduce PSWs at twice or more the scale of neighbouring Trusts: the next few months will set a critical platform for a 26-28 funded plan of growth
2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	Assessing the trajectory for this application was delayed from February to July owing to pressure of other work, so no change to planned rating.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence. The positive 'aura' created by the Carers Network will help – as will the impetus to improve flexible working arising from the staff survey.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	CLE has approved the changes discussion within the HQTC process and revised open visiting seven days a week will go into operation from September 1st.	Amber green	Carer feedback will be critical, as we implement the new approach – and gather insight into what works (critical too with changes to MHA). We have not delivered until that feedback is available.
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber green	The plan presented to the Board, which was previously considered through CLE, sets out some of the actions needed to move forward with this – it is work which has a broad and enthusiastic support among local leaders.	Amber red	This cautious rating reflects the hidden scale of need and the work required to match that with support

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	Identify all-age carers that use our services and ensure their rights under the carers act are recognised.	Amber Red	We need a little time to test the delivery path, collate the current state, and assure ourselves we understand the barriers to action now.	Amber Red	This remains an exceptionally challenging measure and the heart of Promise 2. Concerted work through 2026/27 will be needed to make a reality of this commitment.
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.	Green	There is now confidence that all involved understand what needs to be done, and importantly in many cases, why. The late delivery of dataflows and other key enablers is an important lesson for other promises, notably promises 1 and 2.	Amber green	We need not only to achieve but to sustain, and we know that volunteers leave as well as join. Truly achieving this promise is best assessed in March when we have met the measure for six months.
	For that body of volunteers to reflect the diversity of our populations.	Amber green	A little reflection will be needed in August on whether further steps are needed – on unvalidated data this increased diversity has been achieved with our expanded numbers.	Amber green	There is now clear focus on this aim, and with more people entering volunteering on a career-development pathway there is a route apparent to delivery.
4. Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Green	Both via Care Opinion, and bearing in mind other routes, we can see that the scale of feedback we have in place will continue to expand.	Green	This scale measure we would expect to meet during 2025/26.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	The pilot for this work has proved successful and has been assessed by the Board's MHAC: we now need to sustain the work over time.	Green	We will track this work in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received.

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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.	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Green	Directorates have provided good evidence of use of feedback and of Care Opinion: in the three acute adult MH, rehab and children's mental health directorates we have more work to do to expand use and make documented use of alternatives.	Amber green	Recognising that feedback is not all about 'change' – we need to be able to evidence a small number of meaningful impactful changes in our 26/27 Quality Account. A draft of that evidence will be tested within our CQC work due in November 2025.
	Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work continues and has been evaluated for further improvement. The remaining step planned is to create communities of practice among those involved, for example through our shadow CLE.	Green	As the work continues, the need to ensure accountability from representatives back to the local community will grow. The route and agency through which to do that remains to be established.
	Deliver the Board's community involvement framework in full.	Green	This CIF has broad support (and is now approved) but needs operationalisation plans to deepen with Care Groups, supported by a revised VCSE register (new received).	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Amber green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming weeks.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.
	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber Green	This was launched within the annual members' meeting. We will use the N&F delivery review in August to test plans for delivery.	Green	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 2025 we would expect to meet the measures we set in 23/24.

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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).	Green	Directorate level deployment is agreed and a revised ‘approach’ is being taken learning from pilots. There is a good ‘buy in’ now from those involved.	Amber green	As the cover report outlines, implementation of key agreed changes has been slower than hoped: and this will be a focus within the Leaders’ Conference in late September.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	Our current plan is to poverty proof. It remains to be established in early 25/26 what other interventions are needed to achieve this measure.	Amber green	The lack of a final timescale for this improvement explains the positive rating – there is time in 2025 to iterate delivery over following months/years.
	Benefits and debt advice access to be routine within Trust services to tackle ‘claims gap’.	Amber green	Teams have begun to describe how this will be integrated within their DIALOG+ deployment: more detail is needed on how patients will experience this access before the plan goes green.	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.
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.	Green	This now moves to green with the consistent data flow and ability for the E&I group to track progress, with strong evidence we are succeeding.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.

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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”). (next report will include neurodiversity measure and peri-natal MH)	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber red	This rating reflects the position in terms of Learning Disabilities. As the IQPR illustrates for Serious Mental Illness, we have and continue to make progress against our joined-up QOF measure.	Amber red	For LD, we need to resolve in Q2 a trajectory to achieve coverage *or revise our aim.* For SMI, there is confidence we can go beyond what is currently being achieved, and materially intervene to improve physical health status among the SMI population.
	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Amber red	There is not yet a cogent plan to address this (and the investment fund bid proved unaffordable). A reset of approach needs to be undertaken considering what can be achieved (and what problem we are trying to solve)	Amber red	The LOD has deteriorated in view of the plan being unaffordable, and the wider challenges for this AHC approach outlined under promise 7 reporting.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green	A strong proposal to make progress with this is funded for 25/26, rooted in evidence from elsewhere. We need to ensure all 3 memory services are engaged with the Rotherham led work.	Amber red	The LOD is improved based on a emerging and coherent plan. As waits for diagnosis reduce, we have capacity to reach into communities and work at pace (as we evidenced in NL).
	Improve access rates to talking therapies among older adults.	Green	We have reviewed plans to act (and increase by over 1000 the number of older adults using the service annually) within the latest delivery review (the service is managed cross Trust). There is a cogent stepped plan through the balance of 25/26 to meet the goal.	Amber green	The known-unknown is whether the steps outlined in the plan give rise to sufficient referrals: if they do sufficient capacity exists to shift the dial towards 12% coverage.

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9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.	Achieve the levy requirements in 2024/25 and thereafter.	Amber green	The Board has received the plan of action for this measure: It is now being enacted. It is clear we will expand our levy spend beyond 24/5 outturn but we need to see over 100k committed on band 4 roles to meet our 830k goal.	Amber red	During Q2 we need to recruit over 100 band 4 postholders into apprenticeships: the service offer has moved under the Executive Director in order to grip this significant challenge.
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Red	We will review the plans in the August delivery review.	Amber red	Whilst there are differences between these three ambitions they currently have in common delivery doubts based on a lack of oversight and cogent approach. This is being urgently addressed – as schemes exists elsewhere and deploying them to the Trust is entirely possible with focus in Q2.
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Red	We review the plans in the August delivery review.	Amber red	
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	Learning from what is above, we need to start work now on the scheme for twelve months hence. Working with our ID/LD teams, we need to consider how best we can establish a targeted programme.	Amber red	
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and misusing substances, and forced migrants.	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	Comparison vs. standards will go the September E&I sub group (it missed July).	Amber red	It is possible to meet the standards in time, with rapid use in 25/26 of the funds set aside with partners. This will require concerted work to make ‘mainstream’ services available, as well as to develop specialised services.

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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	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	This access plan will rest on ensuring mainstream services thresholds for exclusion are changed in theory and practice: initial discussions to this effect have begun. A more organised and concerted approach will be needed (with new resource in place to move this forward).	Red	Until a baseline plan is in place it is not possible to offer a more optimistic view of changes needed – nor how much resistance in practice could be experienced in developing TIC models in this field.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	The Trust has invested in GRT specialist service support. Service offers for sex workers and those experiencing homelessness are developing – there remains work to do in considering how best to ensure refugee access.	Amber green	Most inclusions health groups can benefit from revised access arrangements, and some element of specialised support, over the next two years. But only if organisation and emphasis is stepped up in H1.
	Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place.	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.
	Introduce peer-led service support offer for local residents.	Amber green	This offer is in place in trial and further expansion is being into place. We'd expect this to be live at full scale during 25/26.	Amber green	This input and effort measure can be met, and is in fact ahead of expectations.

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12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.	Green	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams.	Amber green	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into early 25/26.
	Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated in the context of the digital transformation plans we have during the balance of 25/26.	Amber red	Rating reflects planning comments made.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Amber green	A strong plan exists, has been peer reviewed, and is being delivered. We are exploring further winter expansion plans which would assist with this model.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We need to agree a final plan with the Care Group, and crucially with DRI, for the service's further growth. We will aim to do this in our September Delivery Review.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Green	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Green	The first Rotherham community patient has used the service. CLE will explore in October progress across all three places.
	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…	Amber Green	This measure is ours, and others, and will see substantial emphasis in coming years – no doubt.

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14. Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Meet four hour wait standard in 2025/26, where it applies.	Amber green	We have reviewed progress in the Clinical Leadership Executive in July and a further paper will come in August: rapid access is including within the oversight framework metrics.	Amber green	We appear on current data to be largely delivering this promise. We have some to do to understand the problem we need to solve to make this consistent.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Amber red	Thinking about routes to success has taken place and CLE is moving to define what this promise in practice means in July and August.	Red	Until we commence implementation it is too early to be confident we do not have glitches, notably in relation to MDT decision making and weekend working.
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Green	Strong consistent work has taken place to understand our waiting lists and demand/supply in relation to waits themselves. Investments reflect only areas where productivity cannot meet the measure.	Amber green	Delivery relies on both supply side change and some stability in demand, both across a year and by month (as a proxy for four weeks). We will use 25/26 to identify difficulties with that assumption.
	Meet 4 week standard from April 2026 across all services.	Amber green	There is increasing confidence that this measure could be met: the cultural shift doing so requires is not inconsiderable. Delivery reviews provide strong evidence that in four of five care groups there is a detailed plan that can be relied upon.	Amber red	There are three groups of services: neurodiversity; those who will meet the measure; and those in the balance. It is the in the balance group where we need to make changes to succeed.
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	Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Amber red	It is broadly positive that the ten-year plan places such emphasis on this space. The emerging challenge is to ensure that we work as neighbourhoods not place.	Amber red	Time passes and 26/27 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings

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physical and mental health needs.	Restructure Trust services into those INTs during 2025/26.	Red	During Q3, realistically, it should be possible to review the scale of changes needed in our teams to move from current to future state. This will be important to wider work to reform how community teams work and the balance of generalism and specialism.	Amber red	on a pilot or targeted basis.
	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!
	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	Needs a clear frame of analysis. This will be documented over coming weeks.
16. Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	We are moving from training to use and support teams to doing: led by Jude Graham. A rollout plan of support is in place. The scale of change involved is substantial.	Amber green	This remains a challenging programme and one that can deliver, but will face competition from other priorities at a local level, albeit corporate leadership and support is now defined.
	Report and improve patient recorded outcome measures (PROMS) supported nationally.	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber red	An improvement trajectory remains to be understood and defined, but data is beginning to be shared to build it.

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	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red	This forms part of our Q&S plan but may take us into 2026/27.	Amber red	We need to reserve development time in Q4 to put in place the agreed data flows to enable delivery to be feasible in the following year.
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 green	A challenging plan exists, which has strong support from across corporate functions and is led through the Children's Care Group.	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan. This feels feasible, if difficult, in Doncaster and North Lincs.
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber red	Establishing this data feed is taking time and requires collaboration across a number of teams inside and outside the Trust. Annual data is feasible as we look to stem a deteriorating position.	Amber red	It is much easier to be confident of the inputs than the results in this field: the Trust has developed and is implementing a clinically led hypothesis which may transpire to make a difference.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	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 – with Q1 25/26 seeing some better real time data available to teams, for instance in relation to S17.	Amber green	With continued focus we have some confidence that this can be met over the balance of the year.

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	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 green	We have made progress in defining the steps of the plan, hence the improved rating. The Board will hear about the pilot.test ward and we'd expect to be live across all our wards by November at the very latest.	Amber red	Mobilising this work will be a significant endeavour in 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, and this will be reflected in our QA for 24/25.
19. End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Cease to place patients out of their home district except where that is their choice or in their best interests.	Amber green	The plan of action is widely understood. Success will come from sustained effort to avoid OOAP choices, and the work to return people current locations. The steps needed to deliver (for inappropriate OOAP) are in place.	Amber green	This is an improved rating consistent with late Q1/early Q2 delivery. Moving to zero may not be achievable.
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 as does the new willingness of DRI clinicians to support non-admitted patients through the model.

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	Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber green	We have agreed to develop a pilot proposition in North Lincolnshire older adult care, as part of implementing the Phase ¾ changes. By November 2025 we'd expect to be better able understand what it will take to do this at greater scale.	Amber green	Clearly the timescale has passed, but it remains possible to deliver this measure within 25/26 at least on one site.
	Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Red	The intent and commitment to do this is clear from the leadership team – but a tangible plan to trial this is not yet visible and did not come forward within planning for 25/26. Discussions will continue with the CCG.	Red	Evaluation in that time period may not be feasible, but deployment, if funded, will be.
21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness.				
	Contribute actively to the city-wide Thrive programme within Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced.				
	Implement anticipatory preventive care models supported within the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care.				

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	Understand and act on local research into patterns of referral, cross referral and best fit services for mental health in adults and older adults linked to general practice.	.			
	Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes.				

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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.	Amber green	This will be an important part of our work on promise 19, and efforts to reduce LOS. As outlined above the actions needed to make progress are understood: deployment has commenced.	Amber green	There is very substantial executive emphasis on this work and over coming months we'd expect to see change.
	Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber red	This is not currently our priority, and we'd anticipate baseline data is scarce. N&F resourcing this work during 25/26 – due in July – now revised to September.	Amber green	By the end of 2025 this input measure can be met.
23. Invest in residential care projects and programmes that support long-term care outside our wards: specifically supporting expansion of community forensic, step-down and step-up services.	Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations.	Amber green	We have made a start in Rotherham, and are trying to define final work packages elsewhere. Turning these opportunities into bed flow that impacts acute care needs further grip.	Amber green	Strong buy in from clinicians and partners – and work can be taken forward within the auspices of HQTC. Will need diligent oversight to avoid atrophy.
	Expand the scale of our residential forensic rehabilitation service.	Green	Additional capacity will open by October – and a wider review of role and function is underway.	Green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support. We did not obtain national funding but are next step is to bring all partners together at Tickhill Road under the auspices of the HWBB.	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 2 years to deliver.
24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.	Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. Some uncertainty over what drives positivity. We might expect the 2024/5 NETs survey to show some deterioration.	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 our principle difficulty (retention exemplar work needs to be effective to sustain seniority within disciplines over time) ie retirement risk.
	Trust meets expectations applied through national Long Term Workforce Plan roll out.		We may pause monitoring of this measure unless the operating plan guidance sheds light on the national future of these plans.		Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)
	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received). Social work assessment due in 2025.	Amber green	No identified reason why assessment outcomes would change over coming period, albeit some emerging concerns among postgraduate medical education which we will test in October.
25. Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	Obtain Real Living Wage Foundation accreditation in first half of 2025.	Green	Engagement started some time ago. Components required all being taken forward and visible within corporate delivery reviews.	Green	For summer 2025 we are confident of achieving accreditation unless external intrusion into our pay plans.

Promise	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
26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We have completed the work on both back pay and RLW for implementation to the timetable agreed with the Board.	Green	As above.
	Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).	Amber green	Clear plans developed during 2024. Implementation deadlines are clear and being met but some supply chain issues to resolve in Q1.	Green	Measure defined, suppliers aware. Food and travel most challenging areas to execute, albeit both consistent with P27 agenda.
	Implement suite of policies and practice to Kick Racism Out of our Trust.	Amber green	The agreed plan has had difficulty being deployed, and audit review criticised the diversity of approaches taken. This is largely addressed but rapid action is needed in Q1.	Amber green	Practice as well as policy change needed, but visible start made and weaknesses caught in time.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber green	Some positive movement within the 2024 staff survey results when compared to 2023 and to peers. Further work needed to deliver in 2025 survey on which the success measure will be based. However, there are some adverse indications in our recent quarterly HR data.	Amber red	A complex and longstanding issue, which, as August 2024 illustrated, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues.
	Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Amber green	There is strong commitment to the measures contained in NW accreditation: work needed now to look across excluded groups for relevant assessment tools.	Amber green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Tackle our gender pay gap.	Green	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Green	We are increasingly confidence of delivering this measure moving into 2025/26.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Amber red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our estate plan.	Red	Estimated £18m investment is not entirely foreseeable, and we are working through what may be possible as an alternate to the heat pump route to gas reduction.
	Agree and deliver specific contribution to local authority climate change plans.	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in due course this work will need to be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are doing what is asked. The plan may give rise to a larger ask in time.
	Change service models for patients and staff to reduce travel required by 2027.	Amber red	A plan to achieve this, and to scale ‘this’, is being developed during Q1. Our ‘remote’ policy and practice will be crucial to success. A positive climate adaptation day has moved forward thinking inside teams as well as at corporate level.	Amber green	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 25-26-27.
28. Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring	Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Amber green	This is very much a well led measure and we would expect to succeed again in 2024/25

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
investment and employment to our local community.	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. The Trust is now hosting EMRI, which further contributes to our aspirations.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Board and Committee reporting – August 2025 to March 2026	**Agenda Item**	Paper W
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 July 2025

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

The Trust's Operating Framework provides structure and clarity of role for the Board and its Committees – agreed terms of reference set out that clarity. Previously agendas were developed against a workplan but typically detailed agenda setting very much focused on the next meeting only. In order to reduce the time spent undertaking these planning meetings and to plan for the forthcoming meetings of the Board and its Committees, giving all members maximum notice of agenda items, the schedules attached outline the planned agenda items (excluding the standing items) for the meetings of the Board and four Committees through to the end of the financial year, ensuring the key components within the terms of reference are covered. Of course, additional items may be suggested and considered, albeit there will be a corporate check of whether such items are covered by the terms of reference. Any variation (addition or deletion) to these schedules should be minimal during the year. A programme to create a rolling update will be introduced to ensure that attention is always four or five meetings in advance.

What this helps all Board members to collaborate to do is to look across forward agendas and explore what might be being missed or overlooked – or indeed duplicated.

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

None.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the work schedules for the Board of Directors and four Committees for the remainder of the financial year.

Alignment to strategic objectives (indicate those that the paper supports)	
Business as usual	
Alignment to the plans: (indicate those that this paper supports)	
Estates plan	X
Digital plan	X
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

N/A

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

None

System / Place impact (advise which ICB or place that this matter relates to)

None

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

Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
Appendix 1 - Planned agendas for Board and four Committees through to the end of the financial year 2025 – 2026							

Board and Committee reporting – August 2025 to March 2026

1. Background

The Trust's Operating Framework provides structure and clarity of role for the Board and its committees, as set out in each respective terms of reference. Key focus for the committees would be on four roles: statutory compliance, plan delivery, partnership duties and matters delegated by the Board

2. Situation

Previous committee agendas were developed against a workplan but through a frequent set of meetings that focused very much on the next meeting only. The Board and its committees require future focus to overwhelmingly be on strategy and multi-year delivery.

3. Future Reporting

In order to reduce the time spent undertaking these planning meetings and to plan for the forthcoming meetings of the Board and its committees, giving all members maximum notice of agenda items, the schedules set out in Appendix 1 outline the planned agenda items (excluding the standing items) for the meetings of the Board and four committees through to the end of the financial year.

Any variation to these schedules should be minimal during the year. A programme to create a rolling update will be introduced to ensure that attention is always four or five meetings in advance.

It is acknowledged these workplans may, when and where necessary, be added to as matters emerge or escalate during the year that require the Board's attention or decision. These may be unplanned matters, but they may also be current matters that need to continue based on current work

In addition, there is an intent to continue a thematic focus for future Board's meetings starting in July with an 'Education' focus. Over the coming weeks, proposed topics will be identified.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the work schedules for the Board of Directors and four Committees for the remainder of the financial year.

Philip Gowland, Director of Corporate Assurance
18 July 2025

Appendix 1

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Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

September 2025		November 2025		January 2026		March 2026	
Item	**Lead**	**Item**	**Lead**	**Item**	**Lead**	**Item**	**Lead**
Patient story		**Staff story**		**Patient Story**		**Staff Story**	
Research & Innovation Plan	Diarmid Sinclair	Promise 3 Update and evaluation plan	Steve Forsyth	Final revenue and capital plans for 2026/27	Toby Lewis and D o F/E	Contract submissions with commissioners	Toby Lewis
Medium financial Plan	Izaaz Mohammed	Estate Plan funding	Toby Lewis	CQC Self Assessment – Gaps to Good	Steve Forsyth	Promise 14 Delivery Update	Richard Chillery
Promise 1 – Peer Support Workers	Toby Lewis	Well Led	Philip Gowland	HQTC Closure Report	Toby Lewis	CQC Readiness: Well-Led (external commissioned review)	Phil Gowland
SDR – intended review of10 year plan	Phil Gowland	Promise 5 Forward look	Toby Lewis	Anti-Racism Action Plan – Closure Report	D o POD	Promises planning for 26/27	TBC

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NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

September 2025		November 2025		January 2026		March 2026	
Item	**Lead**	**Item**	**Lead**	**Item**	**Lead**	**Item**	**Lead**
Complaints and Care opinion Q1 lessons learned	Steve Forsyth	Freedom to Speak Up	James Hatfield	Review of Trust People Council (12+ months)	Dave Vallance	Complaints and Care opinion Q2/3 lessons learned	Steve Forsyth
Neurodiversity position	Toby Lewis / Richard Chillery / Jude Graham	HDU / community rehab services – Go live update		Promise 2 – Carers Plan: Look into 26/27	Steve Forsyth	Audit Plan 26/27	Philip Gowland
EPRR Self Assessment pre peer test	Richard Chillery	Promise 14 Delivery Update	Richard Chillery	Look back on Regulation 28 Letters (since 2023) to the Trust and Peers	Diarmid Sinclair / Steve Forsyth	Always Events update and forward look	Steve Forsyth

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NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

September 2025		November 2025		January 2026		March 2026	
Item	**Lead**	**Item**	**Lead**	**Item**	**Lead**	**Item**	**Lead**
		Internal Audit Appointment	Philip Gowland	Safe Staffing beyond Nursing	Jude Graham / Diarmid Sinclair / Steve Forsyth / D o POD	LDO Review, evaluation and succession plan	D o POD
		Apprenticeship Levy 25/26 forecast and actions	D o POD			Governance of Out of Area Placements 26/26	Toby Lewis
		Always Events Go Live	Steve Forsyth				

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AGENDA

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

FINANCE, DIGITAL AND ESTATES COMMITTEE

August 2025	
Item	**Lead**
Finance Medium Term Finance Plan – 2026 to 2027 Savings Plan Development	Izaaz Mohammed
Finance National Cost Collection Exercise	Izaaz Mohammed
Digital Digital Enabling Plan 2023 – 2028	Richard Banks
Digital Cyber Security	Richard Banks
Estates Estate Enabling Plan – Frailty Centre of Excellence tender options and funding considerations	Izaaz Mohammed

October 2025	
Item	**Lead**
Digital Digital Enabling Plan – digital engagement with patients supporting 4 week waiting times	Richard Banks
Digital DSPT Update Report	Richard Banks
Digital Information Quality Work Programme	Richard Banks
Estates Estate Enabling Plan – Communication Plan	Izaaz Mohammed
Estates Health and Safety Act Compliance – Air Quality, Legionella, Fire Safety	Izaaz Mohammed

December 2025	
Item	**Lead**
Finance Medium Term Finance Plan – 26/27 Savings Plan Development Update	Izaaz Mohammed
Finance Trust Procurement Function Development	Izaaz Mohammed
Digital Digital Enabling Plan – Evaluation of Artificial Intelligence Pilots	Richard Banks
Estates Estate Enabling Plan – Rotherham Considerations	Izaaz Mohammed
Estates Estates Maintenance Function – Sustainability and Future Options	Izaaz Mohammed

February 2026	
Item	**Lead**
Digital DSPT update	Richard Banks
Digital Cyber Security	Richard Banks
Digital Clinical Coding Audit Report	Richard Banks
Digital Information Quality Work Programme 2025-26	Richard Banks
Estates Estates Enabling Plan – Disposal Strategy	Izaaz Mohammed

AGENDA

Rotherham Doncaster and South Humber NHS Foundation Trust

PUBLIC HEALTH, PATIENT INVOLVEMENT & PARTNERSHIPS COMMITTEE

September 2025		November 2025		January 2026		March 2026	
Item	**Lead**	**Item**	**Lead**	**Item**	**Lead**	**Item**	**Lead**
Promise 2 Unpaid Carers	Steve Forsyth	Promise 6 – Poverty Proofing	Jo McDonough	Promise 15 – Integrated Neighborhood Teams	Toby Lewis	Promise 20 – Virtual Care Models	Diarmid Sinclair
Promise 5 – Community Involvement	Paula Rylatt	Promise 12- Rurality	Vicky Clare	Promise 21 – Primary Care Networks and hyperlocal	Jo McDonough	Promise 28 – Extend scale of research	Diarmid Sinclair
Promise 10 – Inclusion health - Homelessness	Toby Lewis	Promise 17 – School Readiness	Roberta Radcliffe-Bird	Aspire Partnership	Richard Chillery	Flourish	Phil Gowland
Eating Disorders Collaborative	Jo McDonough	Flourish Partnership	Phil Gowland	Partnership Scorecard	Jo McDonough	Partnership Scorecard	Jo McDonough
Partnership Scorecard	Toby Lewis	Partnership Scorecard	Toby Lewis	Joint Strategic Needs Assessments	Jo McDonough	HI Data report	Jo McDonough
HI Data report	Jo McDonough	HI Data report	Jo McDonough	Patient and carer race equality framework (PCREF)	Jo McDonough	-	-
-	-	Health and Wellbeing Board Priorities – North Lincs	TBC	-	-	-	-

AGENDA

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

People and Organisational Development Committee

August 2025	
Item	**Lead**
Biannual report on CPD Spend overview/Training Needs Analysis	Clare Almond
WRES Annual submission	Jayne Collingwood
WDES Annual submission	Jayne Collingwood
Guardian of Safe Working Hours Report	Dr Babur Yusufi
RIDDOR	Steve Forsyth

October 2025	
Item	**Lead**
Promise 26	Jayne Collingwood
Engagement including Staff Survey and Pulse Check	Leanne Young
Apprenticeship Levy and Placement Delivery	Clare Almond
FTSU/Complaints and Employee Relations data triangulation	James Hatfield/Clare Almond
Leadership offers and ROI	Jayne Collingwood

December 2025	
Item	**Lead**
Trust People Council	Dave Vallance
People Promise Theme report covering vacancies, turnover, volunteers, local recruitment, Peer Support Workers	Lisa Earnshaw
Real Living Wage Annual update and next steps	Carlene Holden
Training Needs Analysis 26/27 plans	Clare Almond
Staff Survey and Pulse update – 2025 campaigns	Leanne Young

February 2026	
Item	**Lead**
Biannual report on CPD Spend overview/MAST	Clare Almond
Trust People Council	Dave Vallance
Organisational Design and Effectiveness 2026/27 plans	Jayne Collingwood
Promise 26 – review against delivery plan	Jayne Coliingwood
Work Experience	Clare Almond

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AGENDA

NHS
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QUALITY COMMITTEE

September 2025	
Item	**Lead**
Safety Ligature Report – what has change	Steve Forsyth
Safety Patient Safety Escalations	Steve Forsyth
Experience Patient Feedback	Steve Forsyth
Quality Promise 16	Steve Forsyth
PSIRF E&L plan integration with PSIRF	Steve Forsyth
PSIRF Mortality Report	Diarmid Sinclair

November 2025	
Item	**Lead**
Safety Peer reviews mid-way review	Steve Forsyth
Safety Patient Safety Escalations	Steve Forsyth
Experience Patient Feedback	Steve Forsyth
Quality Promise 4 and 5 update	Steve Forsyth
PSIRF Mid-year review of the PSIRF approach	Steve Forsyth
PSIRF Mortality Report	Diarmid Sinclair

January 2026	
Item	**Lead**
Safety National report benchmarking – GMMH and NHFT	Steve Forsyth
Safety Patient Safety Escalations	Steve Forsyth
Experience Patient Feedback	Steve Forsyth
Quality Promise 7/365 working	Steve Forsyth
PSIRF PSII presentation	Steve Forsyth
PSIRF Mortality Report	Diarmid Sinclair

March 2026	
Item	**Lead**
Safety Patient Safety Escalations	Steve Forsyth
Experience Year review and learning across all directorates	Steve Forsyth
Quality End of year promise impact and what next?	Steve Forsyth
PSIRF What have we learnt – year review	Steve Forsyth
PSIRF Mortality Report	Diarmid Sinclair
-	-

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper X
Sponsoring Executive	Philip Gowland, Board Secretary and Director of Corporate Assurance		
Report Author	Philip Gowland, Board Secretary and Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 July 2025

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

The Board received at its May 2025 meeting the Strategic Delivery Risks in a new format, noting the recent internal audit report on strategic risk management and the forward plans in terms of regular engagement with executive leads and the tri-annual reviews with the Audit Committee Chair / Director of Corporate Assurance.

It acknowledged the forthcoming publication of the NHS 10-year plan and the need to take the opportunity to reflect on its impact on the Trust, its Strategy and the SDRs. The Trust's Strategy remains the clear focus of the Trust until 2028 and whilst the now published 10-year Plan is indicatively pointed in the same direction, there is the need to take the time to digest and understand its impact fully so that any alteration or adjustment is with a clear basis.

Whilst the current five SDRs remain, the paper sets out the progress made with respect to controls and assurances. Risk owners remain cautious about hitting the target scores at year end 2025/26. This will be a key feature of upcoming reviews led by the author and Audit Committee chair.

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

None.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and NOTE the update position for each SDR.

NOTE the next steps outlined in the report to further refine and enhance plans to mitigate these risks

NOTE the intended review of SDRs following the full consideration of the NHS 10 year Plan

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x
SO2: Create equity of access, employment, and experience to address differences in outcome	x
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	x
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x
Business as usual	x
Alignment to the plans: (indicate those that this paper supports)	
Digital plan	x
People and teams plan	x
Quality and safety plan	x
Equity and inclusion plan	x
Education and learning plan	x
Research and innovation plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)				
People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
	Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
SDR1, SD2, SDR3, SDR4 and SDR5
System / Place impact (advise which ICB or place that this matter relates to)
All SDR in the paper are set within an external (system/place) impact / requirement for engagement.

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

Appendix (please list)
Individual Strategic Delivery Risk forms are in the Annex to the Report.

Strategic Delivery Risks

1. Background

1.1 The Strategic Delivery Risks are those risks that the Board has determined as having most potential to disrupt the delivery of the strategic objectives. These are different from the risks manged via the range of risk registers (operational risks). The latter reflects the challenges to the organisation's functioning on a year by year, week by week basis. It is a live document that will show identification, mitigation and escalation of key risks faced by teams across the organisation. In contrast, the SDRs focus on factors which could interrupt delivery of the organisation's objectives over the medium term. These are also risks that the Board has a unique ability to solve.

1.2 The Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect.

1.3 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)

1.4 The Trust's new approach to strategic risk management was subject to an internal audit review in Q3 by 360 Assurance and received a positive (significant assurance) outcome with recommendations to the Trust, relating to format, actions, version control, review of the risks and link to the Risk Management Framework.

2. Strategic Delivery Risks

2.1 The Board of Directors will recall the staged process through which it identified and agreed the five strategic risks – the risks that most significantly could impact on the ability of the Trust to deliver its Strategy (and its strategic objectives). Essentially a 'long list' of some forty plus risks were initially identified and subsequently reduced in number to the final five. The second audit recommendation seeks to afford the opportunity for the Board to review the risks and to ensure they remain those that most significantly could impact on the ability of the Trust to deliver its strategy (and its strategic objectives) Whilst opportunistic to consider the risks, the process of identification was robust and comprehensive and the five risks were identified against the long term delivery of the strategy, that is to say they were the most significant and they were expected to take time and effort to address.

2.2 The Internal Audit report recommended that the Board of Directors considered the risks ensuring that they remained those that had the most opportunity to disrupt or prevent the progress with the delivery of the Clinical and Organisational Strategy. In the last report to the Board (May 2025) it was noted that the NHS 10-year plan was due to be published and that it may have implications for the Trust and impact on both what the Trust was trying to or required to achieve and / or the risks to achieving that.

2.3 The NHS 10-Year Plan is now published. The Trust will take some time to reflect and digest and to fully understand the implications (see Chief Executive's Report on today's agenda). Given that the Plan and the Trust's Strategy are not, in the broadest sense, at odds with one another, the likely impact or change required in the SDR is initially considered to be limited. But by the time the Board meets again in September, that review and assessment will be complete and a formal recommendation in relation to the SDRs will be presented.

2.4 Review and monitoring work will continue through

- 2.4.1 Individual executive leads
- 2.4.2 Board Committees (SDR1 and SDR3 were both presented to and discussed by PHPIP Committee in July 2025)
- 2.4.3 the tri-annual reviews with Executive leads by the Audit Committee Chair and Director of Corporate Assurance – July 2025. These meetings will identify progress but seek to confirm the likelihood of achievement of the target scores by March 2026 with each lead director.
- 2.4.4 Board of Directors

2.5 The current position in respect of each SDR is presented in Appendix 1. The work to address the audit recommendations has afforded an opportunity to review the content such that it is now a priority action, to be concluded by the end of Q2, that actions / controls are confirmed and the respective assurance process is identified to demonstrate that those controls are operating. Once this is complete a more insightful assessment of the risk score, the next actions and path towards mitigation will be achieved, in line with a specified risk appetite level. A further report to the Board of Directors will be made in September 2025.

3 Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the update position of each SDR.

NOTE the next steps outlined in the report to further refine and enhance plans to mitigate these risks

NOTE the intended review of SDRs following the publication of the NHS 10 year Plan

Philip Gowland, Director of Corporate Assurance
18 July 2025

SO1: Nurture partnerships with patients and citizens to support good health										
What could get in the way? **The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027								
	because	of the leadership's inability to identify, communicate and engage							SF	PHPIP
	then	it will lead to a loss of confidence locally and likely non-delivery of SO1								
Risk Score	Current (July 2025)					Target (March 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – however, the report noted some further work (Gap) to finalise and embed stakeholder management processes and reports, which is due to be responded to by 31 August 2025.
Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power' — Both cohorts now launched.	Feedback loop: (Gap)Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026. Of particular relevance is the response to two questions: 1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities? and 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community *Baseline data is now available for the two cohorts and the initial data points have been shared at the June LDO Steering Group. Further detailed analysis now commences based on the questionnaire review data points and the structured interviews will also be scheduled*

Educating our Staff: Induction - Revised induction process; 5-day event that includes a focus on introducing colleagues to the Trust and its communities.	Feedback loop: Evaluation of induction asks for participants to respond to the question, *'I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) *The evaluation will be presented in the Autumn following the anniversary of the new Induction programme alongside the 360 Audit*
Educating Our Staff: Learning Half Days (Gap) *forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the mitigating actions needed.*	(Gap) – agreed mechanism needed for capturing the outcome and evaluation of activities that feature within the LHD programme. *Discussion at the Education and Learning meeting in June 2025, paper to CLE in June 2025 and a paper to Board in Mach 2025. This will be further enhanced following the appointment of the coordinator and the development of the learning library alongside the trialling of different delivery models for inpatient areas.*
Cultural Shift: Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed.	The LDO features as learning outcome *2: Enhance our ability to lead change and deliver improvements (Gap) As per the 1st point and a meeting has been scheduled for late July 2025 to further explore the measurements associated with this. The LDO provides have now also included a question as part of the evaluation questionnaires to capture the views and ratings of Line Managers who also have delegates on the programme.*
Cultural Shift: Recruitment and appraisal processes that focus on the appointment based on alignment to the Trust's Values	*(Gap)* Confirmed process to ensure processes effectively include this 'test' to ensure colleagues have values that align to those of the Trust *This will be explored via Trust People Council and also the annual Staff Survey. In addition we are triangulating a report on Employee Relations cases, FTSU and Complaints to be presented to POD which will further support analysis in this area.*
Representation within our colleagues: A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve – this would include number of as well as diversity and representation within these cohorts.	*(Gap)* Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities. *We are currently in the processing of recording our volunteers on ESR to support the production of the demographic data, which will then be analysed against the current workforce data and also the ONS* Improved WRES data *the WRES report will be reviewed and approved by the POD Committee in August, whilst some areas have improved we have also seen a decline in others – the detailed scrutiny will take place in August.*
Engaging our communities – seeking feedback Care Opinion launched (patients and carers)	Care Group Delivery meetings in 2024 and in May 2025 featured Care Opinion and Care Opinion within February 25 Board Timeout Led by CEO of Care Opinion. Council of Governors in June 2025.

	(Gap) Overarching analysis of responses via Care Opinion including those leading to action – *Quarterly updates will be presented to the Board from September 2025*
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 4 (Quality – Quality and Safety Plan) o Promise 5 (Board – Quality and Safety Plan) o Promise 6 (PHPIP – Equity and Inclusion Plan) o Promise 8 (PHPIP – Equity and Inclusion Plan) o Promise 10 (PHPIP – Equity and Inclusion Plan) o Promise 11 (PHPIP – Equity and Inclusion Plan) o Promise 26 (POD – People and Teams)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing Board of Directors – March/May 2025 – Promise 26
PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	Most recent July 2025
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion – Significant Assurance Internal Audit work on Induction – 25/26 audit plan

SO2: Create equity of access, employment and experience to address differences in outcome											
What could get in the way? **Challenges generating data and / or evidence to support interventions to address Health Inequalities**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	we do not execute plans to consistently create, use and respond to data inside our services and with others									
	because	our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities								RB	FDE
	then	this will lead to a lack of precision in how the Trust reshapes services									
Risk Score	Current (July 2025)					Target (March 2026)					
	I	4	L	3	12	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Data Availability: Health Inequalities – Reportable Data Sets of data relating to Promises. Identify a baseline position and detail planned further work across a range of data points including the establishment of targets (via Reportal 521 Health Inequalities Dashboard) (Pointed towards health inequality related promises 6, 7, 8, 10, 11, 12 and 17)	Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities. July 2025 marks the first significant change to date being reported including HI - Analysis provided to Strategic Development team of all in-scope IQPR metrics. DSD to present new paper to Board of Directors.
Data Quality	Information Quality Programme and reports to FDE noted structured and demonstratable process was in place. Kitemarking – (Gap) Current position Internal Audit report of IQPR (Significant Assurance) Internal Audit report on Waiting Lists (Significant Assurance – waiting list management / Limited Assurance – waiting list validation) Audit on Clinical Coding (Feb 25) FDE assured by the Clinical Coding Audit Report that robust processes are in place to facilitate the accurate application of clinical coding.
Educating our leaders: Digital Needs Survey (completed in Q2)	

Data Saves Lives Campaign (Launched 26 November 2024) – 'Giving health and care professionals the information they need to provide the best possible care'. Series of posters have been distributed and series of three Vlogs launched (December 2024) Key messages in December including Improving trust and transparency; Accurate and timely recording of data / Knowledge is Power; The benefits of using the Yorkshire & The Humber Care Record; How data flows through the system/organisation. An 'Ask me anything' session took place in January 25. Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities. Specific related events to date: October 2024: establishing mental health and community use cases associated with the use of the Yorkshire & The Humber Shared [clinical] Record; November 2024 : New personalised care visualisation (20 attendees in total). The personalised care visualisation is a new development for PROMs and 4ww / Saving events in SystmOne (14 attendees in total). Accurately recording both clinical consultations of different types, as well as administration events / Communicating with patients digitally (40 attendees in total). Use of health inequalities data for frontline staff: Jan 2025: SMI physical heath checks new visualisation overview (joint session with Change & Transformation) / Feb 2025: shared care records, patient care access considerations (joint session with Information Governance); SystmOne roadmap 25/26	Summary outcome reports provided to Digital transformation Group and used to inform both the Data Saves Lives programme and also considerations for both bespoke and broader training, particularly associated with aspects around the requirement to interface with our electronic patient record, SystmOne. Post Data Saves Lives Campaign, 'business as usual' plan agreed. Incorporates Q3/Q4 evaluation and identifies changes and enhancements to systems training offer. (Gap) Identification of key responses from colleagues to the educational efforts to demonstrate learning and great understanding. Board Timeout June 2025 – NHS Digital Board session facilitated by NHS Providers.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 6 Poverty Proofing (PHPIP – Equity and Inclusion Plan) o Promise 8 Inequalities (PHPIP – Equity and Inclusion Plan)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing PHPIP Committee – July 2025 - paper on promises data presented. Committee now assured with the progress made and the dashboard now in place.

FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	

SO3: Expand our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services.				
What could get in the way? **Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies**	As a Strategic Delivery Risk:		**Lead Exec**	**Board Committee**
	If	we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level		
	because	there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive	TL	PHPIP
	then	we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.		

Risk Score	Current (July 2025)					Target (March 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – report noted some further work (gap) to finalise and embed stakeholder management processes and reports which is due to be responded to by 31 August 2025..
Regular and well established touchpoints within each of the three places with GP representatives: • Individual Practices • PCNs • Federations Via GP Liaison Role – programme of visits established to every practice with touchpoints into PCNs and the local Federations.	Feedback mechanisms with GPs are established and embedded – these will be used to confirm strong alignment on Primary and Community MH services and adult and children's community nursing. Engagement (differing levels) with circa 90% of practices. Initial survey how practices rate the current level of integration, collaboration and partnership with

	RDaSH of practices identified score of 2.52 (out of 5) – benchmark to assess future progress.
Facilitate insight into General practice within: 1. Senior individuals: via Dr Richard Falk – Non-Executive Director / Dr Dean Eggitt – GP Partner Governor / Laura Sherburn – Primary Care Doncaster Chief Executive (route to CLE) / GP Liaison role (within the Strategic Development Team) 2. *Care Groups:* GP related appointments into Care group structures (7 / 13 Care Group Directorates are community based – these leaders are especially important in the development and work supporting the mitigation of this risk.)– 2 Medical Leads and the Nurse Director in the Physical Health CG appointed. *(Gap) Appointment to Physical Health Care Group Medical Director of Primary Care / GP (Interviews scheduled 18 July 2025)* 3. Wider Workforce: A: Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care. LDO Launched. Cohort 1 commenced January 2025; Cohort 2 launched in April 2025. B: Learning Half Days (LHD) programmed to align to known GP training schedules such as 'Target' in Doncaster (i.e. Wednesday afternoon training sessions across GPS in the city to afford joint training and engagement)	(Gap) Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) Cohort 1 launched January 2025 / Cohort 2 launched April 2025 This feedback will secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care and other partners in particular via the following research and evaluation question. *Has the LDO improved RDaSH Leaders' engagement with each other and the community* Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026.
Practical Programme of Change: Agreed programme of change with Primary Care Colleagues that addresses the issues that they raise via other routes, in particular via GP Liaison Role. CLE (Dec 24) identified four areas of focus + additional fifth subsequent. 1. Remove any and all practices which prevent our clinical teams within RDaSH making cross referrals or transferring care. 2. Move to simple electronic forms for all referrals, with prompts which ensure that mandatory information is provided: 3. Introduce simple, coherent routes of communication to our clinical teams from primary care, and provide 'backdoor' contact models to permit escalation senior clinician-senior clinician for any patients where there is a concern. 4. Audit and justify any practices which tend to pass work or tasks to GPs that could be done by the secondary care team.	(Gap) Comprehensive action plans within Care Groups and reporting mechanism to ensure agreed timescales are achieved and have the intended benefits. Progress being made with significant next step imminent in respect of number 5 and the publishing of waiting times.

5. Waiting time information – Providing up to date waiting time information and making it simple to patients to find out their place in queues to reduce purely administrative appointments in primary care.	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 12 Rurality (PHPIP - Equity and Inclusion Plan) o Promise 15 Neighbourhood teams (PHPIP - Equity and Inclusion Plan) o Promise 21 Hyper Local (PHPIP - Equity and Inclusion Plan)	Via Promises and Priorities Scorecard Paper E (Nov 24 PHPIP) – set out (for P12) – what needs to happen and by when to move to an Amber / Green position against each success measure. PHPIP return to this in Nov 25. PHPIP Committee – January 2025 – verbal item linked to P21 PHPIP plan to return to this in Jan 26. PHPIP Committee – March 2025, presentation GP Liaison role and work to date Board Timeout – April 2025. GP Liaison role and work to date
PHPIP Strategic Delivery Risk Report relating to the oversight and management of SDR3	Most recently at July 2025's meeting.

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 2025)					Target Score (March 2026)					
	I	4	L	3	12	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Staff Engagement (linked to necessary change and impact on staff) Unions and Staff Side – consultation / engagement processes with union and staff side reps to discuss and agree. (This will likely include revised 'standard' terms and conditions to create opportunity for more flexibility, changes to JDs to reflect new ways of working.) Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety	(Gap) Comprehensive mechanism for collation and reporting of feedback gained via: ○ Staff Survey ○ Pulse Check ○ Peer Reviews ○ Consultation responses ○ Responses via Unions and Staff Side Employee Relations indicators
Service provision (RDASH) Newly established High Quality Therapeutic Taskforce from January 2025 to take forward a range of issues and significantly support the delivery of 7-day therapeutic services within an inpatient and acute context. Data • Base line developed of number of discharges in relation to days of the week, and timing of discharges by wards	IQPR reporting improvements in • Waiting times – greater awareness and regular oversight of waits. Plan to publish on website. • Out of Area Placements – reducing in number • Delays in discharges • Utilisation of talking therapies

• "live" Flow Dashboard in place Enhance the Current Offer • enhanced discharges during weekdays using current infrastructure - includes using EDD's more consistently and appropriately • weekly meetings with senior nurses to review EDD (Q2) • complex CRFD forum with the 3 Local Authority Partners and 2 ICB Developing New Models • To ensure therapeutic discharges 24/7 are part of the inpatient improvement programme "the middle bit" (Q3 onwards) • Consider Pilot programme on one ward to test the ability, capacity and affordability of proposed changes.	And via 'live' Flow dashboard
Service provision - Alternative (others) Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis. (Gap) This will likely be in the form of an options paper to go to CLE in Q1, 2025/26) to consider below. - This may include better provision of the current crisis provision as a potential step down using 2 additional beds in Rotherham to test this - Co locates with partners who are already 24/7 (i.e. LA, acute, police) or extend hours (GP's) - Expansion of virtual offer, AOT and "remote working" - Outsourcing to community partners to abridge to RDaSH services - Future investment in a needed "step down provision" - Offer A Service With A 24/7 Assistant (expansion of virtual; apps?) Increase self-help services - with swift access to advice and support – enhanced community support and offer for those discharged in first 72 hours	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: This will include all linked to SO3 – Promises 13 to 17, but more specifically those linked to SO4 – Promises 18 to 23	Promises and Priorities Scorecard P19 Out of Area Placements – Board of Directors May 2025
QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk	

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations											
What could get in the way? **The Trust lacks the cultural capability and competence on wider issues**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027									
	because	We do not develop and practice the skillsets required to make change occur								CH	POD
	then	The Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees									
Risk Score	Current Score (July 2025)					Target Score (March 2026)					
	I	4	L	3	12	I	3	L	3	9	

Developing our Leaders	
Leadership Development Offer – circa 130 individuals inc 15 community leaders; Two cohorts are now underway Leaders Conference – circa 130 staff as the Top Leaders Cadre – September 2024 Learning Half Days for every member of the Trust commenced in September 2024. Induction (all new starters) – RDASH and our communities – Launched 28 October 2024 First Line Managers Training Scheme – Launched April 2025 'Wider leadership' proposals – B5+ / Very Senior Clinicians Revised appraisal process developed and implemented People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly	Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) (Gap) - This feedback will secure confirmation that our leaders have the necessary skillsets linked to the partnership work LEIPA Response LDO participant Self-assessment Induction Feedback and Evaluation - Specific question: *I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) Other mechanisms of feedback from leaders to demonstrate their increased competence and confidence regarding making change occur and adding social value.

Increased Capacity Fully utilising the apprenticeship levy (delivery of Promise 9) Fully recruiting to all posts – 97.5% Commitment to designated training budget – demonstrate increase in spending year on year Re-development of the Change function - complete	 May 2025: 80% utilised in 24/25; Forward plan developed to increase spend including levy transfer to community partners. July 2025: Current vacancies in CEX Report Annex (recruitment at 94.6%) 2025/26: Ringfenced training budget in place again.
Feedback Mechanisms From stakeholders regarding the approach of the Trust	Gap – structure, frequency of collation of related feedback mechanisms including: o Staff Survey / Pulse Check o 'Voice' Scorecard o Care Opinion o LEIPA (part of LDO) assessment o LDO participants self rating Reduction in Employee relations cases / matters
Consistent timely exit and delivery of **time bound projects**, and achievement of key measures with respect to the wider issues within the Strategy – inc the delivery of 'social value' and implementation of P25 where the use of local suppliers will contribute.	P25 – Real Living Wage accreditation received in July 2025.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 9 Apprentice Levy (PHPIP - Equity and Inclusion Plan) o Promise 26 Anti-Racism (POD – People and Teams Plan)	 Promises and Priorities Scorecard P9 – Apprenticeships – March 2025 P26 – Board of Directors March / May 2025
POD Strategic Delivery Risk Report relating to the oversight and management of SDR5	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper Y
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 July 2025

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

This report provides an update to the Board of Directors on the current operational risk profile, reflecting the organisation's transition to reporting risks in relation to defined appetite and tolerance levels. It therefore aligns with the updated Risk Management Framework and refreshed risk appetite categories and levels, which were approved by the Board of Directors in May 2025. These developments reflect ongoing efforts to strengthen the Trust's approach to risk oversight and to improve consistency and clarity in risk assessment and reporting.

Rather than focusing solely on extreme-rated risks, this report offers a broader overview of the total operational risk landscape, highlighting how risks are distributed across appetite, tolerance, and out-of-tolerance categories. It also confirms the position of risks previously reported as extreme, following recent recalibration and moderation. Whilst executive members are available to discuss any of the risks, it should be noted that in August and September all directorates will present their risk profiles to delivery reviews.

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

Risk Management Group (RMG) & CLE have considered the matters within the paper

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the operational risk report

NOTE the revised reporting thresholds based on risk appetite and the planned work to address the extended number of risks that are currently outside of appetite and tolerance

Alignment to strategic objectives (indicate those that the paper supports)	
Business as usual	x

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	x
Quality and safety plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	128
Patient care risk	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	220 / 292
External and partnership risks	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	152 / 158

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

Not applicable

System / Place impact (advise which ICB or place that this matter relates to)							
Not applicable							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
None							

1. Overview

1.1 Historically, operational risk reporting to the Board has focused solely on risks rated as extreme. This approach provided visibility of the most significant risks but did not reflect the broader operational risk landscape or how risks sit in relation to our defined appetite and tolerance levels.

1.2 This report marks a transition to a more comprehensive approach – not least as it also is provided in the month when we have transferred / implemented a new risks management system, part of the wider, new RADAR system. In terms of risk reporting to the Board of Directors, we are closing off the previous position by confirming where those risks previously categorised as extreme now sit against our current risk appetite and tolerance levels, following recent moderation and recalibration exercises.

1.3 Looking ahead, future reports to the Board will not be limited only to extreme risks but will focus on operational risks that are at, or approaching, thresholds outside agreed tolerance levels. This will ensure the Board has assurance not only over the highest-rated risks but also over those areas where risk levels may be emerging or escalating beyond what the trust deems acceptable.

1.4 This change aligns our operational risk reporting more closely with our risk appetite framework and will support better-informed decision-making and oversight at Board level.

2. Previously Reported Extreme Risks

2.1 As part of the transition to risk reporting aligned to appetite and tolerance levels, we have reviewed all risks previously escalated to the Board as extreme.

2.2 These risks have been reviewed by the Risk Management Group (RMG) and the Clinical Leadership Executive (CLE), both of which continue to support their current classification. A total of five risks were previously reported to the Board as extreme. Following the recent recalibration of risk scores across the organisation:

- Three of these risks now sit outside of appetite levels but remain within tolerance limits, indicating they are being managed but still require close monitoring.
- The remaining two risks are outside of tolerance levels pending further mitigation or resolution.

2.3 Details of these risks are listed in the table below:

Number	Directorate	Category - Sub-category	Description	Likelihood x Impact = Risk Score	Appetite	Tolerance Status
128	Doncaster Acute	People Risk - Planning & Supply	Due to challenges in recruiting and retaining sufficient medical staff, particularly within the Acute Directorate, and the emergence of new vacancies, there is a risk that patient care and safety will be compromised. Limited availability of consultant psychiatrist functions, including Responsible Clinician roles, may also result in a lack of clinical leadership, further impacting the quality of care across the Care Group.	4 x 3 = 12	Moderate Tolerance	Amber - Within Tolerance
220	Children's Physical Health	Patient Care Risk - Patient Experience	If waiting times for ASD and ADHD assessments remain above target, there is a risk that children and young people will receive delayed diagnoses, which may result in poorer educational and health outcomes, increased strain on the service and staff, failure to meet Strategic Objective Promises 8 and 14, reputational damage, and additional unfunded financial pressure on the Care Group.	5 x 3 = 15	Moderate Tolerance	Amber - Within Tolerance
292	Operations	Patient Care Risk - Patient Experience	If patient flow into and through the Mental Health inpatient units is not improved, there is a risk of continued reliance on out-of-area acute beds, which may result in poorer patient and family experience, increased wait times, and failure to meet national performance targets.	5 x 3 = 15	Moderate Tolerance	Amber - Within Tolerance
152	Neurodiversity	External and Partnerships Risk - Delivering our promises	Due to insufficient capacity to meet the demand for ADHD assessments, there is a risk that patients will remain unassessed, which may result in compromised wellbeing and health outcomes for patients and their families, adversely affect service delivery and staff wellbeing, jeopardize the Trust's ability to meet Strategic Objective Promises 8 and 14, and damage the Trust's reputation.	5 x 3 = 15	Low Tolerance	Red - Escalate
158	Neurodiversity	External and Partnerships Risk - Delivering our promises	Due to insufficient capacity to meet demand for Autism assessments in Doncaster and Rotherham, there is a risk that patients will remain undiagnosed, which may result in compromised health outcomes, negative impacts on patient and family well-being, and staff health and well-being. This also constitutes a breach of NICE guidance, threatens the Trust's ability to deliver Strategic Objective Promises 8 and 14, and damages the Trust's reputation.	5 x 3 = 15	Low Tolerance	Red - Escalate

3. Current Operational Overview

3.1 The current operational risk profile reflects a broader and more balanced view of risk exposure across the organisation, in line with our updated approach to reporting against risk appetite and tolerance levels.

3.2 We are now live on the RADAR system, which has fully replaced the previous Ulysses platform for recording and monitoring risks across the Trust. RADAR has been rolled out to all services, enabling staff to enter, update, and view risks in real time. It provides clearer visibility of risks across care groups and backbone services and improves how risks can be tracked and managed.

3.3 Of the 318 risks currently recorded across the organisation as at last review:

- **98 risks sit within appetite** and are considered controlled under the new definition.
- **158 risks sit within tolerance but above appetite**. These are not automatically treated as controlled and will require RMG approval, supported by evidence that controls are both effective and assured. The general approach for these amber-rated risks is to continue active management, with the aim of bringing them within appetite while ensuring they do not drift upward into red status.
- **61 risks are outside tolerance limits and are marked for escalation.** These reflect the highest levels of residual exposure and require prompt attention and targeted action to

4. Conclusion

4.1 Overall, this profile demonstrates that while the majority of operational risks are either within appetite or tolerable with active management, a significant proportion remains outside tolerance and requires focused attention. We anticipated this outcome, as it is the first time this approach has been applied across the trust, and the volume of risks identified outside tolerance does not, in itself, give cause for alarm. The shift toward reporting risks in relation to appetite and tolerance provides clearer visibility of where operational risks align with the organisation’s capacity and where further intervention may be required.

5. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report

NOTE the revised reporting thresholds based on risk appetite and the planned work to address the extended number of risks that are currently outside of appetite and tolerance.

Philip Gowland
Director of Corporate Assurance
15 July 2025